Welcome...

Ford Center for Pain Management, PLLC

PATIENT INFORMATION FORM

Patient's Name _____ Date _____
(First) (Middle) (Last)

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other ☐

Social Security Number ____-____-____ Date of Birth ____/____/____ Female ☐ Male ☐

Phone Numbers: Home _____ Cell _____

Address: _____

Employed ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student ☐

Employer's Name/Address: _____

Referring Physician: _____ Primary Care Physician: _____

Referring Physician's Address & Phone No.: _____

Emergency Contact: _____ Relationship: _____ Phone No. : _____

Primary Insurance Company: _____ Policy Number: _____

Group Number: _____ Policy Holder: Self ☐ Spouse ☐

If spouse is the primary policy holder, please provide: Spouse's Name : _____

Spouse's SS No.: ____-____-____ Spouse's Birth Date: ____/____/____

Secondary Insurance Company: _____ Policy Number: _____

Group Number: _____ Policy Holder: Self ☐ or Spouse ☐

I authorize the release of medical information to insurance company and payment benefits to Dennis C. Ford, M.D. and...

I, the undersigned, hereby consent to and authorize the administration and performance of all treatments, the administration of any needed anesthetics; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, the use of prescribed medication; the performance of diagnostic procedures, the collection and process of specimens and performance of other medically accepted laboratory test, all of which the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable. I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be considered as valid as the original.

Patient's Signature _____ Date _____
(or responsible party)

2020 Keith Street, N.W., Suite C, Cleveland, TN 37311 · (423) 614-0535 · Fax (423) 614-0545

Ford Center for Pain Management, PLLC

Patient Name: _____ Today's Date: ____/____/____

(YOU MUST LIST ALL MEDICATIONS. YOU ARE NOW TAKING TO RECEIVE PRESCRIPTIONS).

Medication Name	Strength	Dosage	Prescribing MD & City
EX: NEURONTIN	300 MG	3X/DAY	DR. J. DOE, CLEVELAND

YOU MUST LIST ALL ALLERGIES & MEDICATION ALLERGIES:

_____

_____

_____

Ford Center for Pain Management, PLLC
Initial Evaluation

NAME: _____ DATE: _____

Referring M.D. : _____

Primary Care M.D. : _____

Primary pain complaint: _____

Location of pain (*Where is your pain?*): _____

Radiation (*Does is spread anywhere else?*): _____

Present since (*How long have you had this pain?*): _____

Severity of pain (*How bad is it?*): Mild ☐ Moderate ☐ Severe ☐

Frequency (*How often do you experience this pain?*): _____

Duration (*How long does it last?*): _____

Precipitation factors (*What brings it on?*): _____

Prior treatment for pain: Medication ☐ Surgery ☐ Nerve Block ☐ TENS ☐

Physical Therapy ☐ Acupuncture ☐ Occupational Therapy ☐

Psychological Therapy ☐ Biofeedback/Relaxation Therapy ☐

Other: _____

Ford Center for Pain Management, PLLC

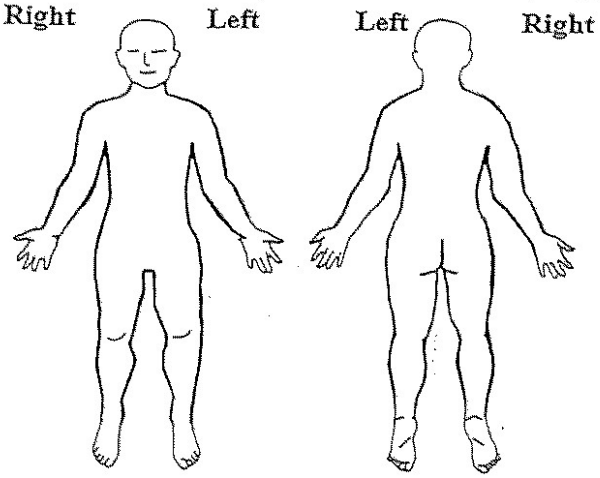
BRIEF PAIN INVENTORY

Date: _____ / _____ / _____

Name: _____
(Last) (First) (Middle Initial)

(1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
1. Yes 2. No

(2) On the diagram, shade in the areas where you feel pain. Put an **X** on the area that hurts the most.



(3) Please rate your pain by circling the one number that best describes your pain at its **WORST** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
NO PAIN — PAIN AS BAD AS YOU CAN IMAGINE

(4) Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
NO PAIN — PAIN AS BAD AS YOU CAN IMAGINE

(5) Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**.

0 1 2 3 4 5 6 7 8 9 10
NO PAIN — PAIN AS BAD AS YOU CAN IMAGINE

(6) Please rate your pain by circling the one number that tells how much pain you have **NOW.**

0 1 2 3 4 5 6 7 8 9 10
NO PAIN — PAIN AS BAD AS YOU CAN IMAGINE

(7) What treatments or medications are you receiving for you pain? _____

Ford Center for Pain Management, PLLC

Brief Pain Inventory

Name: _____
(Last) (First) (Middle Initial)

(8) In the last 24 hours, how much pain reliefs have pain treatments or medications provided?

Please circle the one percentage that shows how much RELIEF you have received.

0% 10 20 30 40 50 60 70 80 90 100%
(No relief) (Complete Relief)

(9) Using a scale from 1 (very little) to 10 (a whole lot).. enter the number that most nearly describes how the pain has interfered with the following: (1,2,3,4,5,6,7,8,9 or 10).

A) Your General Activity _____

B) Your Mood _____

C) Your Walking Ability _____

D) Normal Work (home and outside the home) _____

E) Relations with other people _____

F) Sleep _____

G) Enjoyment of Life _____

Family History: Mother's Age _____ Health Problems _____
Father's Age _____ Health Problems _____
Number of sibling's _____ Health Problems _____

Social History: Single _____ Married _____ Widowed _____ Divorced _____

Occupation: _____

Out of Work? Yes___No ___ Disability? Yes ___ No ___Retired? Yes ___ No __

Name:_____
(Last) (First) (Middle Initial)

PLEASE CHECK ALL THAT APPLY TO YOUR HEALTH.....

ARE YOU PRESENTLY ON A BLOOD THINNER: Yes _____ No _____

HEART Heart Trouble _____ Heart Murmur _____ High Blood Pressure __Chest Pain _____
Heart Attack _____ Palpitations _____ Leg Swelling _____ Pace-Maker _____

LUNGS Cough _____ Wheezing _____ Asthma _____ Bronchitis _____ COPD _____
Pneumonia _____ TB _____ Sputum Color (yellow, brown, blood) _____

EYES Glasses/Contacts _____ Pain _____ Excessive Tearing _____ Double Vision _____
Glaucoma _____ Cataracts _____

EARS Ringing in Ears _____ Dizziness _____ Earaches _____ Infection _____
Drainage _____ Difficulty Hearing _____ Hearing Impaired _____ Hearing Aid (L___R___)

NOSE & SINUS Frequent Colds _____ Nasal Stuffiness _____ Hay Fever _____ Nosebleed _____
Sinus Trouble (explain) _____

MOUTH & THROAT Bleeding Gums _____ Sore Tongue _____ Sore Throat _____ Hoarseness _____

SKIN Rashes _____ Lumps _____ Itching _____ Drying _____ Color Change _____
Sensitive Skin _____ Change in Hair/Nails _____

HEAD Headache _____ Head Injury _____

NECK Lumps _____ Pain _____ Swelling _____

GASTRO-INTESTINAL Trouble Swallowing _____ Heartburn _____ Ulcer _____ Nausea _____
Constipation _____ Diarrhea _____ Hemorrhoids _____ Hepatitis _____
Jaundice _____ Gallbladder _____

ENDOCRINE Diabetes _____ Thyroid Disorder _____

KIDNEYS & BLADDER Frequent urination at night _____ Pain during urination _____
Frequent urge for urination _____ Unable to control bladder _____
Diagnosis of infection _____ Kidney stones _____

FEMALES ONLY Menstrual Problems _____ Pelvic Inflammatory Disease _____ Menopause _____
Sexually Transmitted Disease _____

MALES ONLY Testicular Pain/Masses _____ Prostate Problems _____ Hernia _____
Sexually Transmitted Disease _____

Ford Center for Pain Management, PLLC

Brief Pain Inventory

Name: _____
(Last) (First) (Middle Initial)

MUSCULOSKELETAL Muscle Pain ____ Muscle Cramps ____ Artificial Joints ____ Gout ____
Joint/Pain Stiffness ____ Backache ____ Arthritis ____

VASCULAR Leg Pain ____ Leg Cramps ____ Varicose Veins ____ Thrombophlebitis ____
DVT ____

NEUROLOGIC Fainting ____ Light Headedness ___ Blackouts ____ Seizures ____ Tremors ___
Numbness ____ Tingling ____ Pins & Needles ____ Memory Problems ____

OVERALL Weakness ____ Fatigue ___ Recent Weight Loss ___ Weight Gain ___ Fever __
Hot/Cold Intolerance ___ Excessive Sweating ___ Easy Bruising ___ Tension __
Nervousness ____ Depression ____ Anxiety ____ Panic Attacks ____

ALLERGIES Hay Fever ____ Food Intolerance ____ Frequent Infections____ Other _____

Please list all MEDICATION allergies:

_____

_____

Medical History:

Illnesses: _____

Hospitalizations: _____

Injuries: _____

Psychiatric Illnesses: Depression ____ Anxiety ____ Panic Attacks ____

Other (please describe): _____

Surgical History:

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Ford Center for Pain Management, PLLC

Brief Pain Inventory

Name: _____
(Last) (First) (Middle Initial)

Habits:

1) Alcohol..... Beer amount per week _____ Wine amount per week _____

Hard liquor amount per week _____

2) Tobacco..... Yes☐ No☐ Packs per day _____ Years _____

Recreational Drugs? Yes☐ No☐

Type _____ Route _____

Circle the words that best describe your pain:

Aching	Burning	Cramping	Deep	Dull	Exhausting
Gnawing	Miserable	Nagging	Numb	Penetrating	Radiating
Sharp	Shooting	Stabbing	Squeezing	Throbbing	Tiring
Unbearable					

Circle any other symptoms that you have:

Continually cold hands/feet	Drowsiness	Difficulty sleeping	Hot flashes
Impotence	Indigestion	Lack of appetite	Nightmares
Vomiting	Weakness		

What kinds of things make your pain feel BETTER (Example: heat, rest, medicine):

_____

What kinds of things make your pain feel WORSE (Example: walking, standing, and lifting):

_____

2021 Ford Center Payment Authorization

We file claims to your insurance company as a courtesy to you. You are responsible:

(1.) For full payments of your balance, co-payment and deductible at the time of services are rendered, for your remaining balance if you do not provide secondary insurance when services are rendered.

(2.) You need to notify our office before seeing the provider if you have changed your insurance or if you need to postpone your appointment to a later date for financial reasons.

(3.) To know your co-payment and deductible amounts determined by your insurance company which you have agreed to pay to receive their insurance coverage. Please be aware that your deductible begins each January 1st, making your balance larger than usual until it has been met. Medicare has determined that their participant's deductible for 2021 is $203.00.

(4.) To know when your insurance requires a referral or authorization number to be seen by our office and to obtain that referral from your primary care physician. If we do not have this number before your visit, you are responsible in full on that date of service.

(5.) To pay the full balance on your account if your insurance is not provided within a timely manner or if insurance denies your claim.

(6.) To keep a good payment history with our office, and reasonable payment will be expected on larger balances in order for us to continue treatments.

(7.) There will be a $10 late fee added to the balance if a payment is not received each month, and a $25 fee for insufficient checks received.

(8.) If a payment is not received for 90 days after your service or last insurance remittance, your balance will be turned over to a collection attorney who will add additional collection expenses incurred if applicable,

(9.) ***State of TN Public Chapter NO 340. Revised on June 16, 2011 Senate Bill NO. 1258 a pain management clinic may only accept on self pay patients a check or credit card or money order payment for services at the clinic, except as provided in §63-1-310(b).***

I_____ have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, be paid to Ford Center for Pain Management. I also authorize the release of any information acquired in the course of my treatment to my insurance and/or workers compensation company as needed to issue benefits. I authorize the Ford Center for Pain Management to administer such treatment as they may deem advisable for my diagnosis and treatment. I certify that I have been aware of the role and services offered by the physician, physician assistant, nurse practitioner and I consent to care by such providers. I understand that these services are voluntary, and that I have the right to refuse these services.

_____ _____

Signature Date

I request that payment of authorization Medigap (Medicare Supplement) benefits be made on my behalf to Ford Center for Pain Management for any services furnished to me by their providers. I release my medical information to Medigap Insurer:

_____

Medicare Lifetime Authorization
Medicare Certification for Payment

I certify that the information given by me in applying for payment under the Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration any information needed for this or related Medicare claim. I request that the payment of authorization benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I request that this authorization also apply to all other insurances.

_____ _____

(Print Name) (Date)

_____

(Signature)

_____

(Witness & Date)

PATIENT NAME: _____ **DATE:** _____

Ford Center for Pain Management Medication Agreement

The purpose of this Agreement is to prevent misunderstandings about medications we may prescribe and to help both you and the providers at Ford Center for Pain Management to comply with the law regarding controlled pharmaceuticals.

FACTS:

Long-term use of some of your medications will result in "habituation" and possibly lead to addiction. "Habituation" means that the longer you take this medication the less effective it becomes. Eventually you will require higher doses to achieve the same benefits, but at the risk of more side effects (*e.g.* mood alterations, stomach problems, constipation). Habituation also means that you will experience withdrawal symptoms if these types of medications are abruptly stopped (*e.g.* stuffy nose, anxiety, stomach cramps, diarrhea). Habituation is easily differentiated from addiction. Addiction involves abnormal social behavior to obtain medication, such as stealing, lying, or abusing the medications that have been prescribed. Addiction is uncommon in patients who do not have a prior history of addiction to narcotics or alcohol. You must notify Dr. Ford at your first visit if you have had any prior history of addiction or sharing your medications with others. Failure to do so may result in immediate dismissal from this practice.

"Acetaminophen" (*e.g.* Tylenol) is a component of many pain-relieving medications. Long-term use of Acetaminophen may cause premature liver or kidney damage. Use of non-prescription pain and cold medication, and use with alcohol or poor diet may aggravate this problem.

Pain medications can interfere with your mental functions and coordination. You could have an accident at home, at work, or on the road.

GOALS:

Because we are an interventional pain management clinic, our goal is to decrease your pain levels, primarily, by medically necessary procedures. By maintaining an unhealthy body you cannot hope to overcome physical and mental disabilities. A 50% decrease in your pain levels is considered a success. We require all of our patients to practice wellness steps:

1. Improve wellness by simple wellness practices (*e.g.* lose weight, stop smoking, exercise, reduce cholesterol)
2. Decrease the use of pain medications
3. A regular exercise routine will be established and demonstrated in the office,
4. Excessive weight will be lost,
5. Maintain pain reduction with a scheduled dose program of pain medications

RULES:

You may possibly receive pain medications in accordance with the American Medical Association's guidelines and the Drug Enforcement Agency's acceptable medical practice guidelines, only after you, the patient, and Dr. Ford have entered into agreement with all of the following terms of this Medication Agreement:

1. I will communicate fully with Dr. Ford and his staff about the character and intensity of my pain, the effects of my pain on my daily activities and how well the medications are helping to relieve my pain.

2. I understand that the use of mood-modifying substances such as tranquilizers, sleeping pills, alcohol or illicit drugs, can cause adverse affects or interfere with opioid therapy. Therefore I agree to refrain from all of these substances without prior agreement from my physician.

3. I will not share, sell or trade my medications with anyone. I will not crush, chew or break these medications.

4. Any calls or letters received implying that I am "dealing" or breaking this agreement will result in discharge from Ford Center for Pain Management.

5. I will safeguard my pain medicine from loss or theft. Lost or stolen medications will not be replaced regardless of the situation.

6. I will not attempt to obtain any pain medications, muscle relaxers, or controlled stimulants from any other medical provider or clinic.

7. I agree that my medications will only be refilled during a monthly office visit, during working hours. No refills will be made during evenings, weekends or holidays. Appointments will be made for me to receive refills or new medications every 30 days but not sooner.

8. I agree to use my medications at the rate that they are prescribed. If I use my medication greater than it is prescribed I will be without it and am subject to dismissal from Ford Center for Pain Management for non-compliance.

9. I will have no bad debt balances with Ford Center for Pain Management.

10. If I break the law, in any way, I will be discharged from Dr. Ford's practice.

11. I will bring all unused pain medications and/or prescription bottles to each appointment. I agree to provide my medications upon request for random pill counts. Refusal to do so may result in dismissal from Ford Center for Pain Management.

12. I agree to submit to random urine or blood drug screens in compliance with my pain management program. Failure to provide specimens, testing positive for illegal substances or medications not prescribed at Ford Center for Pain Management, or absence of prescribed medications in drug screens will result in dismissal from Ford Center for Pain Management.

13. I understand that the common side effects of opioid therapy include nausea, constipation, sweating and itchiness of the skin. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to refrain from driving a motor vehicle or dangerous machinery until such drowsiness disappears.

14. I authorize Ford Center for Pain Management and my pharmacy to cooperate fully with all city, state or federal law enforcement agencies. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to investigation of any possible misuse, sale or other diversion of my pain medicine.

15. I agree to keep all scheduled appointments and will provide 24-hour notice of cancellation if an emergency arises and I am not able to keep my appointment. I understand I may not receive medications if I do not keep appointments for procedures or injections.

16. I understand that if I break this agreement, Dr. Ford will no longer prescribe medications for me. I will then decrease my usage of daily medications and can receive a referral from Dr. Ford for detoxification.

17. I agree to use the following pharmacy _____ for
(Pharmacy Name)
all of my prescriptions. It's location is _____ and
(Street, City, State)
the phone number is (_____) _____. If I decide to change to another
Pharmacy area code and phone number
pharmacy, I will notify Ford Center for Pain Management at my next appointment.

As part of this agreement, Dr. Ford and those acting on his behalf agree to the following:

1. We will be able to provide a list of pain management physicians in the surrounding area if you are dismissed from his practice. We are also glad to forward your records to your next provider upon written request.

2. We agree to provide privacy for you and your information as outlined by HIPPA privacy laws.

3. We are happy to provide answers to any questions or concerns that you have regarding your treatment or this agreement. After scanning this signed agreement, a copy will be returned to you so that you may refer to it as needed.

This agreement is entered into on : _____
(DATE)

Patient Signature: _____

Physician Signature: _____

(FEMALES ONLY): I certify that I am not pregnant. I will notify Dr. Ford or his staff if I plan a pregnancy or believe that I may be pregnant. (Please Initial): _____

Ford Center for Pain Management

PATIENT HIPAA NOTIFICATION

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, in the future you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We realize that any organization can make mistakes. Because of this, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event compromises our policy of integrity. We welcome your input regarding any service problem so that we may remedy the situation promptly.

Is this a Workmen's Compensation Case ____ Yes ___ No If so, list contact name _____

Contact's phone number _____ Date of Injury _____

Employer's name _____ State of Injury _____

Miscellaneous:

Are you eligible for coverage under the Veteran's Administration? YES ____ NO____

Is your injury due to an automobile accident? YES ____ NO____

Is the above injury still under an active claim or lawsuit? YES ____ NO____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, grant permission for the person(s) listed below to have access to any and all of my medical information that pertains to my care from the providers of this group. I understand that any person (s) not listed on this agreement will not be given my account information unless this form is updated to include their name. This includes, but is not limited to, appointment time, lab results, my physician's plan for health care, billing, account balance, etc. **IF NO ONE IS LISTED WE WILL NOT SPEAK WITH ANYONE OTHER THAN THE PATIENT, WHETERE IT BE A SPOUSE, ATTORNEY'S OFFICE OR FAMILY MEMBERS.**

* Signature _____ Date _____

Full Name _____ Relationship _____

Full Name _____ Relationship _____

Full Name _____ Relationship _____

I UNDERSTAND I MUST NOTIFY FORD CENTER FOR PAIN MANAGEMENT, IN WRITING, TO CHANGE THIS CONSENT.

PAYMENT AUTHORIZATION

It is a courtesy for our office to file your insurance; however you are responsible before seeing your physician to provide your co-pay, deductible and/or percentage, which the insurance company will not pay. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor your account will be given to our collection agency and you will be responsible for additional collections (*i.e.,* interest and attorney's expenses incurred) if applicable.

* I, _____, have fully read and understand the above statement of payment policy. I also state that all of the above information is the most current and updated information.

*Patient's Signature _____ Date _____