 **The Comprehensive Center for Pain Management  
and West Central Surgical Center**

Phone: 419-843-1370 Fax: 419-843-1362

- Toledo Pain Services 7053 W. Central Ave. Toledo, OH 43617
- Bayside Center for Pain Management 2751 Bay Park Dr. Suite 209 Oregon, OH 43616
- Aspen Grove Center for Pain Management 7575 Secor Rd Lambertville, MI 48144

**RE: PAIN MANAGEMENT APPOINTMENT**

Dear \_\_\_\_\_

Welcome to the Comprehensive Center for Pain Management.

Your appointment is on \_\_\_\_\_ at \_\_\_\_\_

with Dr. \_\_\_\_\_.

Please arrive @ \_\_\_\_\_ to complete the registration process.

**Please Remember:**

1. You will need to arrive thirty minutes (30) prior to your appointment to complete the registration process.
2. Bring your insurance or BWC card and any approval papers. (Have you checked with your insurance carrier regarding the coverage of these procedures?).
3. Please plan 1½ to 2 hours for your first appointment.
4. You will need to bring any films and reports of any MRI, CAT-scan, X-Rays, etc.
5. You will need to obtain any information from any other physicians, hospitals, physical therapists, or clinics regarding your condition and bring this information with you to your first appointment. This may involve contacting these offices and signing a release of information form.
6. Due to the limited number of appointment times available, \$50.00 may be charged to all patients who have missed appointments or have not cancelled 48 hours prior to their scheduled appointment.

Thank You.

*The Staff of Comprehensive Centers for Pain Management and West Central Surgical Center*



# The Comprehensive Center for Pain Management and West Central Surgical Center

- Toledo Pain Services       Bayside Center for Pain Management  
 Aspen Grove Center for Pain Management       West Central Surgical Center

## PATIENT REGISTRATION FORM

Please complete all forms with blue or black ink only.

### PATIENT INFORMATION:

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

Do you have access to a computer with Internet? Yes No

Would you like your medical information accessible through the Internet? Yes No

Your e-mail address: \_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION

LAST NAME: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

OTHER PARENTS NAME: \_\_\_\_\_

### PRIMARY INSURANCE NAME:

### SECONDARY INSURANCE:

INSURED LAST NAME: \_\_\_\_\_

INSURED LAST NAME: \_\_\_\_\_

INSURED FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

INSURED FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

INSURED SS#: \_\_\_\_\_

INSURED SS#: \_\_\_\_\_

INSURED DOB: \_\_\_\_\_ SEX: \_\_\_\_\_

INSURED DOB: \_\_\_\_\_ SEX: \_\_\_\_\_

POLICY# /RID#: \_\_\_\_\_

POLICY # /RID #: \_\_\_\_\_

GROUP#: \_\_\_\_\_

GROUP #: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

### EMERGENCY NOTIFICATION:

NAME: \_\_\_\_\_

PHONE(S): \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

### **AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS**

I authorize the release of any medical information necessary to process my insurance claim(s). I also assign all medical and/or surgical, benefits including major medical benefits, liability, auto accident and Worker's Comp., to which I am entitled, to **West Central Surgical Center and Toledo Pain Services**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. Even though I have provided all my insurance information, I understand I am financially responsible for any balance not covered by my insurance.

### **MEDICARE – MEDICAID**

I certify that the information given be me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

Signature of Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

 **The Comprehensive Center for Pain Management**  
**and West Central Surgical Center**

- |   |  |
|---|--|
| <input type="checkbox"/> Toledo Pain Service                | <input type="checkbox"/> West Central Surgical Center    |
| <input type="checkbox"/> Bayside Center for Pain Management | <input type="checkbox"/> Aspen Grove for Pain Management |

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**CONSENT TO DISCLOSE MEDICAL INFORMATION**  
**What type of message can we leave for you???**

In an effort to better serve you, Comprehensive Centers for Pain Management needs to know what type of messages we can leave on your message machines/voicemail. Please indicate your preference for contacting you by phone.

**CC4PM may leave a detailed message on my answering machine/voicemail:**

YES \_\_\_\_\_ NO \_\_\_\_\_ Other \_\_\_\_\_  
 If no, we will leave enough information for you to call us back.

**CC4PM will always leave detailed information when confirming your appointments, unless otherwise indicated by you, the patient.**

AGREE \_\_\_\_\_ DISAGREE \_\_\_\_\_ if you disagree, a message to call us back will be left on your answering machine/voicemail.

**Who can we speak to concerning your Protected Health Information???**

Please tell us to whom we can disclose or discuss your Protected Health Information. Please check the types of information that you authorize CC4PM to disclose/discuss with indicated family/friends:

\_\_\_\_\_ Relationship \_\_\_\_\_  
 \_\_\_\_\_ Relationship \_\_\_\_\_  
 \_\_\_\_\_ Relationship \_\_\_\_\_  
 \_\_\_\_\_ Relationship \_\_\_\_\_

**My Entire File \_\_\_\_\_ or specifically: (circle choices)**

- |              |   |                    |                       |
|--------------|---|--------------------|-----------------------|
| Diagnosis    | Progress to Date                                | Dates of Treatment | Clinical Psychologist |
| Prognosis    | Billing Information                             | Treatment Plan     | Symptoms              |
| Test Results | Modalities & Frequencies of Treatment Furnished | Other _____        |                       |

I understand that I may revoke or change this authorization at anytime by completing another Consent to Disclose Medical Information form. I understand that I will not be denied or refused treatment if I refuse to sign this authorization. I understand that I have the right to receive a copy of this authorization, if requested. I understand that this authorization will not expire.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **SUMMARY OF JOINT NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**

This is a brief summary of your privacy rights. A copy of the entire Joint Notice of Privacy Practices which provides a full description of your rights is available at the registration desk.

This notice summarizes the privacy practices of West Central Surgical Center and Comprehensive Centers for Pain Management. These organizations are allowed to share medical information with each other for treatment, payment and operational activities. We will use this information in order to provide our patients with complete and comprehensive health care services.

### **Our Commitment to You**

We are committed to protecting your medical information. We are required by law to keep medical information about you private, to give you notice about our privacy practices and to follow the practices outlined in the notice.

### **How We May Use and Disclose Your Medical Information**

We may use your medical information for treatment (such as sending medical information about you to your referring physician, payment (such as sending a bill to your insurance company), and for health care operations (such as evaluating the performances of our staff).

Under certain circumstances we are allowed to use or disclose your medical information without your written permission. We may give out information about you for public health purposes, reports or abuse, neglect, or domestic violence, health oversight audits or inspections, research studies, funeral arrangements and organ donations, government programs, workers compensation and emergency situations. We also disclose patient information when required by law, such as in response to request from law enforcement or in response to judicial orders.

We also may contact you for appointment reminders, or to tell you about possible treatment options and health services. We may disclose medical information about you to a friend or family member who is involved in your care.

### **Your Rights Concerning Your Medical Information**

You have the right to access or copy your medical information. There may be a fee for this service; you may ask us to amend the medical information you believe is incorrect or incomplete. You may have a list of non-routine disclosures we have made about you. You may request special confidential communications. You may request restrictions on information disclosed about you. You have the right to complain to us and to the federal government if you believe your privacy rights have been violated. You have the right to a paper copy of the entire Joint Notices of Privacy Practices.

We have the right to make changes to the Joint Notice of Privacy Practices. A copy of the current Joint Notice of Privacy Practices is available in the locations where you receive services.

**THIS IS A SUMMARY ONLY. THE FULL TEXT OF THE JOINT NOTICE OF PRIVACY PRACTICES IS AVAILABLE AT THE REGISTRATION DESK**

***Comprehensive Centers for Pain Management  
and West Central Surgical Center***

*A multi-disciplinary approach to pain care*

**Notice of Privacy Acknowledgement**

**Patient Name:** \_\_\_\_\_  
**Printed Name**

I understand and acknowledge the receipt of the Health Insurance Portability and Accountability Act (HIPAA).

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Patient is unable/unwilling to sign for the following reason:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Notice of HIPAA was given to patient. (Please check)**

**Employee signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**ADVANCED DIRECTIVE  
INFORMATION**

Dear Patient:

The Ohio Department of Health requires Ambulatory Surgical Centers (ASC) to have on file a patients' Advanced Directives. Advance Directives include a Living Will, Durable Power of Attorney (pertaining to medical care), and Do Not Resuscitate orders.

**Please initial your response in each area below .**

***LIVING WILL***       Yes       No       No, but would like information

***DURABLE POWER  
OF ATTORNEY***       Yes       No       No, but would like information

***DO NOT  
RESUSCITATE  
ORDERS***       Yes       No       No, but would like information

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you,  
The Comprehensive Centers for Pain Management &  
West Central Surgical Center

## Declaration of Insurance

### Non-Work Related Injury

**Please Read Carefully**

By signing this form you are declaring that the injury or disease for which your Comprehensive Centers for Pain Management (CCPM) Physician is treating you is not a work related injury, **It is understood you will not be filing a Worker's Compensation claim.** Should you file such a claim at a later date, CCPM cannot and will not support your claim based on this signed declaration. Furthermore, you are financially responsible to CCPM for all charges unless otherwise specified by a contractual agreement with you insurance carrier.

I \_\_\_\_\_ hereby declare that my injury is not work related and I authorize CCPM to submit a claim and complete information to my insurance carrier for covered services rendered by my physician. I authorize my insurance carrier to issue payments directly to CCPM for all payable services. I understand that I am financially responsible to CCPM for all charges unless otherwise specified by a contractual agreement with my insurance carrier, or otherwise prohibited by applicable Ohio Law.

### Non-Auto Related Injury

**Please Read Carefully**

By signing this form you are declaring that the injury or disease for which your CCPM Physician is treating you is not a auto accident related injury, **It is understood you will not be filing a Auto Insurance claim.** Should you file such a claim at a later date, CCPM cannot and will not support your claim based on this signed declaration. Furthermore, you are financially responsible to CCPM for all charges unless otherwise specified by a contractual agreement with you insurance carrier.

I \_\_\_\_\_ hereby declare that my injury is not auto related and I authorize CCPM to submit a claim and complete information to my insurance carrier for covered services rendered by my physician. I authorize my insurance carrier to issue payments directly to CCPM for all payable services. I understand that I am financially responsible to CCPM for all charges unless otherwise specified by a contractual agreement with my insurance carrier, or otherwise prohibited by applicable Ohio Law.

**If I am not covered by a health insurance policy, I understand that all payments will be due at the time of service.**

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

## **PATIENT CONSENT TO PHOTOGRAPH**

*It is the policy of this facility to take the photograph  
of each patient for proper identification.*

The patient or a legal representative of the patient must acknowledge this documentation by signing below as indicated.

This consent will serve as identification documentation for the duration of the treatment for the particular condition or injury.

**Patient Name:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**Witness to Signature:** \_\_\_\_\_

# COMPREHENSIVE CENTERS FOR PAIN MANAGEMENT

## TOLEDO PAIN SERVICES/WEST CENTRAL SURGICAL CENTER

### *Patient Responsibility Statement*

1. To provide the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his health. Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
2. To participate in health care decisions and for following the treatment plan outlined by the practitioner responsible for his care. This includes following instructions of the physicians, nurses and other health care personnel carrying out the plan of care and enforcing the Center's rules and regulations.
3. For assuring that the financial obligations of his health care are fulfilled as promptly as possible, and in the case of financial difficulty, making all reasonable efforts to meet any agreed upon financial payment plan. Accept personal financial responsibility for any charges not covered by his/her insurance.
4. For his actions if he refuses treatment or is non-compliant in following a plan of treatment recommended by his physician. Patient are informed of their right to change their provider if other qualified providers are available.
5. To know the rules and regulations of the Center affecting his care and conduct, and for following those Center's rules and regulations.
6. For being considerate of the rights of other patients and Center personnel, and for assisting in the control of noise and smoking.
7. For being respectful of the property of other persons and the Center.
8. To make known to his physician, attending nurse, or other health care personnel, any concerns or complaints he may have.
9. To make sure he understands all information regarding the implications of his symptoms, his surgery or procedure (if applicable) and any risks related to having or declining such surgery or procedure, the expected outcomes of the plan of care outlined by this physician, and his responsibilities in regards to that plan of care.
10. The patient has the right to be free from all forms of abuse or harassment

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# ***WEST CENTRAL SURGICAL CENTER***

## **Patient Bill of Rights**

- To expect to be treated with respect, consideration, dignity and provided appropriate privacy.
- The patient has the right to be free from all forms of abuse and harassment
- To be assured confidential treatment of disclosure of records and afforded the opportunity to approve or refuse the release of such information, except as otherwise permitted by law of third Party Payment contract and when law requires release.
- To know the name and function of any person providing health care services to the patient.
- To know names and professional relationships of other physicians who may care for him in the absence of his attending physician.
- To be provided, to the degree known, information concerning their diagnosis, treatment, and prognosis. When it is not medically advisable to give such information to the patient, the information will be made available to an appropriate person in his behalf.
- To have the opportunity to participate in decisions involving their health care.
- To request a second opinion.
- To expect reasonable response to any reasonable requests he may make for service.
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences of his action.
- To expect communication in the language which they understand.
- To expect treatment without regard to race, color, creed, religion, sex, national origin or source of payment, except for fiscal capability thereof.
- To know services available, such as provisions for after hours or emergency care, educational material available, and policies concerning Payment of fees.
- To examine and receive an explanation of his bill, regardless of the source of payment.
- To expect reasonable continuity of care and how to know in advance the time and location of appointments.
- To designate any area of where he is cared for or treated as non-smoking area.
- To leave the Center even against the advice of his physician.
- To have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- To be informed prior to procedure, that West Central Surgical Center is a "Physician Owned" facility.
- Will be aware that advanced directives will not be honored during elective surgery or procedures.
- Medicare patients have the right to file a written report to the QIO (Quality Improvement Organization) about the quality of care they are receiving or have received from the Ambulatory Surgical Center (West Central Surgical Center). They can file the written report at *CMS at Centers for Medicare & Medicaid Services, Dept of Human Services, Attention: CMS-3225-P, PO BOX 8010, Baltimore, MD 21244-8010.*

For Complaints call the Ohio Department of Health at 1-800-342-0553.TDDline for hearing impairment.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**❖ Comprehensive Centers for Pain Management  
and West Central Surgical Center**  
*A multi-disciplinary approach to pain care*

**PATIENT INFORMATION FORM**

**Please complete with blue or black ink only.**

**Please complete and bring with you to your appointment.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Male Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Physician Information:**

**Family:** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Referring:** \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Present Problem:**

Briefly list the main reason(s) for your visit today: \_\_\_\_\_

\_\_\_\_\_

How did your pain problem first start (describe): \_\_\_\_\_

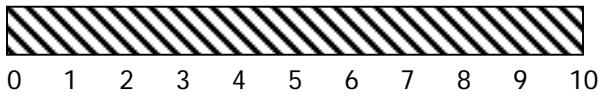
\_\_\_\_\_

Please describe what your pain is like: Sharp Shooting Burning Pressure Throbbing  
Cramping Achy Constant Stabbing Gnawing Tender Comes and goes

How long have you had this pain? \_\_\_\_\_

At any given time, think of your pain intensity as falling somewhere on a scale from 0 to 10.  
Please rate your pain on the following diagrams: **0=No pain** **10=Very severe pain**

**Current Level of Pain**



**Average Level of Pain**



When is your pain the worst? (check one): Morning Afternoon Evening Night Varies All the time

Are you awakened at night by your pain? No Yes

What improves your pain? : \_\_\_\_\_

What worsens your pain? : \_\_\_\_\_

Patient Name: \_\_\_\_\_

**Pain Evaluation Instructions:** In each section, check **ONE** box that best describes your pain.  
If section has no description that applies to your pain, please skip that section.

1.flickering	<input type="checkbox"/>
2.quivering	<input type="checkbox"/>
3.pulsing	<input type="checkbox"/>
4.throbbing	<input type="checkbox"/>
5.beating	<input type="checkbox"/>
6.pounding	<input type="checkbox"/>

1.jumping	<input type="checkbox"/>
2.flashing	<input type="checkbox"/>
3.shooting	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>

1.pricking	<input type="checkbox"/>
2.boring	<input type="checkbox"/>
3.drilling	<input type="checkbox"/>
4.stabbing	<input type="checkbox"/>
5.lacinating	<input type="checkbox"/>
	<input type="checkbox"/>

1.pinching	<input type="checkbox"/>
2.pressing	<input type="checkbox"/>
3.gnawing	<input type="checkbox"/>
4.cramping	<input type="checkbox"/>
5.crushing	<input type="checkbox"/>

1.tugging	<input type="checkbox"/>
2.pulling	<input type="checkbox"/>
3.wrenching	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>

1.hot	<input type="checkbox"/>
2.burning	<input type="checkbox"/>
3.scalding	<input type="checkbox"/>
4.searing	<input type="checkbox"/>
	<input type="checkbox"/>

1.dull	<input type="checkbox"/>
2.sore	<input type="checkbox"/>
3.hurting	<input type="checkbox"/>
4.aching	<input type="checkbox"/>
5.heavy	<input type="checkbox"/>

1.tender	<input type="checkbox"/>
2.taut	<input type="checkbox"/>
3.rasping	<input type="checkbox"/>
4.splitting	<input type="checkbox"/>
	<input type="checkbox"/>

1.tiring	<input type="checkbox"/>
2.exhausting	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>

1.fearful	<input type="checkbox"/>
2.frightful	<input type="checkbox"/>
3.terrifying	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>

1.punishing	<input type="checkbox"/>
2.gruelling	<input type="checkbox"/>
3.cruel	<input type="checkbox"/>
4.vicious	<input type="checkbox"/>
5.killing	<input type="checkbox"/>

1.wretched	<input type="checkbox"/>
2.blinding	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>

1.spreading	<input type="checkbox"/>
2.radiating	<input type="checkbox"/>
3.penetration	<input type="checkbox"/>
4.piercing	<input type="checkbox"/>
	<input type="checkbox"/>

1.tight	<input type="checkbox"/>
2.numb	<input type="checkbox"/>
3.drawing	<input type="checkbox"/>
4.squeezing	<input type="checkbox"/>
5.tearing	<input type="checkbox"/>

1.cool	<input type="checkbox"/>
2.cold	<input type="checkbox"/>
3.freezing	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>

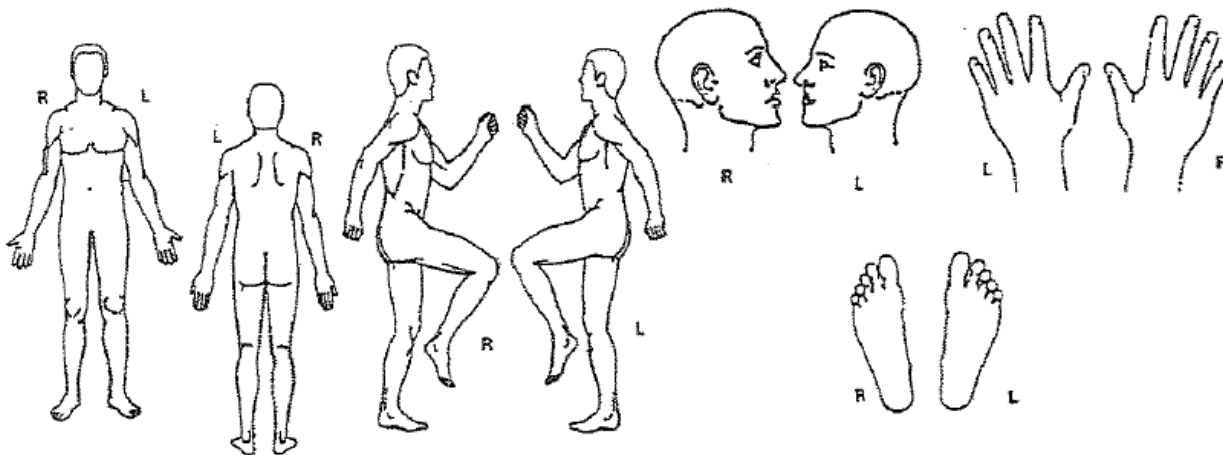
Patient Name: \_\_\_\_\_

**Previous Treatment for Pain:**

Which of the treatments listed below have you participated in to relieve your pain.

Treatment	Helpful				Date
	Y	N	Y	N	
Nerve Blocks					
TENS Unit					
Occupational/Physical Therapy					
Bio-Feedback					
Hypnosis					
Counseling					
Chiropractor					
Acupuncture					
Other (please note treatment)					

Please shade in the areas where you feel pain and the degree of pain you are feeling on the drawings below. Please use the following examples: **minimal pain-light shading** **severe pain-dark shading**



Which of the tests below have you had to evaluate your pain problems?

Test	Y	N	Date	Where were tests done?
X-Rays				
CT Scan				
MRI				
EMG				
Myelogram				
Other (please indicate type of test)				

Patient Name: \_\_\_\_\_

**Medical History:**

Check All that Apply

**Head/Eyes/Ears/Nose/Throat**

None
Cataract
Glaucoma
Sinus Infection

**Heart**

None
Rheumatic Fever
Heart Failure
Abnormal Heart Rhythm
High Blood Pressure

**Lung**

None
Asthma
Sleep Apnea
Tuberculosis
Emphysema/COPD
Pneumonia

**Gastrointestinal**

None
Stomach/Duodenal Ulcer
Cirrhosis
Hepatitis (Type)_____
Gallstones
Pancreatic Disease
Esophagus Disease
Crohn's or Colitis
Diverticulitis
Acid Reflux/GERD

**Genitourinary**

None
Kidney Infection
Kidney Stones
Kidney Failure
Dialysis
Prostate Problems

**Muscle Skeletal**

None
Rheumatoid Arthritis
Gout
Lupus
Serious Joint Injury
Broken Bone/Fracture
Degenerative Arthritis
Osteoporosis
Fibromyalgia

**Neurological/Psychological**

None
Headache
TIA(Mini Stroke)
Multiple Sclerosis
Stroke/Paralysis
Seizure/Epilepsy
Depression
Anxiety
Eating Disorder

**Endocrine**

None
Thyroid Disease
Diabetes

**Hemtological/Oncological**

None
Cancer (Type)_____
Chemotherapy
Radiation
Anemia
Blood Clot (Leg__Lung__other_____)
Bleeding Tendency

**Peripheral Vascular**

Aneurysm
Varicose Veins
Peripheral Vascular Disease (PVD)

**Skin**

Skin Ulcer-Lower Leg
Psoriasis
Rash

**Other**

Alcoholism
Drug Abuse
Immune Deficiency
Chronic Fatigue Syndrome
Other_____

Patient Name: \_\_\_\_\_

**Past Surgeries:**

Please list all surgeries

SURGERY	DATE	SURGERY	DATE

**Allergies:**

Are you allergic to any medications?  Yes  No If Yes, which medications? \_\_\_\_\_

\_\_\_\_\_

Have you ever had difficulties with spinal, epidural or anesthetics?  Yes  No

**Current Medications:**

What, if any, medications are you currently taking. Please list all medications, prescriptions and over the counter, including herbs and vitamins.

Medication/Dosage	Frequency	Medication/Dosage	Frequency

List any medications that you have previously taken for your pain.

Medication/Dosage	Frequency	Why did you discontinue??

Patient Name: \_\_\_\_\_

**Family History:**

Check All That Apply

	Mother	Father	Sisters	Brothers	Grandmother	Grandfather
<b>Cancer</b>						
<b>Heart Disease</b>						
<b>Lung Disease</b>						
<b>Diabetes</b>						
<b>Kidney Disease</b>						

**Social History:**

**Alcohol Use:** Frequency \_\_\_\_\_ Amount: \_\_\_\_\_

**Tobacco Use:** None: \_\_\_\_\_ or per day: \_\_\_\_\_

**Marital Status:** Married \_\_\_\_\_ Single: \_\_\_\_\_ Widowed: \_\_\_\_\_ Divorced: \_\_\_\_\_

**Employment Status:** Full-Time: \_\_\_\_\_ Part-Time: \_\_\_\_\_ Unemployed: \_\_\_\_\_ Student: \_\_\_\_\_ Retired: \_\_\_\_\_ Disabled: \_\_\_\_\_

**Occupation:** \_\_\_\_\_

What does your work involve? \_\_\_\_\_

Who lives at home with you? \_\_\_\_\_

**Drug Use:**  None  Prescribed  Marijuana-frequency \_\_\_\_\_  Cocaine-frequency \_\_\_\_\_

Other: \_\_\_\_\_

Patient Name: \_\_\_\_\_

**Review of Systems:**

In the **PAST 4 WEEKS** have you noticed any of the following symptoms? Please check all that apply.

<b>General</b>		<b>Genitourinary</b>	
None		None	
Weight Change		Problems with passing urine	
Appetite Change		Urine Leakage	
Fever, Chills, Sweats		Menstrual problems	
Dizziness/Fainting		I may be pregnant	
<b>Head/Eyes/Ears/Nose/Throat</b>		Pain with passing urine	
None		<b>Musculoskeletal/Neurological</b>	
Vision Change		None	
Hearing Change		Headache	
Dry Mouth		Joint Pain	
Trouble swallowing		Joint Swelling	
Mouth Sores		Stiff Muscles	
<b>Cardiopulmonary</b>		Painful Muscles	
None		Weakness	
Shortness of Breath		Numbness/Tingling	
Chest Pain		Where? _____	
Swollen Ankles		Back Pain	
Coughing up Blood		Neck Pain	
Rapid heart rate		<b>Skin</b>	
<b>Gastrointestinal</b>		None	
None		Rashes	
Heartburn		Skin Ulcers	
Nausea		<b>Peripheral Vascular</b>	
Abdominal Pain		None	
Constipation		Cool Hands/Feet	
Diarrhea		Color Change	
Bleeding from Rectum		Leg Pain when Walking	
Black Bowel Movements			

Patient Name: \_\_\_\_\_

**Patient Plan of Care/Goals:**

(To be completed with the Nurse at the time of the first appointment)

It is important that you take an active role in a plan to control your pain. Please communicate with our Pain Management Staff, your Pain Management goals. (Including any educational needs)

1. Restore or improve functioning by reducing pain whenever possible: \_\_\_\_\_
2. Develop self-help and maintenance skills for managing pain and it's related problems: \_\_\_\_\_
3. Increase knowledge of Chronic Pain Management: \_\_\_\_\_
4. What do you expect from the Pain Management Clinic? \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_

Completed By: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

## FINANCIAL POLICY

**The Comprehensive Centers for Pain Management (CCPM)** – physician services are billed through **Toledo Pain Services**. Procedural services to be rendered at West Central Surgical Center will be billed separately by West Central Surgical Center. CCPM is dedicated to serving our patients with the highest quality of care at the lowest possible cost. We ask that you help keep our fees at a competitive level by observing the following financial policy. The **purpose of this statement** is to help you understand our policy in relation to the centers charges. We encourage open discussion of services and fees prior to treatment.

**For questions regarding either service, please call 419-843-1370, option 5 billing questions and option 6 for W/C questions**

You may receive **TWO** bills for your services:

- One bill from **Toledo Pain Services**, for the professional services of our centers physicians.
- One bill from **West Central Surgical Center**, the facility fee (i.e. nursing and technician services, anesthesia, supplies and equipment).

**It is ultimately your responsibility to make sure that all of your services are paid in full. Failure to do so will result in cancellation of your procedures and delay in your treatment.**

\_\_\_\_\_  
Patient's initials

## YOUR HEALTH INSURANCE POLICY/COVERAGE

Since insurance plans vary, we recommend that you be familiar with your plan benefits as they relate to deductibles, **co-pays**, non-allowed charges and pre-certification. Your insurance coverage represents a contract between you and your insurance carrier.

If you have an insurance policy, such as an **HMO/PPO** that requires **pre-certification / pre-authorization or referrals for any service, including office visits, it is your responsibility** to obtain it, update it and keep it current. If you need any help, our staff will be more than happy to help you through the process. On your insurance card will be a telephone number that you should call for pre-approvals or information on deductibles, co-pays, and pre-certification. You can also use this number to find out what your insurance company's allowable is for the proposed treatment.

If you have any questions about the requirements of your coverage, please contact your employer or insurance carrier. We cannot interpret policies for you. We cannot tell you what your financial responsibility will be for a procedure until the claim has been processed. You must contact your insurance company for this information.

Remember that the difference between the allowable and the cost of the treatment will be your personal responsibility unless a current contract is on file with your insurance company and us.

You will be responsible for services rendered that are outside the scope of any referral issued by your insurance carrier. You are expected to be aware of any and all conditions of your insurance coverage. Please provide us with information on any secondary insurance coverage that you may have as they may cover the difference.

No one can overturn a **denial for coverage** more effectively than the patient. If your insurance company has denied coverage for the proposed services, our physicians will be more than happy to write a **“letter of Medical Necessity”**. Despite this, some companies will continue to deny coverage, in which case, it becomes the patient’s responsibility to try to overturn the decision; otherwise, the responsibility for payment becomes entirely yours.

We will provide you with the information necessary for you to request a review of a denied claim or to follow up on disputed claims. It is your responsibility to follow up on any outstanding claims and to see that your carrier pays promptly. Claims status does not relieve you of your responsibility to pay your bill. Be aware that for some insurance carriers, granting *authorization* for treatment does not mean that they will actually pay for it. Denial of payment after pre-approval or authorization will make you responsible for the charges.

**Filing claims** with and accepting benefit assignment from your insurance company is a courtesy to patients provided by many physician offices. However, an increasing number of physician offices require full payment at the time of service and the patient is responsible for securing payment from the insurance company. When a medical practice chooses to help patients by filing for insurance payments, the result to the physician is that he often waits 45 days or more for payment. **Toledo Pain Services** has chosen to continue to work with insurance companies for as long as possible to make it easier for patients to receive the specialized healthcare they need. This means both us as the provider, and you as the patient have certain responsibilities.

**The balance due is your responsibility if we do not receive payment from your insurance company within 30 days.** Therefore, you may receive a bill after those 30 days. If we receive duplicate payment from the insurance company, we will promptly refund any overpayment to your insurance carrier.

\_\_\_\_\_  
Patient’s initials

## YOUR RESPONSIBILITIES

- Provide us with current insurance information; primary, secondary and tertiary
  - To help us provide the most efficient and reasonable health care services, **we need your insurance information to be accurate**, complete and up-to-date
- Update our office when insurance coverage and personal information changes
  - Failure to give your current and correct personal information can result in your account being sent to a collection agency
- Obtain pre-certification for services from your insurance carrier (telephone number is on your insurance card)
- Pay co-payments and deductibles at the time of service
- Pay outstanding balances when you receive statements
- Work with employers and insurance companies if collection from insurance companies becomes a problem
- Stay in touch with our billing office regarding your account

\_\_\_\_\_  
Patient's initials

## SELF-PAY PATIENT POLICY

A self-pay patient is a patient who has no medical insurance or medical benefits. 100% of all services must be paid for at the time of service. The initial consultation cost is \$165.00. We are unable to quote prices for procedures until after you have been seen by the physician and a plan of care has been established. You may not accrue a balance on your account.

\_\_\_\_\_  
Patient's initials

## YOUR COPAY IS DUE AT THE TIME OF SERVICE.

**Failure to pay your co-pay at the time of service will result in an additional charge of \$10.00.**

- Your co-pay may be paid in cash, a check or paid using your credit card at the time of your service.
- Please indicate your preference to the receptionist at the time of your service.
- Unpaid copays will result in cancellation of appointments.

\_\_\_\_\_  
Patient's initials

## **DEDUCTIBLE AMOUNTS MUST BE PAID IMMEDIATELY ONCE CLAIM IS PROCESSED**

A deductible is a set amount of medical expenses a patient must pay to become eligible for insurance benefits under an insurance program. What does that mean exactly? It means that before an insurance company begins to make payments for a patient, the patient must meet their deductible. We will call your insurance carrier before you are seen and inquire as to the amount of your deductible and if any of it has been satisfied yet. If you are scheduled for a procedure and your deductible has not been met, we will collect this amount from immediately once claim is processed.

Deductible amounts must be made to Toledo Pain Services for the professional fees and to West Central Surgical Center for the facility/anesthesia fees.

\_\_\_\_\_  
Patient's initials

## **PAYMENT ARRANGEMENTS**

Other than co-pay amounts and deductibles; when you accrue an account balance we will be happy to work with you to establish a monthly payment plan. You will be required to pay 25% of the balance due every month. Payments **MUST** be made every month. Your need for potential payment arrangements should be discussed before services are rendered. Payment plans may not be set up once accounts reach delinquent status (i.e. collections, bankruptcy). The 25% must be paid monthly or the account balance will become due in full and balances will be forwarded to a collection agency for continued collection proceedings.

\_\_\_\_\_  
Patient's initials

## **CANCELLATION POLICY**

A charge may be incurred at a rate of:

- **\$25.00 for a missed office visit with a nurse practitioner**
  - 24 hour cancellation notice required
- **\$50.00 for missed office visit with a physician**
  - 24 hour cancellation notice required
- **\$100.00 for a missed procedure visit and an additional \$200.00 if anesthesia was scheduled**
  - This includes procedures scheduled at West Central Surgical Center, our Bay Park office and any area hospital.
  - 48 hour cancellation notice required

**Three missed appointments without proper notification may lead to discharge from the practice.**

\_\_\_\_\_  
Patient's initials

There will be a **\$25.00** charge for any form completion over and above any medical request fee. This includes Disability, legal documents, etc.

We ask that you read this policy and assist us in keeping our costs down by ensuring that we can be paid on a timely basis for our services. We welcome the opportunity to discuss with you any aspect of our financial policy.

***To help us fulfill this policy, we ask that you assist us by:***

1. Providing us with current and updated information on yourself and your insurance coverage and advise us immediately of any changes in insurance coverage, personal address, etc.
2. Making payment at the time of service for the entire balance if you are a "Self-Pay" or "Self-Insured" patient or for the amount of the deductible or co-payment if you have insurance.
3. Keeping your balance current or continue to make regular monthly payments on your balance.
4. Discussing your account status and balance only with the checkout staff or our billing staff.

**Your physician is not in the billing department. Please do not discuss the financial aspects of your care with the physician(s).** It is important for them to be allowed to practice medicine and provide patient care. We have employed professional billing staff that is familiar with the services we provide and with all of the insurance plans with which we participate. Please call them at 419-843-1369 anytime you have questions about your coverage or your account.

We ask that you pay ahead of time on the balance or any unmet deductible that is your responsibility. For **Medicare patients**, we will wait until we have received payment or other response from Medicare before billing you for any remaining balance due.

For **Worker's Compensation claims**, it is our policy to bill your employer or the Worker's Compensation carrier for services rendered. However, you must bring proof of acceptance of the claim; complete billing information and authorization from the compensation carrier. **Otherwise, you will be responsible for all fees incurred.** If you are covered, we will accept the payment made by Worker's Compensation as payment in full. If Worker's Compensation denies payment or goes into litigation, the entire balance will become your responsibility and will be due within 10 day of the date of the denial. We will, however, as a courtesy bill your private health insurance plan if you provided us with the appropriate information at your initial visit. For this reason, and for your protection, we ask that you provide complete information on all your health insurance at the time of your initial appointment.

For **Standard Insurance carriers** that do not cover office visits, you will be required to make full payment for the services not covered on the day of service.

For **Commercial contracted carriers**, we will wait until we have received payment or other response from your insurance before billing you for any remaining balance due.

We ask that you pay ahead of time on the balance or any unmet deductible that is your responsibility.

**We do not hold bills for pending litigation** or bill attorneys for services rendered to patients. Presenting a letter or representation from an attorney does not alleviate you of the responsibility for your bill. **If your treatment is required as a result of an accident, we will expect 50% of charges for service at the time of service.**

**If you do not have any health insurance and are not covered by Medicare, Medicaid or Worker's Compensation, you will be considered a "Self Pay" patient. Payment is due at the time we deliver services to you and we require that you pay 50% of the charge for the service at the time of your visit. We will then bill you for the balance with the expectation of 10% a month until paid.**

\_\_\_\_\_  
Patient's initials

### ***Our Responsibilities***

- File claims with insurance companies in a timely manner
- Send appropriate documentation of procedures and medical necessity when necessary
- Post payments received in a timely fashion
- Send statement of account activity and patient balances due in a timely manner



The **Comprehensive Center** for **Pain Management**  
and **West Central Surgical Center**

It is the policy of this facility to make available to each patient a copy of the current Welcome Packet and Financial Policy.

Please acknowledge below that you have read, understand and accept the information in both the Welcome Packet and Financial Policy.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Witness: \_\_\_\_\_