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

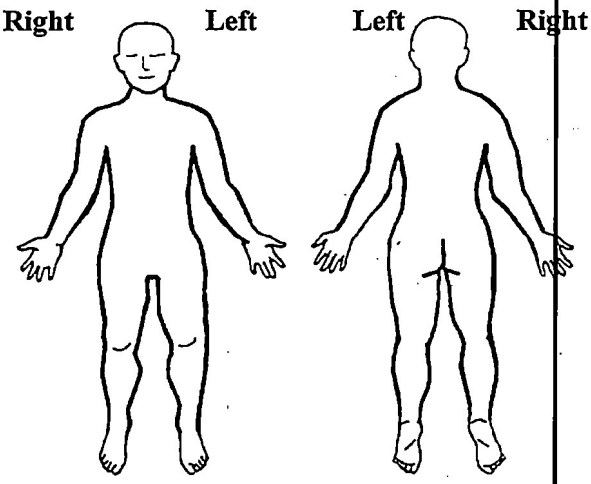
BRIEF PAIN INVENTORY

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 ANTI-AGING PAIN MANAGEMENT

Medical History

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 __

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 ____

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FORD CENTER for ANTI-AGING PAIN MANAGEMENT

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

HEAD Headache _____ Head Injury _____

NECK Lumps _____ Pain _____ Swelling _____

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

ENDOCRINE Diabetes _____ Thyroid Disorder _____

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

FEMALES Menstrual Problems ___ Pelvic Inflammatory Disease ___Menopause__
ONLY Sexually Transmitted Disease _____

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

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 _____

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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)

Ford Center for Pain Management

PATIENT CONSENT FORM

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 entitles 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, at some future time 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 HIPPA 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 (HIPPA) 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 also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.