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 actually 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.
  - Images 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.

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) _____

FIRST Name ***LAST Name***

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

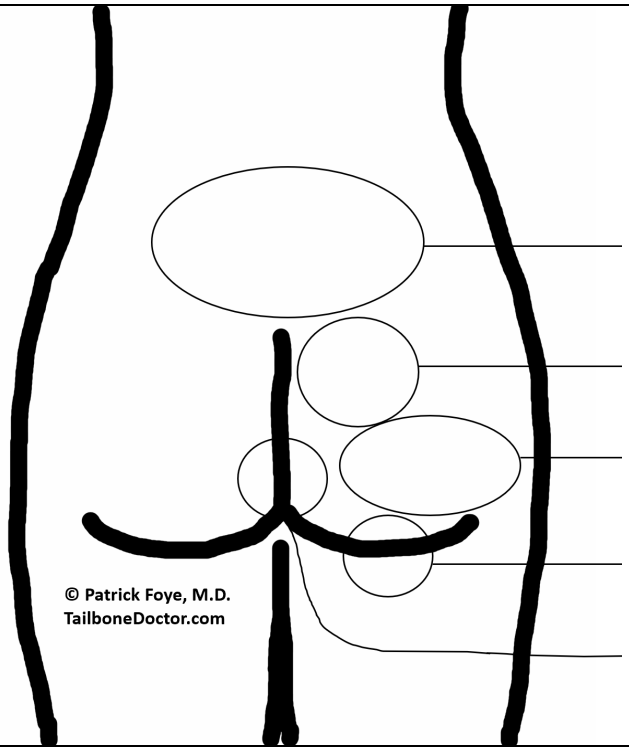
Patrick Foye, M.D., Director of the Coccyx Pain Center, Rutgers New Jersey Medical School
90 Bergen St., DOC Suite 3100, Newark, NJ 07103 Phone: 973-972-2802. Fax: 973-972-2825

Name: _____ **Date:** _____
[Nombre] ***FIRST Name*** ***LAST Name*** *[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

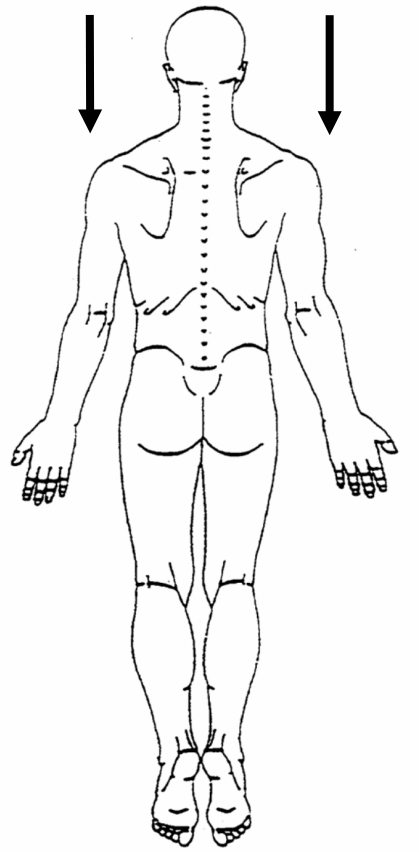
○-Lower Buttocks: ○-Right ○-Left

○-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.)

First Name: _____ Last 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)			◯ 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 | ☐ Lidocaine | ☐ NONE= No-Known-Drug-Allergies

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: _____ 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:

	***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.
  - Ideally, send those in now with your paperwork. But if you can not get them now, at least try to bring them with you to your Initial Evaluation with Dr. Foye.

- **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 your 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. (If the boxes below do not work, just send in a scan or photo of your insurance card, front and back.)

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 a few 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 for Dr. Foye's medical care.**
     - 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), $991 (coccyx nerve ablation).

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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**. (Currently this is $78.) Your insurance company may pay some or all of that. If there is an unpaid balance, you will get a radiologist bill 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 = TWO HOURS 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.** We are in the **"DOC" building** ("Doctors' Office Center", 90 Bergen Street. Our building *next to* the hospital where you will have the seated x-rays done.)
    - 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 University Hospital Radiology Dept..**
    - When you arrive, if you have prior images, first drop those computer CD's off at Dr. Foye's office.
    - Then go directly to the Radiology department next door, at University Hospital (**see Map**).
    - 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, arrive TWO HOURS before your appointment with Dr. Foye, so that you can first have the seated x-rays done.** Their last patient must arrive by 2:30pm.
    - After your x-rays, then come directly to Dr. Foye's office: DOC 3rd floor, suite 3100.
    -

3. **See Dr. Foye for an in-person office visit, at DOC 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 1-2 hours, then the office visit is ~ 30 minutes, and then time in the injection room is ~ 30 minutes. So expect over 3 hours here (and some time for parking, registration, any delays, etc.). Do not stress yourself out by scheduling a flight home within 3 hours after your appointment.

Prior Imaging studies: You can send in advance any typed radiology reports. You can also send in advance any any prior imaging on computer CD's. We can NOT use USB flash drives, nor website portals. CD's only.
If you do not send CD images and reports in advance, then bring the CD with you and drop it off before your x-rays.

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.

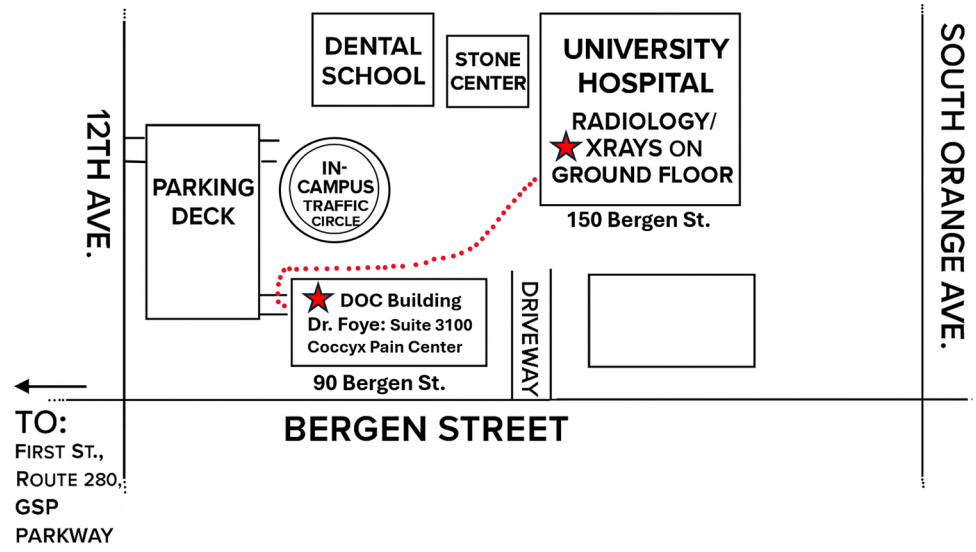
Dr. Foye's office, Coccyx Pain Center. Rutgers New Jersey Medical School.
DOC building: Doctors Office Center, 3rd floor, Suite 3100
90 Bergen St., Newark, NJ 07103. (on the corner of Bergen Street and 12th Ave.).
Phone: 973-972-2802

PARKING DECK: This is also on the corner of Bergen Street and 12th Ave.
If you have prior Radiology computer CD images: Drop those off at Dr. Foye's office **BEFORE** going to University Hospital for the sitting-versus-standing coccyx x-rays.
If you do NOT have prior Radiology images to drop off: Go straight to Univ. Hospital Radiology.

DIRECTIONS TO RADIOLOGY (x-rays) at University Hospital:

- **From Dr. Foye's office** (DOC Suite 3100): **take elevator down to Level 1** (Ground-floor = lobby)
- **Leave the lobby:** Go outside and immediately **turn RIGHT**.
- After you turn to the RIGHT you will be **walking under the shade** of the overhead awning/canopy. And if you walk under that it will take you directly to University Hospital (easy to see: it is the biggest, tallest building, and says **"150"** and **"Hospital Entrance"**).

GETTING TO UNIVERSITY HOSPITAL:



1. **Enter University Hospital**.
2. Walk straight ahead. Just before the elevator, check-in at the **Information Desk**.
   - From the Information Desk, **walk to the left of the elevators**, going through the Lobby area.
3. Then **turn RIGHT** to go down the first **hallway**. Radiology **"Registration" will be on your left.**
4. After Registration, they will send you a little further down that hallway to the x-ray area.

INSIDE UNIVERSITY HOSPITAL: