CENTER FOR
PAIN MANAGEMENT

It is our goal to provide you with a one-on-one informative consultation with one of our pain specialists. During you consultation you will be able to discuss your history and ask questions you may have about the treatment options available.

Your appointment is scheduled at the address below. A map is located on the back.

1602 Physicians Drive
Suite 103
Wilmington, NC 28401
(910) 442-1200

Please pay attention to the following:

- Complete the enclosed Patient Registration & Medical History forms **BEFORE** your visit and bring them with you to the office along with your **INSURANCE & COPAY**
- If you have had MRI(s), CT(s) and/or X-rays please obtain the **DISC and/or WRITTEN REPORTS** from the diagnostic facility where preformed and bring those with you to the appointment
- Bring **ALL** medications you are currently taking with you in the original bottles to the appointment – this includes over-the-counter & herbal medication
- If you are scheduled for a **PROCEDURE/INJECTION** at the time of your first visit **CAREFULLY READ** and follow the instructions on the **BACK**

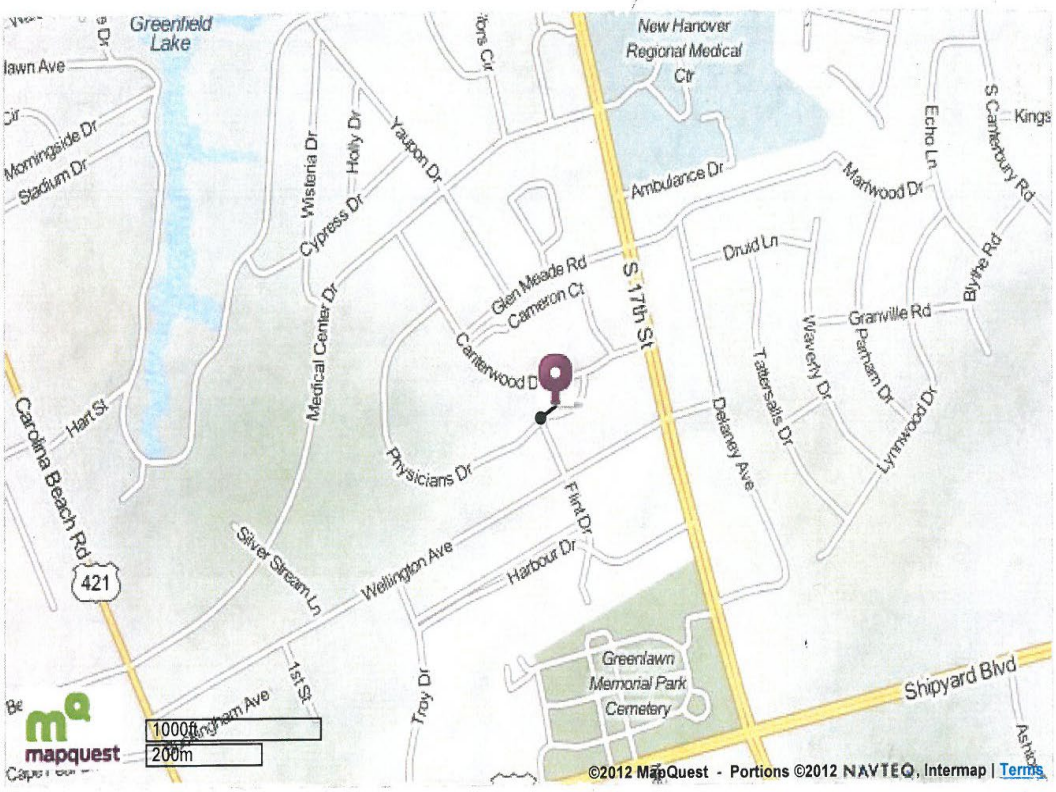
If you have any additional questions please call our Referral Coordinator at (910) 442-1200.

Thank you.

CENTER FOR PAIN MANAGEMENT

These instructions are intended for patients who are scheduled for a **PROCEDURE/INJECTION**:

- Take regularly scheduled medication as prescribed. **DO NOT SKIP YOUR PAIN MEDICATION**
- If you are taking a **BLOOD THINNER MEDICATION** call our office at (910) 442-1200 prior to the appointment date
- You will need a **DRIVER**. You will not be allowed to drive after the injection so make sure you have someone that can drive you home
- If you are **SICK** on the day of your scheduled appointment please call our office at (910) 442-1200 to **RESCHEDULE**
- If you take a **FISH OIL, OMEGA-3 or GINGO SUPPLEMENTS** discontinue use for one (1) week prior to procedure/injection
- If you have been on an **ANTIBIOTIC** or had a **FLU, SHINGLES OR PNEUMONIA SHOT** in the last two (2) weeks contact our office before coming to the appointment.



CENTER FOR PAIN MANAGEMENT

CONSULTATION POLICY

To better serve your needs in both the short term and long term, we have established a **Consultation Policy.** We find it helpful if both you and your **primary care physician** are well informed of our policy prior to your arrival at the clinic. We fully understand your pain concerns and are anxious to help you and your physician better manage this problem. We appreciate your honoring our policies and we look forward to seeing you in our clinic.

Please read the following carefully.

1. You must have a ***Local*** primary care physician. This physician must agree to continue to play an active role in your care ***after your consultation.***
2. ***No medications*** will be given at your first visit with us. Your primary care physician must give you enough medications for ***both before and after your consultation.*** At the time of your consultation, medication usage may or may not be recommended.
3. At your initial visit it will be determined if we have anything to offer you in terms of new pain management therapies.
4. If it is established that we have a therapy that may help you, a recommendation will be made to your primary care physician and if he/she agrees we will begin a treatment plan.

We thank you for your understanding of our policy and look forward to seeing you in our clinic.

Center for Pain Management

Financial Policy

No Show / Cancellation Policy:

Please notify our office at least twenty-four (24) hours prior to the appointment time if you are unable to attend your appointment. Failure to do so will result in a missed appointment fee. The amount will depend on the type of appointment missed. If an office visit is missed without a 24 hour notice, the fee will be $30.00. If a new patient appointment is missed, the fee will be $50.00. If a procedure appointment is missed, there will be a $75.00 fee. Missed appointment fees will need to be paid prior to being seen again by your doctor. Multiple non-cancelled missed appointments will be considered grounds for being discharged from this practice. We accept payment by Cash, Check, Visa, MasterCard, Discover and American Express. For your convenience, our billing office is staffed Monday through Thursday from 8:00 AM to 4:30 PM. The phone number is (910) 442-1200 option 5.

Benefit Authorization of Payments:

I request that payment of authorized benefits be made on my behalf to the Center for Pain Management, for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent (or other insurance carrier) any information needed to determine those benefits or the benefits payable for related services.

Pre-Certification Assistance:

We are happy to assist you with pre-certification/authorization and filing of claims however you are responsible for ensuring this process is complete so be sure to ask prior to your appointment. Pre-Certification/authorization must be received prior to your office visit. In the event you are treated without authorization from your insurance company and they have not approved the treatment, FINAL RESPONSIBILITY FOR PAYMENT FOR SERVICES RENDERED REMAINS YOURS.

PATIENTS WHO HAVE INSURANCE MUST PAY THEIR CO-PAY AND/OR DEDUCTIBLE AMOUNTS AT THE TIME OF THE OFFICE VISIT.

I understand and agree to the above policies, including the policy regarding reimbursement.

Signature: _____ Date: _____

Printed Name _____Witness_____

CENTER FOR
PAIN MANAGEMENT

PATIENT REGISTRATION DATE:_____

PLEASE PRINT

Patient's Name_____ Home Phone #_____
Last First Middle
E-mail:_____@_____Would you like reminders sent here? Y N Cell #_____

Address_____City_____State_____Zip_____

Social Security #_____Birthdate_____ Sex_____ Marital Status: M S W D Sep

Employer_____Occupation_____Work Phone #_____

Employer Address_____City_____State_____ Zip_____

Spouse's Name_____Spouse's Employer_____Spouse's Phone #:_____

Employer Address_____City_____State_____Zip_____
Nearest Relative/
Friend not Living with you_____Relation to you_____Phone #_____

HEALTH INSURANCE COVERAGE- **To be completed by all patients.** (In the case of worker's compensation, this information will only be used if your Worker's compensation is denied.)

Health Insurance Company_____Policy Effective Date_____

Address_____City_____State_____Zip_____

ID#_____Group#_____Insurance Phone #_____

Subscriber's Name_____ Birthdate_____Relation to Patient_____

Do you have secondary insurance?_____Secondary Insurance Company_____

LIABILITY- Please complete this section if your illness/injury is the result of an **accident** (auto or otherwise – **but not work related**)

Auto Insurance Company_____Date of Accident_____

Address_____City_____State_____Zip_____

Policy #_____Claim #_____State where accident occurred_____

Claims Adjuster Name_____Phone #_____

WORKER'S COMPENSATION – Please complete this section if your illness/injury is **work related.**

Worker's Comp Insurance Company_____Date of Accident_____

Address_____City_____State_____Zip_____

Claims Adjuster Name_____Phone #_____Claim #_____

Rehab Nurse/Caseworker (if applicable)_____Phone #_____

Employer at time of accident_____Phone #_____

Address_____City_____State_____Zip_____

Contact Person_____When was First Report of Accident Filed?_____

ATTORNEY- Please complete if an attorney is representing you regarding this particular illness/injury.

Attorney's Name_____Phone #_____

Address_____City_____State_____Zip_____

REFERRING PHYSICIAN/FAMILY PHYSICIAN/ PHARMACY:

Referring Physician Name_____

Family/Primary Care Physician (if different from referring physician)_____

Pharmacy Name_____Location_____

NOTICE OF PRIVACY PRACTICES: A federal regulation known as the "HIPAA Privacy Rule" requires that we provide you with a detailed notice in writing of our privacy practices. This notice is available to all patients who ask to read it.

"I acknowledge that I will be given the opportunity to read the Center for Pain Management Notice of Privacy Practices."

CONSENT FOR EXAMINATION AND TREATMENT:

"I do hereby give Center for Pain Management and its designated personnel my consent for examination, the ordering of appropriate lab tests, diagnostic procedures and prescribing medication and treatment on the patient named below. Medical diagnostic and treatment procedures will be explained to me and I will have had a chance to ask questions regarding advantages, alternatives and possible adverse effects. These questions will be answered to my satisfaction for this consent to remain valid."

ACCEPTANCE OF FINANCIAL RESPONSIBILITY AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

"I understand that I am responsible for all medical expenses, regardless of insurance coverage and whether or not there is a job related accident or an accident with another person at fault. I hereby authorize Center for Pain Management (CPM) to file insurance claims for all services provided to me and I authorize payment for those services to be made directly to the provider. I authorize CPM to release any information about me to any referring physician or other provider or to any institution or provider as necessary to provide treatment or diagnosis for me. I authorize my physician or other provider at CPM to release information about me as necessary to process claims for payment for services provided for me including health and liability insurance companies, agencies processing Medicare, Medicaid or Worker's Compensation claims, medical benefits plans, case managers or reviewers or third parties responsible for paying claims for services provided to me."

OPT-IN PERMISSION:

The Center for Pain Management would like to stay in touch with our patients with occasional newsletters, updates on our clinic and any special offers for our patients. Please check here [ ] to allow us to send you periodic e-mails or SMS alerts such as appointment reminders.

UNDERSTANDING OF PATIENT GUIDELINES AND POLICIES:

"I have read the attached Patient Guidelines and Policies and have had answered to my satisfaction any questions I may have concerning the information in these guidelines."

_____
Patient Name

_____ _____
Signature of Patient or Legal Guardian Date

Form reviewed for completeness by CPM Staff:

_____ _____
CPM Staff Signature Date

CENTER FOR
PAIN MANAGEMENT

1602 Physicians Drive, Suite 103 Wilmington, NC 28401 - (910) 442-1200

Name: _____ Date of birth: _____

FEMALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very severe (4)
Hot flashes	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	☐	☐	☐	☐	☐
Depressive mood (feeling down, sad, on the verge of tears, lack of drive)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)	☐	☐	☐	☐	☐
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sexual problems (change in sexual desire, sexual activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory	☐	☐	☐	☐	☐
Problems with thinking, concentrating or reasoning	☐	☐	☐	☐	☐
Difficulty learning new things	☐	☐	☐	☐	☐
Trouble thinking of the right word to describe persons, places or things when speaking	☐	☐	☐	☐	☐
Increase in frequency or intensity of headaches or migraines	☐	☐	☐	☐	☐
Hair loss, thinning or change in texture of hair	☐	☐	☐	☐	☐
Feel cold all the time or have cold hands or feet	☐	☐	☐	☐	☐
Weight gain or difficulty losing weight despite diet and exercise	☐	☐	☐	☐	☐
Dry or wrinkled skin	☐	☐	☐	☐	☐
Total score	0				

Severity score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80

Name: _____ Date of birth: _____

MALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very severe (4)
Sweating (night sweats or excessive sweating)	☐	☐	☐	☐	☐
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	☐	☐	☐	☐	☐
Increased need for sleep or falls asleep easily after a meal	☐	☐	☐	☐	☐
Depressive mood (feeling down, sad, lack of drive)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (inner restlessness, feeling panicked, feeling nervous, inner tension)	☐	☐	☐	☐	☐
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sexual problems (change in sexual desire or in sexual performance)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate)	☐	☐	☐	☐	☐
Erectile changes (weaker erections, loss of morning erections)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory	☐	☐	☐	☐	☐
Problems with thinking, concentrating or reasoning	☐	☐	☐	☐	☐
Difficulty learning new things	☐	☐	☐	☐	☐
Trouble thinking of the right word to describe persons, places or things when speaking	☐	☐	☐	☐	☐
Increase in frequency or intensity of headaches/migraines	☐	☐	☐	☐	☐
Rapid hair loss or thinning	☐	☐	☐	☐	☐
Feel cold all the time or have cold hands or feet	☐	☐	☐	☐	☐
Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise	☐	☐	☐	☐	☐
Infrequent or absent ejaculations	☐	☐	☐	☐	☐
Total score	0				

Severity score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80

CENTER FOR
PAIN MANAGEMENT

NEW PATIENT QUESTIONNAIRE

Name_____Date_____Referring MD_____

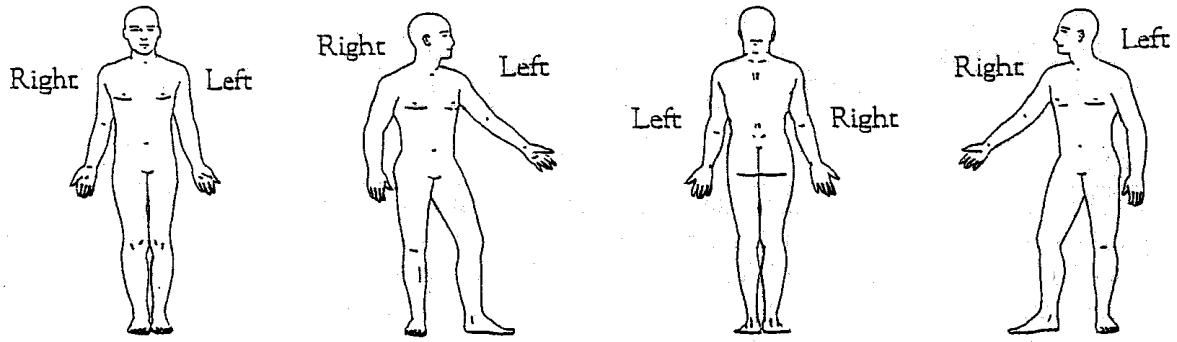
Age_____Weight_____Height_____Primary Care Physician_____

CHIEF COMPLAINT:_____

_____

_____

PI: Please shade all areas covered by your pain: (location)



PAIN ASSESSMENT

Quality: ☐Constant ☐Intermittent ☐Sharp ☐Dull ☐Burning ☐Aching ☐Throbbing ☐Shooting (electric shock)	**Associated Symptoms**: ☐Numbness ☐Spasms ☐Weakness ☐Bladder or Bowel Incontinence ☐Other _____
Onset/Duration: Month_____ Year_____ ☐Sudden ☐Gradual ☐Motor vehicle accident ☐Disease process ☐Work related injury ☐Following Surgery ☐Unknown	**Severity: (Circle one)** (No Pain=0; Worst Pain=10) Worse Pain Gets 0 1 2 3 4 5 6 7 8 9 10
	Best Pain Gets 0 1 2 3 4 5 6 7 8 9 10
What makes it feel better? ☐Cold ☐Heat ☐Sitting ☐Lying ☐Walking ☐Standing ☐Other:_____	Usual Pain Level 0 1 2 3 4 5 6 7 8 9 10
What makes it feel worse? ☐Sitting ☐Walking ☐Standing ☐Lying ☐Driving ☐Lifting ☐Bending ☐Twisting ☐Getting up ☐Other	Acceptable Level 0 1 2 3 4 5 6 7 8 9 10

FUNCTIONAL ASSESSMENT: **Occupation** _____Date last worked if disabled_____

What types of activities are required to do your job? ☐Walking ☐Standing ☐Lifting ☐Bending ☐Sitting ☐Carrying ☐Driving ☐Pushing ☐Pulling ☐Other_____	**What type of activities are you doing at home?** ☐Cleaning ☐Cooking ☐Lifting ☐Other_____	**What type of leisure activities are you doing?** ☐Running ☐Walking ☐Swimming ☐Playing with Pets ☐Church ☐Bike riding ☐Family Activity ☐Golf ☐Other_____

MEDICATIONS

Current **PAIN** Medications (Name, Dose, Frequency)	Previous **PAIN** Medications	Other Medications **(Blood Thinners??)**

PREVIOUS TREATMENT

Have you ever had any previous nerve blocks or Cortisone injections? ☐Yes ☐No (When? Where? Did they help?)
Have you ever had any Physical Therapy? ☐Yes ☐No
Have you ever used TENS unit? ☐Yes ☐No
Have you ever been treated for alcohol or drug abuse? ☐Yes ☐No
Have you ever been admitted in a hospital for mental illness? ☐Yes ☐ No
During the past 3 months did you visited the ER due to pain? ☐ Yes ☐ No How many times?

REVIEW OF SYSTEM

☐Fever ☐Weight loss ☐Sweating ☐Fatigue ☐Palpitations ☐Breathlessness ☐Chest pain ☐Cough ☐Cold
☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Burning urine ☐Blood in stool or urine ☐Easy Bruising ☐Nose Bleed ☐Anemia ☐Headache ☐Seizure ☐Visual symptoms ☐Depression ☐Crying spells ☐Suicidal thoughts
☐Panic attacks ☐Anxiety ☐Trouble with sleep ☐Cold intolerance ☐Increased appetite ☐Increased urination
☐Increased thirst ☐Muscle spasm ☐Skin rash/discoloration ☐**PREGNANT? Y N**

☐ **Allergies :**

PAST MEDICAL/ SURGICAL HISTORY

☐Asthma ☐ Bronchitis ☐Emphysema ☐High Blood Pressure ☐ Angina ☐Heart Attack ☐Heart failure ☐ Stroke
☐Migraine ☐Diabetes ☐Thyroid Disease ☐Stomach Ulcer ☐ Heartburn ☐Crohn's disease ☐Ulcerative Colitis ☐Liver disease ☐ Kidney disease ☐Bleeding disorder ☐ Rheumatoid Arthritis ☐Lupus ☐ Fibromyalgia
☐ Chronic Fatigue Syndrome ☐IBS ☐ **Cancer** ☐Other_____
Back Surgery:_____
Neck Surgery:_____
Any other Surgery:_____

SOCIAL HISTORY

Smoking ☐Yes ☐No How many packs a day? Alcohol ☐Yes ☐No – Frequency/Quantity_____ Street Drugs ☐Yes ☐No Spousal Abuse ☐Yes ☐No ☐On going litigation	☐Married ☐Single ☐Divorced ☐Widowed ☐Children ☐Applying for Disability ☐ On Disability ☐Working ☐ On Leave ☐ Family Stress ☐Job Stress

FAMILY HISTORY: **Parents: If deceased, please indicate date and cause of death**

Are any of your family members on long term opioid (Narcotics) medication? ☐Y ☐N
Please list any family diseases, medical problems, and genetic disorders:

Patients Signature_____ **Date**_____

MD Signature_____ **Date**_____

CENTER FOR
PAIN MANAGEMENT

CPM HIPAA, Consents & Financial Policy

Patient: _____
LAST FIRST MI

Patient Acknowledgement of Receipt of Notice of Privacy Practices: I acknowledge that I have received or have been offered a copy of the Center for Pain Management's Notice of Privacy Practices, which provides information about how the Center for Pain Management uses and discloses protected health information ("PHI") about me.

Consent To Disclosure of PHI to Family Members, Relatives, Friends or Others: I agree that the Center for Pain Management may disclose my PHI to the following family members, relatives, friends or others. I understand that, if I am present, Center for Pain Management may disclose my PHI to other family members, relatives, friends or others if I orally agree or do not object. I also understand that, if I am not present or am incapacitated, Center for Pain Management may make limited disclosure of my PHI to other family members, relatives or friends if Center for Pain Management determines in its professional judgment that such disclosure is in my best interest.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Consent for Treatment: I hereby authorize the performance of any medical or surgical treatment which may be advised and recommended by any attending physician at Center for Pain Management. I further consent that Center for Pain Management may obtain and use information from other healthcare providers such as pharmacies and hospitals.

Financial Agreement: I understand that I am financially responsible to the physicians at the Center for Pain Management for services rendered and charges not covered by insurance. I understand that my insurance will be filed as a courtesy to me and allow payment of any filing to be made to the Center for Pain Management and its providers. **If I have no insurance to cover services rendered a $150 deposit for office services or 50% down payment for elective procedures is required prior to scheduling/receiving the service(s) unless prior arrangements have been made.** I understand the Center for Pain Management does not accept third party liability such as legal cases, and I am ultimately responsible for payment.

I certify that the information provided is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Signature of Patient or Legal Guardian **Date**

Witness (CPM Employee) **Date**

CENTER FOR
PAIN MANAGEMENT
BOARD CERTIFIED SPECIALISTS IN PAIN MEDICINE

INFORMATION FOR PATIENTS

Thank you for choosing us as your health care provider. We are committed to providing you with the finest health care available with a courteous and helpful staff. In order to make this process as smooth as possible for our patients, we offer this information outlining some of the policies followed by Center for Pain Management.

Consultation Policy: You must have a local primary care physician. This physician must agree to play an active role in your care after your initial consultation in this office and will be informed of any new recommendations and/or treatments by our provider.

Primary Care Referrals: Please obtain all the necessary referral forms (if required by your insurance) from your primary care physician in advance of your visit. Unfortunately, patients cannot be seen without the appropriate referral.

Copayments: Insurance copayments and deductibles must be paid upon the patient's arrival. We accept cash, check and Visa/Master Card/Discover. Insurance is filed as a courtesy to you. We expect that any and all balances will be paid in full upon receipt.

Worker's Compensation: If your visit to our office is under Worker's Compensation we must have a documented referral at the time of your visit or have your adjuster call and give information about your case prior to your visit. Failure to provide this information may result in your office visit being rescheduled.

Third Party Payers: We do not accept payments from Third Party Payers.

Tardiness: Please call if you are running late. Patients arriving more than 15 minutes late may be asked to reschedule. Obviously, we try to deliver the same respect for your time; if we are running late you will be informed and given the opportunity to reschedule. Patients who arrive more than 15 minutes late will be given a form to complete from which the provider will determine whether the patient will be seen or needs to reschedule the appointment.

Cancellations: We request that patients who are unable to keep an appointment contact our office at least 24 business hours prior to the scheduled appointment time since there are usually other patients that could benefit from the schedule opening. There is a $30 fee for a cancellation that is less than 24 hours and for appointments that are "no shows".

Walk-Ins: The Center for Pain Management is not a walk-in facility. Because our schedule does not allow for walk-ins, patients who walk-in and ask to be seen without an appointment will be scheduled to see the doctor at another time.

Medication Refills: We ask that you call our office for a medication refill at least 5 business days prior to running out of medication unless you are scheduled to return to our office prior to the date you will run out of medication. We will not refill medications on weekends, holidays, or after 4PM Monday – Thursday and after 11AM on Fridays.

Disability Forms: Patients are asked to bring their disability forms to the office and be prepared to pay in advance of the form being completed. This charge will be determined depending on the complexity of the form. The forms are completed within a week or 10 days and returned by mail. Occasionally a provider may request that the patient schedule a visit prior to having a form completed.

Medication Contract and Policies: Depending of the treatment prescribed for you, you may be required to read and sign a Medication Contract. This contract is designed for your protection and will insure the safe and proper usage of prescribed medications. This contract may involve random pill counts and random urine drug screens.