

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: _____ **Home State:** _____

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 an email option for your convenience but you the patient assume the risks in exchange for the convenience and speed of emails.

Evaluations are ONLY for those 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 coccyx book on Amazon.

AFTER completing and sending in this form, staff **will call you** to make your first appointment. 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.
 - Ideally send these in advance, or at least bring them to the initial visit with Dr. Foye.

"CONFIDENTIAL" COVER SHEET (If Health information is attached.) "Confidential Protected Health Information Enclosed": Protected Health Care Information is personal and sensitive information related to a person's health care. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. This may contain privileged and confidential information. It is intended only for the use of the individual(s) or entity(ies) named above. If the reader of this message is not the intended recipient, you are hereby notified that any review, dissemination, distribution or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the originals.

UNIVERSITY REHABILITATION ASSOCIATES (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 not 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 _____

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 _____

Name: _____
[Nombre y Apellido]

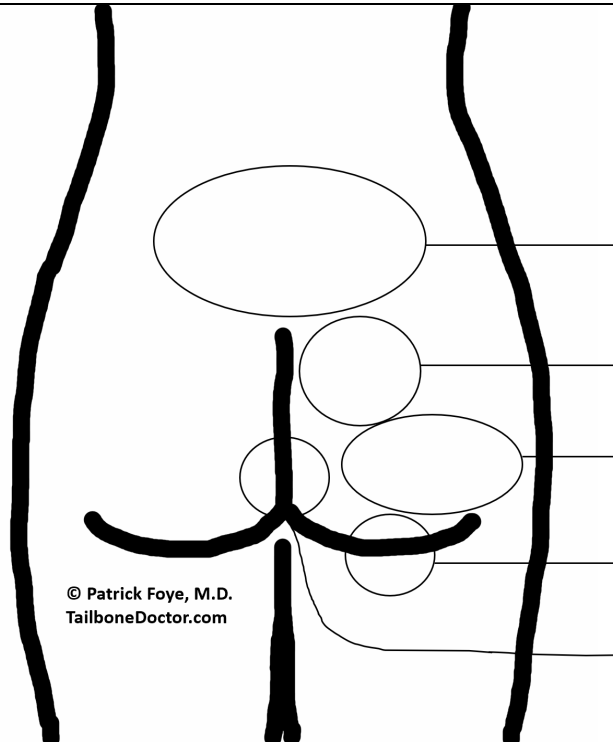
Date: _____
[Fecha]

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?]



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

BACK [DE ESPALDAS]

LEFT

RIGHT

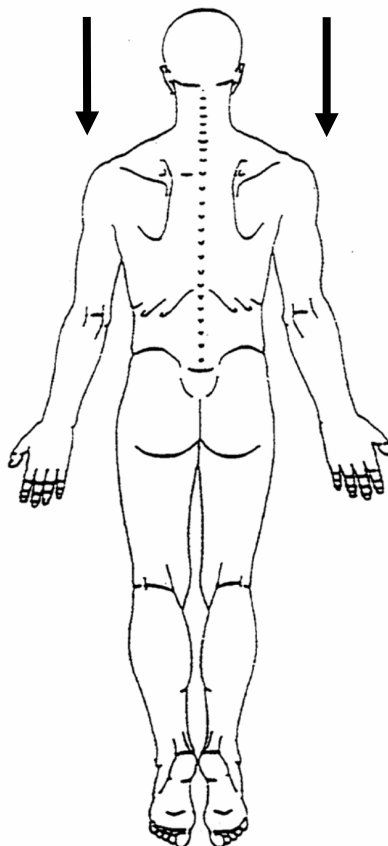
(Lado Izquierda)

(Lado derecho)

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

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: _____ Date of Birth: _____

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) ☐ Other skin issues there ☐ **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?

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

☐ Other cancers (explain):

If yes, what year was the cancer 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: Indicate if you have seen any of the following types of clinicians 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)			<input type="radio"/> Yes <input type="radio"/> No
Coccyx injection with STEROID (with fluoroscopy)			<input type="radio"/> Yes <input type="radio"/> No
Ganglion Impar (sympathetic nerve block)			<input type="radio"/> Yes <input type="radio"/> No
Epidural steroid			<input type="radio"/> Yes <input type="radio"/> No
Piriformis muscle			<input type="radio"/> Yes <input type="radio"/> No
Pudendal nerve			<input type="radio"/> Yes <input type="radio"/> No
Sacroiliac joint			<input type="radio"/> Yes <input type="radio"/> No
Facet joint			<input type="radio"/> Yes <input type="radio"/> No
Other low back / pelvic injections			<input type="radio"/> Yes <input type="radio"/> 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/taped radiology report (**important**).

	Done?	Dates	If done, Can you provide to us the:	
			Radiologist report?	Actual images? (computer CD)
LumboSacral Spine (X-ray)	<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
LumboSacral Spine (CT scan)	<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
LumboSacral Spine (MRI)	<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Coccyx (X-ray) withOUT seated	<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Coccyx (X-ray) seated/dynamic	<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Pelvis (X-ray)	<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Pelvis / Coccyx (CT scan)	<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Pelvis / Coccyx (MRI)	<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Bone Scan	<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> 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:
<input type="checkbox"/> Ibuprofen Motrin Advil <input type="checkbox"/> Naproxen Naprosyn	<input type="checkbox"/> Neurontin Gabapentin <input type="checkbox"/> Lyrica Cymbalta	<input type="checkbox"/> Percocet / Roxicet <input type="checkbox"/> Oxycodone <input type="checkbox"/> OxyContin <input type="checkbox"/> Tylenol /w Codeine (T#3)	<input type="checkbox"/> Lidoderm Lidocaine <input type="checkbox"/> Flector Diclofenac <input type="checkbox"/> Voltaren gel	<input type="checkbox"/> Tylenol <input type="checkbox"/> Tramadol Ultram	

Allergies (check if positive): ☐ Medical contrast | ☐ Iodine | ☐ Lidocaine | ☐ NONE= No-Known-Drug-AllergiesList 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: _____ feet _____ inches. 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:

	<i>If you have any of the symptoms listed below...</i>	<i>Then see this type of Specialist:</i>
<u>Rectum/anus:</u>	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.
<u>Urinary/Bladder:</u>	Any urinary incontinence, urgency, pain with urination, other urine symptoms	See: Urologist.
<u>Cancer</u>	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.
<u>Pudendal nerve:</u>	Any pain, tingling, or numbness in the genital region. Pain with sex.	See: Urologist or Gynecologist.
<u>Pilonidal cyst</u>	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.
<u>Infections:</u>	Any fevers/chills, local skin redness/warmth/swelling/discharge/odor/abscess:	See: Primary doctor or Infectious Disease
<u>Mental Health:</u>	Depression, Anxiety, Hopelessness, Thoughts of harming yourself.	See: Psychiatrist, Psychologist.
<u>Pelvic Floor:</u>	Any pain/difficulty with sex, urination, bowel movements, pelvic muscle pain, etc.	See: Pelvic Floor Physical Therapy
<u>OB/GYN</u>	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 ideally please send these in now, or at least get them yourself for now, to bring to your Initial Evaluation.
- We need them to be on a computer CD.
- We can not accept USB's or portal links for these.

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

- We are HAPPY to see you here EITHER way: whether you are In-Network or Out-of-Network.
- In-Network: This doctor/office is In-Network with Medicare, essentially all versions of Medicaid in New Jersey, New Jersey Charity Care (through clinic), and various other insurance plans. (If one of these applies to you, then you can ignore everything below since essentially it does not apply to you.)
- Out-of-Network: we also see patients from all around the country/world as "Out-of-Network."

Updated: effective for dates-of-service since November 1, 2023.

1. Price Transparency and Discounts for Out-of-Network patients.

- If you are Out-of-Network, we can tell you in advance most or all of the costs for your medical care in this office. This way, it is not a 'surprise' if you are Out-of-Network or the costs of that.
- Out-of-Network patients receive a discount called "**Prompt-Pay**".
- This helps to make your medical costs here **predictable** and more **affordable**.
- This also helps to make your medical billing here **less complicated**, since our office does not bill your insurance company.
- **Your out-of-pocket payment is due on the date of service.**
- **Your insurance will NOT be billed.**
 - Instead, after you pay you will receive a detailed **RECEIPT** that shows how much you paid and shows all of the medical services (with billing codes) that you paid for.
 - Then (if you want to) you can submit that receipt yourself to your own insurance company to ask if they will reimburse you or count those expenses towards your out-of-pocket deductible.
 - If one bill for these specific services somehow gets sent to you or your insurance company in the initial days before your payment is processed/applied to your account, you can ignore it or call Customer Service # 800-424-7782.
- **The following are the typical amounts that Out-of-Network patients pay Out-of-Pocket on the date-of-service:** (current as of November 2023, but subject to change in the future)
 - **Initial Evaluation: \$278.**
 - **Follow-Up Visit: \$214.**
 - **Coccyx injection: \$720.** (ganglion-impar + steroid injection = our most common injection)
 - Our less common coccyx injections: \$336 (test injection), \$406 (coccyx steroid injection), \$979 (coccyx nerve ablation).

2. Seated x-rays: (These x-rays usually **ONLY** happen on the FIRST in-person visit here): These bills are handled separately, NOT by our office.

- **University Hospital x-rays:** The sitting-versus-standing coccyx x-rays done here in our building are done at 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.) When you go for x-rays, you should provide them with your insurance information, since your insurance company might pay for the x-rays. The bill for x-rays is from "University HOSPITAL". It is not from our office. You can pay them your portion of the bill.
- **Radiologist:** For the x-rays that you have done via University Hospital, there will also be a charge for the radiologist who reads those x-rays. This is **typically less than \$100**. Your insurance company may pay some or all of that. If there is an unpaid balance, the radiologist bill will come to you from "**UPA: University Physician Associates**". UPA will expect you to pay your portion of that bill. It is not from our office.

Note: this is not formal or rigid advice about your medical bills/insurance. Every insurance plan is different. Our office staff can provide this general information and answer various billing/insurance questions, and patients can also get information directly from their insurance company if such details are needed. You acknowledge that medical care here is not a medical 'emergency' and it is not a 'surprise' to you if you are out-of-network. The ultimate decision 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 your insurance.

Whether your insurance is in-network or not, YOU SHOULD SEEK THE BEST CARE.

Patient Name: _____ Type or Sign Name: _____ Date: _____

WHAT TO EXPECT DURING YOUR FIRST IN-PERSON VISIT

to Dr. Foye's Coccyx Pain Center, Rutgers: New Jersey Medical School.

We look forward to seeing you in-person so that Dr. Foye can diagnose and treat your tailbone pain. Below is important information to help your first visit here go smoothly for you.

To have your very important sitting-versus-standing coccyx x-rays done, you will generally need to arrive early = ONE HOUR before your appointment with Dr. Foye. Your appointment times will be Eastern time = NYC time zone.

We can usually do the following all on the same single day that you come here, in the order listed here:

1. **Arrive at this address: 90 Bergen St., Newark, NJ 07103.** Note: this is **NOT** the main University Hospital. We are in the "**DOC**" building ("Doctors' Office Center", 90 Bergen Street, which is *next to* the hospital.)
 - By Plane: the best and closest airport is "Newark Liberty Airport", which is only a ~ \$25 taxi ride to our office. (Most folks flying in arrive the night before. Some will fly home later on the same day after their injection, but if you do then leave plenty of time to catch your flight, in case we run behind schedule.)
 - By Train: "Penn Station Newark" (*not* NYC) is about 10-minutes by taxi to our office (cost is ~ \$15).
 - By Car: The best/closest parking deck is on the corner of Bergen St. and 12th Avenue. (That parking deck is right next to our DOC building.)
 2. **X-rays: Have Sitting-versus-Standing coccyx x-rays done in the Radiology department in our building.**
 - When you arrive at my DOC building, go directly to the Radiology department on the ground floor.
 - Dr. Foye will have already entered your x-rays orders into our electronic medical record system.
 - You do not need a formal appointment for x-ray. They are open weekdays, starting at 8am.
 - **On the day that you come in-person, just arrive ONE HOUR before your appointment with Dr. Foye, so that you can first have the seated x-rays done.** Their last patients of their day need to arrive for x-rays by 2:30pm.
 - After your x-rays are done, then come directly upstairs to the 3rd floor to our office: DOC suite 3100.
 3. **See Dr. Foye for an in-person office visit, on the 3rd Floor:**
 - At the visit, Dr. Foye will review your imaging results and see how they match up with your symptoms and the location where you are tender to the touch on your physical exam.
 - If you sent in radiology imaging studies that he reviewed in advance, then the CD's of the images will be returned to you. (We do not return the CD's to patients who do not come in to be seen here.)
 - Dr. Foye will work attentively to make a specific diagnosis, to figure out what is causing your pain.
 - The visit will focus specifically on the coccyx.
 4. **Have a coccyx injection:**
 - After the in-person office visit, if you and Dr. Foye both agree that it makes sense to proceed with placing medications at the coccyx by a small, local injection, then the injection can usually be done right after the office visit. The specific types and locations for injections are usually different than your prior injections.
 - Our staff will reserve the fluoroscopy room for you right after the office visit, so that you have the injection option available, since most people prefer that, to save you from needing to make a separate trip here for an injection.
- **Time estimates:** The x-rays usually take 45-60 minutes, then the office visit is ~ 30 minutes, and then time in the injection room is ~ 30 minutes. But allow for over 3 hours here (e.g., some time for parking, registration, any delays, etc.). Do not stress yourself out by scheduling a flight home within 3 hours after your appointment.

Imaging studies: Please note that during your first in-person office visit Dr. Foye usually will NOT be able to review any **prior** imaging studies that are not submitted to him by at least one week prior to the in-person office visit. But he will review any sitting-versus-standing coccyx x-rays that are done here immediately before the in-person office visit.

Please note that prior to the Initial Evaluation, Dr. Foye does not provide any medical advice or diagnosis, since there is no doctor-patient-relationship until the Initial Evaluation occurs.

If you still have questions, call us: 973-972-2802.