Physical Medicine Associates, Inc.

7269 Sawmill Rd, Ste 150

Dublin, OH 43016

Patient Contract

The following document serves as an agreement between the Physicians and staff of Physical Medicine Associates, Inc. and the patient.

Physical Medicine Associates, Inc.'s mission is to provide quality services to our patients. We strive to improve the quality of service to our patients and to provide our patients prompt and courteous service.

In order for Physical Medicine Associates, Inc. to be able to provide quality care to our patients, we feel the following terms are necessary from our patients:

I _____ understand that as the recipient or the guardian of the recipient of medical care, I, the undersigned, am responsible for scheduling my appointments at convenient times and if I am unable to keep my appointment with my doctor, it is my responsibility to contact the office at least 24 hours in advance to cancel or reschedule my appointment. I understand that if I fail to provide the office with 24 hours notice, and if I, as an established patient, have 2 such occurrences within 12 months, will be charged a $25 fee. This fee must be paid prior to my scheduling another office visit appointment. Procedures and non-established patients are subject to a $50 fee upon first occurrence. I understand that if I am receiving prescriptions from my doctor, it is my responsibility to schedule and keep my appointments as directed by my doctor and that if I fail to do so, my doctor will not be able to prescribe my medications. If I am receiving medications from my doctor, I understand and agree that the office will need five (5) working days for medication refill requests.

I understand that it is my responsibility to provide Physical Medicine Associates, Inc. with my correct contact information and correct insurance information at each visit. I understand that if an insurance claim is rejected because of incorrect information provided (or failed to provide), I am responsible for payment in full for any charges, regardless of the provider status of my doctor. ***I understand that I must provide a state issued ID, my insurance card, along with the subscriber's name, date of birth AND Social Security Number, as well as the patient's Social Security Number for billing purposes.*** I also understand that my copay is due at each visit and if I am unable to pay this at the visit, I may have to reschedule the appointment. As a courtesy to our patients, we will file claims to your primary and secondary insurance. Please note, your health insurance is a contract between YOU and YOUR INSURANCE COMPANY, so it is your responsibility to ensure that our physicians are covered under your plan. Not all insurance companies carry the same benefits, so the services rendered to you in this office may or may not be covered. It is the patient's responsibility to know what is covered and if you need a referral, authorization or otherwise.

I hereby authorize the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my physician and all necessary parties to submit claims and/or to release medical information, as outlined in my contract with my insurance company, to obtain benefits for services rendered.

I hereby authorize my insurance company to pay and hereby assign directly to Physical Medicine Associates, Inc. all benefits. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by Physical Medicine Associates, Inc. will be credited to my account in accordance with my insurance company's assignment if my doctor is a provider for my insurance company. Any unpaid charges or fees for out of network service or non-covered services, regardless of the reason they are non-covered, are my responsibility.

I understand that Physical Medicine Associates, Inc. does NOT accept HCAP that is offered through the hospital. I understand that by keeping my appointment, I will be responsible for the balance of my visit after insurance payments and adjustments.

I agree to make prompt payments for services rendered by Physical Medicine Associates, Inc. . I understand that if I am unable to pay the balance promptly, it is my responsibility to contact Physical Medicine Associates, Inc. to set up a payment plan. I understand that if I fail to make prompt payments or fail to adhere to the payment plan, my account may be turned over to a collection agency. If this is necessary, I will be responsible for any collection fees, attorney fees or any additional fees related to collecting my balance due and could affect my ability to continue to schedule appointments. I agree that I have the primary duty and obligation to pay my doctor for their services, notwithstanding any contract I may have with any third party payer (for example, insurance company, employer, etc.).

I understand that if I have any questions about my responsibilities or this agreement, I am responsible for contacting Physical Medicine Associates, Inc. with my questions.

I have read and agree to the terms outlined above.

Signed (Patient or Guarantor) _____ Date _____

Printed Name _____

Patient Name (If different) _____

PHYSICAL MEDICINE ASSOCIATES, INC.

PLEASE PRINT NEATLY

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP CODE: _____

HOME PHONE: (_____) _____ CELL: (_____) _____

SSN: _____-_____-_____ SEX: - M F MARITAL STATUS: - S M D W DP

EMAIL: _____

LANGUAGE: _____ RACE: _____ ETHNICITY: HISPANIC/LATINO – YES NO

EMERGENCY CONTACT: _____ PHONE: (_____) _____

RELATIONSHIP TO PATIENT: _____

PHARMACY: _____ PHONE: (_____) _____

REFERRING PHYSICIAN: _____ PHONE: (_____) _____

PRIMARY INSURANCE OR WORKERS COMP

INSURANCE COMPANY or MANAGED CARE ORGANIZATION (MCO):

_____

ID# or CLAIM# _____ GROUP # _____

SUBSCRIBER: _____ DOB: _____ SSN: _____-_____-_____

RELATIONSHIP TO PATIENT: _____

ADDITIONAL WORKER'S COMPENSATION INFORMATION **(REQUIRED)**

EMPLOYER: _____ PHONE: (_____)_____

CASE MANAGER: _____ PHONE: (_____)_____

SECONDARY INSURANCE

INSURANCE COMPANY: _____

ID# _____ GROUP # _____

SUBSCRIBER: _____ DOB: _____ SSN: _____-_____-_____

RELATIONSHIP TO PATIENT: _____

I request that payment of authorized benefits be made on my behalf to Physical Medicine Associates, Inc., 7269 Sawmill Rd, Ste 150, Dublin OH 43016, for all services provided to me by Physical Medicine Associates, Inc. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents or my private insurance company any information needed to determine benefits for the services provided by Physical Medicine Associates, Inc. or any related services. I agree to be fully responsible for all lawful debts incurred by myself or my dependents for services rendered, regardless of insurance coverage, benefits, or determinations.

_____

Signature of Patient (or Responsible party) Date

PHYSICAL MEDICINE ASSOCIATES, INC

Consent to Treat

I voluntarily request a physician, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice, or one that has been identified. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____

Signature

Notice of Privacy Practices

I have received Physical Medicine Associates, Inc. Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the Notice.

_____

Signature

Health Information Portability and Accountability Act

By signing this form, I give Physical Medicine Associates, Inc permission to document person(s) whom I authorize Physical Medicine Associates, Inc to discuss my protected health information with, including billing information and balances owed. I acknowledge that any change to my permissions require notice in writing.

_____

Signature

Physical Medicine Associates, Inc.

New Patient Questionnaire

Name: _____ Date of Birth: _____ Age: _____ Today's Date: _____

Referring Physician: _____

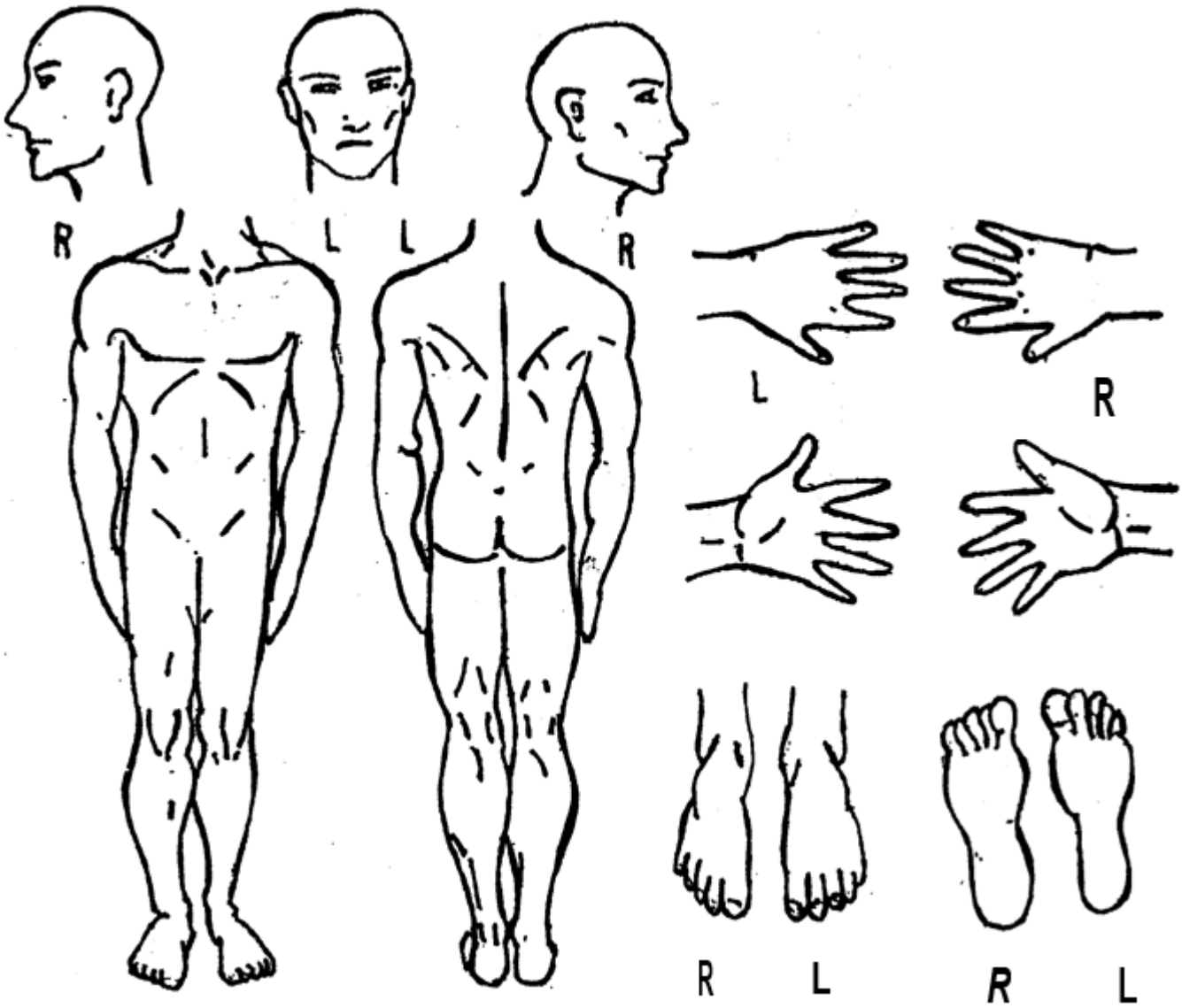
Are you: Right-Handed _____ Left-Handed _____ Height _____ Weight _____

History of Presenting Illness:

Primary Problem: _____

Where is your pain located?: _____

Please mark the figure with the location of your symptoms: Pain = XX Numbness/Tingling = 00



Describe how and when the pain began: _____

_____

Describe your pain (check all that apply):

Sharp ___ Burning ___ Achy ___ Knife-like ___ Twisting ___ Deep ___

Pressure ___ Lancinating ___ Heavy ___ Gnawing ___ Toothache ___

Other (describe) _____

Check the activities that are painful or difficult to do (check all that apply):

Sitting ___ Walking ___ Bending ___ Standing ___ Twisting ___ Sleeping ___ Stairs ___

Reaching Overhead ___ Housekeeping ___ Squatting down ___ Driving/car riding ___

Other (describe) _____

What helps relieve the pain?_____

Please check any of the following treatments you have had relative to this condition:

Physical Therapy ____	Psychologist ____	Pain program ____	Nerve Ablation ____
Occupational Therapy ___	Chiropractor ____	Nerve block/Epidural ____	Spinal Cord Stimulator ___
Massage ____	TENS Unit ____	SI Joint Injection ____	Water Therapy ____
Acupuncture ____	Surgery ____	Facet Injection ____	

Did any of these help? _____

Did any of these make it worse? _____

Have you had any diagnostic tests performed? (MRI, CT-scans, EMG, X-Ray, Myelogram, Bone Scan, etc.)

Yes ____ No ____

If yes, please list: _____

Females: is there a chance you are pregnant? Yes _____ No _____

Please fill in the **PAIN SCALE** with **0 being pain-free and 10 being the worst pain possible.**

Average pain over the past week:

---

0 **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

No Pain — Distressing Pain — Unbearable Pain

Peak pain over the past week:

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0 **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

No Pain — Distressing Pain — Unbearable Pain

Physical Medicine Associates, Inc.

Patient Name: _____
Date of Birth: _____

Please check all that apply:

Past Medical History:

Cardiovascular:

Heart attack ____
Angina ____
Heart Valve Disease ____
Hypertension ____
High Cholesterol ____
Atrial Fibrillation ____
Congestive Heart Failure ____
Stroke ____
TIA (mini stroke) ____
Carotid Blockage ____
Claudication ____
Peripheral Vascular Disease ____
Abdominal Aneurysm ____
DVT (blood clot) ____

Pulmonary:

Asthma ____
Emphysema ____
COPD ____
Pneumonia ____
Lung Cancer ____
Tuberculosis ____
Chronic Bronchitis ____
Pulmonary Embolism ____

Psychosocial:

Depression ____
Stress ____
Anxiety ____
PTSD ____
Panic Attacks ____
Bipolar Disorder ____
Prior TBI (head injury) ____

Musculoskeletal:

Concussion ____
Rheumatoid Arthritis ____
Osteoarthritis ____
Osteopenia ____
Osteoporosis ____
Low Back Pain ____
Fibromyalgia ____
Myofascial Pain ____
Chronic Fatigue Syndrome ____
Rotator Cuff Disorder ____
Carpal Tunnel Syndrome ____
Neuropathy ____
Herniated Disc in Neck ____
Herniated Disc in Lumbar Spine ____
Sciatica ____
Lumbar Stenosis ____
Spasticity ____

Other:

Thyroid Disease ____
Diabetes ____
GERD (reflux) ____
Stomach Ulcer ____
Prior GI Bleed ____
Inflammatory Bowel Disease ____
Irritable Bowel Disease ____
Bowel Polyps ____
Hepatitis ____
Cirrhosis (Liver Disease) ____
Renal Insufficiency (Kidney Disease) ____
Dialysis ____
Multiple Sclerosis ____
Parkinson's Disease ____
Seizures ____
Breast Cancer ____
Prostate Cancer ____
Colon Cancer ____
Lymphoma ____
Leukemia ____
Other Cancer (MUST SPECIFY) ____
_____
Chemotherapy ____
Radiation ____
HIV/AIDS ____

Surgical History:

C-section ____
Hysterectomy ____
Cholecystectomy (gallbladder removal) ____
Tonsillectomy (tonsil removal) ____
Pacemaker/defibrillator ____
CABG (heart bypass surgery) ____
Angioplasty to legs ____
Bypass surgery to legs ____
Heart valve surgery ____
Heart stent placement ____
Knee replacement ____
Knee scope/surgery ____
Hip replacement ____
Hip scope/surgery ____
Fracture Repair ____
Neck Surgery ____
Back Surgery ____
Shoulder scope/surgery ____
Carpal Tunnel Surgery ____
Other (MUST SPECIFY) ____
_____

Prescription Medications (For vitamins and supplements – see check boxes below)

Name of Drug	Dose	Times per Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please check the over the counter medications and vitamins/herbal supplements you take daily.

Aspirin ____ Vitamins/Minerals ____ Glucosamine/Chondroitin ____ Herbals ____

Other Allergies: (Please list additional allergies here):

_____

_____

Physical Activity:

1. Circle the number of days per week you accumulate 30 minutes of daily activity such as walking, climbing stairs, raking leaves, or vacuuming/sweeping? None 1 2 3 4 5 6 7

2. Circle the number of days per week you engage in cardiovascular (aerobic) exercise of at least 20-30 minutes duration, such as brisk walking, cycling, jogging, swimming, etc.? None 1 2 3 4 5 6 7

3. Are you involved in any recreational sports or activities? Please list: _____

4. Please list activities you would like to perform if your pain improves: _____

   _____

Work History:

Occupations: _____ Employer: _____ How long in position? _____

Please describe your job duties:

_____

Are you working: No ____ Date last worked: _____

Yes ____ Full-time: ____ Part-time: ____ Disabled: ____

Job Restrictions: No ____ Yes ____ If yes, please describe: _____

Physical Medicine Associates, Inc.

Name: _____

Date of birth: _____

Family History:

Adopted ____

Please check all that apply:	**Mother**	**Father**	**Sister**	**Brother**
Medical History Unknown				
Alive				
Cardiovascular Disease (heart disease)				
Diabetes				
Hypertension (High Blood Pressure)				
Hyperlipidemia (High cholesterol)				
Stroke				
Breast Cancer				
Colon Cancer				
Lung Cancer				
Osteoporosis				
Arthritis				
Other – must specify				

Social History:

Single ____
Married ____
Life Partner ____
Divorced ____
Separated ____
Widow ____

Check if the answer is YES:

You drink more than two alcoholic drinks per day ____
You smoke tobacco ____
You quit smoking/tobacco use (you were a previous smoker/tobacco user) ____
You use recreational drugs ____
You have ever been addicted to drugs or alcohol ____
You have a family member that is/was addicted to drugs or alcohol ____

Allergies:

Allergies to medications: (Please list others on previous page)

Penicillin ____
Sulfa antibiotics ____
Amoxicillin ____
Lidocaine ____
Latex ____

Allergy to IV contrast dye ____
No known ____

Physical Medicine Associates, Inc.

Patient Name: _____
Date of Birth: _____

Review of Systems:

Have you had any of the following symptoms over the past month? Please check all that apply.

Constitutional:
Weight Gain ____
Weight Loss ____
Fever ____
Chills ____
Weakness ____
Night Sweats ____

Cardiovascular:
Elevated BP ____
Dizziness ____
Chest Pain ____
Heart pounding ____
Palpitations ____
Leg swelling ____
History of rheumatic fever ____

Respiratory:
Cough ____
Wheezing ____
Change in exercise tolerance ____
Shortness of breath ____
Bronchitis ____

Endocrine:
Excess sweating ____
Feeling cold all the time ____
Felling hot all the time ____
Excess thirst ____
Excess hunger ____
Thyroid trouble ____
Diabetes ____

Ear, Nose & Throat:
Ringing in ears ____
Sinus pain ____
Sneezing ____
Change in hearing ____
Vertigo ____
Colds ____
Sore throat ____
Dentures ____

Hematologic/Oncology:
Bleeding problem ____
Easy bruising ____
Blood clots ____
Transfusion reactions ____
History of cancer ____

Gastrointestinal:
Nausea ____
Vomiting ____
Heartburn ____
Abdominal Pain ____
Difficulty Swallowing ____
Diarrhea ____
Constipation ____
Blood in Stool ____
Indigestion ____
Difficulty controlling bowels ____

Genitourinary:
Difficulty urinating ____
Blood in urine ____
Frequent urination ____
Incontinence ____
Frequent urination at night ____
Sexual problems ____
Pregnant ____

Psychological:
Insomnia ____
Memory concern ____
Irritability ____
Feeling down/depressed ____
High stress level ____
Anxiety/nervousness ____
Suicidal ideation ____
Mood changes ____

Skin:
Rash ____
Itching ____
Dryness ____
Jaundice ____
Hair changes ____
Nail changes ____
Easy bruising ____
Lumps ____

Eyes:
Blurred vision ____
Double vision ____
Cataracts ____
Light sensitivity ____
Wear glasses/contacts ____
Tearing ____

Neurological:
Seizures ____
Paralysis ____
Numbness ____
Tingling ____
Fainting ____
One sided weakness ____

Musculoskeletal:
Joint inflammation ____
(pain, redness, swelling)
Morning stiffness ____
Muscle Pain ____
Neck Pain ____
Back Pain ____
Trauma ____
Weakness ____
Cramps ____
Arm or leg pain ____

PHQ2

Over the past 2 weeks, how often have you been bothered by any of the following problems:

1. Little interest or pleasure in doing things?

◯ Not at all
◯ Several days
◯ More than half the days
◯ Nearly every day
◯ Declined to specify

2. Feeling down, depressed, or hopeless?

◯ Not at all
◯ Several days
◯ More than half the days
◯ Nearly every day
◯ Declined to specify