INTERVENTIONAL
PAIN CENTER

Office # 615-972-1100 | Fax # 615-537-4950

Hendersonville Medical Center location
353 New Shackle Island Rd Suite 148C
Hendersonville, TN 37075

Skyline Medical Center location
3443 Dickerson Pike Suite 730
Nashville, TN 37207

Your appointment is scheduled on:_____ arrive at time:_____
(if you are 15 minutes or more late for your appt, you may be asked to reschedule)

Dear Patient,

Thank you for choosing Interventional Pain Center for your pain needs. Bring the following items to your new patient visit.

- ☐ New patient paperwork
- ☐ Insurance card(s)
- ☐ Current driver's license or state identification (you will not be seen without valid identification).
- ☐ List of your current medications.
- ☐ Please call us 24 hours in advance if you are unable to make your appointment.
- ☐ If you need assistance via wheelchair, please bring someone to assist you along with a wheelchair, we do not provide this service.

Directions once arriving at the Hendersonville Hospital: The easiest way to find our office is to enter through the front door of Medical Office Building C. We are on the first floor and we are at the end of the hallway on the left in Suite 148C.

Directions once arriving at the Skyline Medical Center: The easiest way to find our office is to enter through the front door of Medical Office Building and take the elevator to the 7th floor Suite 730.

Only the patient will be allowed in the exam room, family and friends must wait in the waiting area.

For patients with small children:

We understand that you may not be able to find someone to watch your child/children while you are here with us. It is important that you are able to give your undivided attention while seeing our providers. We ask that you make the proper arrangements for someone to watch your children in order for us to best serve you at your visit with us.

Our hours of operation are 6:30am to 5pm, Monday through Thursday. If you have any questions, please give us a call at the number listed above. We look forward to participating in your care.

Interventional Pain Center Patient Information

Patient Name:_____Date of Birth:_____/_____/_____Age:_____ M ☐ F ☐

Address:_____City/State/Zip:_____
Mailing Address (if different from above):_____
Home Phone:_____ Work Phone:_____
Cell Phone:_____ Email Address:_____

Employer Name: _____ Employer's Phone #:_____
Employment status: ___FT ___PT ___Retired

May we leave messages?
At home: Yes/No At Work: Yes/No Cell: Yes/No Email: Yes/No

May we send text appointment reminders to your cell phone? Yes/No

Emergency Contact:_____Phone:_____
Primary Care Physician:_____Phone:_____

Primary Insurance Information

Primary Insurance Name:_____ Policy #:_____
Policy Holder's Name:_____Policy Holder's Date of Birth:_____
Policy Holder's Social Security #:_____
Group Number:_____ Insurance phone #:_____

Secondary Insurance Information

Secondary Insurance Name:_____ Policy #:_____
Policy Holder's Name:_____Policy Holder's Date of Birth:_____
Policy Holder's Social Security #:_____
Group Number:_____ Insurance phone #:_____

IS THIS RELATED TO AN AUTOMOBILE or WORKER COMP ACCIDENT? **Yes/No**

Auto? Yes//No Workers Compensation? Yes/No
If yes, please answer the following questions:
Company Name: _____ Claim #:_____
Contact Person: _____ Contact Person's Phone #: _____ Date of Injury: _____

Consent for Insurance Assignment/Payment: I hereby authorize the assignment of benefits (payments) directly to Interventional Pain Center for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party:_____ Date: _____
Relationship if not patient:_____

Interventional Pain Center Authorization for the Release of Medical Records

Patient's Name: _____Date of Birth: _____

Social Security Number: _____Phone: _____

FAX RECORDS TO: 615-537-4950
REASON FOR DISCLOSURE: Continuity of Care

I authorize _____to release or disclose to the above-named entity all of my medical records, including any specially protected records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle-cell anemia, or HIV infection for the purpose of medical treatment. If you do not want certain portions of your medical records released, please read this section carefully and identify the information you do not want released below:

Please circle all that apply: Past Dates of Service Present Dates of Service Future Dates of Service
Specific Records Needed (to be completed by the provider/nurse):

□ Imaging of _____ □ Operative Report _____

□ Discharge Letter □ Recent Progress Notes □ Other _____

* I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by Interventional Pain Center (IPC) or its physicians, employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to Interventional Pain Center.
*I understand that I am not required to sign this Authorization. IPC will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.
*I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit IPC or its physicians', employees' or agents' ability to use or disclose my information for treatment, payment, or health care operations, or as otherwise permitted by law.
*I authorize IPC to request records pertinent to my treatment from providers and other healthcare entities, as needed, within the time this authorization is valid. This Authorization will expire a year from date of signature.

Signature of Patient/**Representative**:_____

Printed Name: _____Date Signed: _____

Relationship, if not Patient: _____

**If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany this request (i.e. court appointed guardian, durable power of attorney for health care, etc.). For a deceased patient, a death certificate coupled with executor or administrator of estate paperwork must accompany this request. Exception: Parents signing for a patient under the age of 18.

Financial Responsibility

Patient's Name: _____Date of Birth: _____

As your medical provider, our relationship is with you. Your insurance is a contract between you and your insurer, which may not cover 100% of your care. As a courtesy to you, we may obtain eligibility and/or benefit information from your insurance company and communicate this to you as well as file a claim for any services rendered. You are financially responsibility for the services rendered by Interventional Pain Center and agree to pay at the time of service. To protect your identity, you must present a valid insurance card and photo ID at each visit. You are also responsible to pay any applicable co-payments or past due balances at each visit.

Payments that you are responsible for include, but are not limited to any and all co-payments, coinsurances, and deductibles. You have agreed with your insurance company to pay these at each doctor's office visit. Additional diagnostic and therapeutic procedures may be subject to separate co-payments, co-insurances, and deductibles than your office visit. Check with your insurance carrier to determine how your benefits apply. Though Interventional Pain Center will attempt to determine and collect your payment responsibility at the time of service, you are responsible for any additional payment responsibilities determined after any claims are processed by your insurance company.

Referrals-HMO and POS Plans

You are responsible for obtaining an authorization for examinations and treatments if required by your insurance company. Often separate referrals will be required for examinations, diagnostic tests, and procedures. Though we may attempt to assist you in obtaining a referral as a courtesy, it is your responsibility to have authorization on file with us before your visit. Without this the insurance company will not pay for your visit. Without a referral you have the option to receive services on a fee for service basis.

Keeping Your Account Up to Date

It is your responsibility to inform us of any changes in your insurance, telephone numbers, and address. Please have your insurance card available at all office visits. Insurance companies give us ninety (90) days to file a claim. Therefore, if we bill the wrong insurance carrier because you failed to provide the correct information, the visit will be your responsibility.

Accounts ninety (90) days or older may be turned over to a collection agency. You may also be given notice legally dismissing you from our practice and be asked to find another physician. You agree to pay all reasonable attorney fees and collection costs in the event of default of payment.

Forms

Your insurance doesn't cover forms completed by the provider that may be required by you in collecting disability benefits or maintaining employment. Our fee is $20.00 per page.

Returned checks: **$50.00 charge** for all returned or cancelled checks.
Release of Medical Records: **$20.00 charge** for copies up to forty (40) pgs, each additional page is **$0.25** cents.

I have read and understand all the information on this financial policy. I agree to its terms and to the assignment of benefits and release of information described above. With my signature I am also authorizing medical treatment to be performed by Interventional Pain Center.

Responsible Party Signature:_____**Date:**_____
Relationship if not patient:_____

Authorization for the Use and Disclosure of Protected Health Information

Patient's Name: _____Date of Birth: _____

Federal law states that we cannot share your health information without your permission except in certain situations. If you sign this form you are giving us permission to share the information you indicate below. If you decide later that you do not want us to share your information, you may revoke this authorization at any time in writing.

I give Interventional Pain Center permission to share the health information below with the following person or group:

_____

Purpose for which disclosure is authorized (Examples are: for my health condition or at the request of the individual):

_____

Describe the specific information that you want to be disclosed and the time period that this authorization should cover (Examples are: information on my back surgery in April 2006):

Information:_____
Time Period:_____To:_____

If you do not enter a date, then this authorization will not expire until you inform us otherwise. I understand that the information described above may be re-disclosed by the person or group that I hereby give Interventional Pain Center permission to share my information with, and that my information would no longer be protected by the federal privacy regulations. Therefore, I release Interventional Pain Center and its workforce members from all liability arising from the disclosure of my health information pursuant to this agreement.
I understand that I may request copies of any information disclosed by this authorization. I understand that I may revoke this authorization by notifying Interventional Pain Center in writing, with the understanding that previously disclosed information would not be subject to my revocation request. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

Responsible Party Signature:_____Date:_____
Relationship if not patient:_____

(Attach documentation that you are a personal representative, for example: authorization form, durable power of attorney, court order, guardianship documents).

Notice of Privacy Practices Acknowledgement

I have read and may request a copy the notice of privacy practices and I have been provided with an opportunity to review it. The Notice of Privacy Practices is displayed in the waiting room and beside the check in and check out desk.

Signature:_____ Date:_____

No Show Policies and Procedures

Patient's Name: _____Date of Birth: _____

The medical staff at Interventional Pain Center is here to provide a comprehensive approach for your spine and musculoskeletal problems with use of physical therapy, therapeutic spinal procedures, orthotics, and medication management. It is our intention to assist with rehabilitating every area of physical injury by utilizing our professional and experienced providers to care for your entire being and not just treating the symptoms. Our goal is to improve your ability to function independently and also to increase your quality of life. It is your responsibility to comply with our facility's policies and procedures by keeping all of your scheduled appointments.

*Our policies and procedures **require <u>24 hours of advanced notification</u> to be given prior to the cancellation of your scheduled appointment or it is considered a "no show"**. Not showing up to your appointment as scheduled represents a cost where other patients could have been seen at that time. **A <u>$25.00 fee</u> will be charged for the first missed follow-up appointment. A <u>$50 fee</u> will be charged for the second missed follow-up appointment. A <u>$75 fee</u> will be charged for the third and all subsequent missed follow-up appointments. A <u>$100 fee</u> will be charged for any procedure appointments**.

*We will not prescribe any controlled substances, especially narcotics, as policy if you are non-compliant with any aspect of your treatment plan.

*Your referring physician and insurance company may be notified of non-compliance.

*Non-compliance with this policy may result in immediate discharge.

Payments

Co-Pays: To be paid on the day services are rendered.

Self-Pay Patients: Payments must be made in full at time of service unless arrangements have been made. ***Per Tennessee State guidelines, we are <u>not allowed</u> to accept cash or money order from self-pay patients so your payment must be made in the credit/debit card or prepaid credit card.***

Payments: Payments are due on or before your next scheduled appointment. If your account is sent to collections, you will not be re-scheduled for future appointments until your balance has been paid in full.

Prescription Refills

Call your pharmacy and have them fax a request for refills on non-narcotic medication. Narcotics/opiates can only be refilled at office visits and at the discretion of the provider. **Lost or stolen narcotics/opiates will not be replaced**. Losing your prescription or having your medication stolen is not considered an emergency. Your signature is an acknowledgement of your understanding and agreement with these policies.

Your signature is acknowledgement of your understanding and agreement with the policies listed above.

Responsible Party Signature:_____Date:_____
Relationship if not patient:_____

Interventional Pain Center - **Patient History**

Patient's Name: _____ Date of Birth: _____

Marital Status: (Circle one) Single Married Separated Divorced Widowed **Primary Language:**_____

Patient's Race:_____ **Patient's Ethnicity:** _____

Who do you live with:	☐ spouse	☐ spouse & children	☐ children	☐ parents	☐ alone	☐ friend
Work status:	☐ employed full time	☐ employed part time	☐ unemployed	☐ retired	☐ short term disability	☐ long term disability
Tobacco use:	☐ no	☐ yes	_____years	_____ packs per day		
Alcohol use:	☐ no	☐ Rarely	☐ occasionally	☐ regularly		
Street drug use:	☐ no	☐ yes				

Medical History and Family Medical History (Please check all that apply):

Disease	**SELF**	**Mother**	**Father**	**Sister(s)**	**Brother(s)**	**Moms Mom**	**Moms Dad**	**Dads Mom**	**Dads Dad**	**Comments**
No significant history known	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Addiction	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Arthritis OA/RA	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Bowel Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Cirrhosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Coronary Artery Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Emphysema	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Gallbladder Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Head Injury	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Heart Arrhythmia	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Heart Attack (MI)	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Hepatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Hiatal Hernia	☐	☐	☐	☐	☐	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Kidney Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Migraine Headaches	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Muscle Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Pancreatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Peripheral Nerve Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Prostate Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Reflux	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Seizures	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Sleep Apnea	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Spine Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Ulcers	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Vascular Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Patient's Name: _____Date of Birth: _____

Past Surgical History (Please list all surgeries you have had and date it was performed):

_____

_____

_____

Medications: List ALL of your current medications: If no medications, check here: ☐

Medication Name:	Dosage: (ie. mg)	Frequency: (times per day)	Route: (i.e. Pill, Patch)

Allergies: If no known allergies, check here: ☐

_____

_____

_____

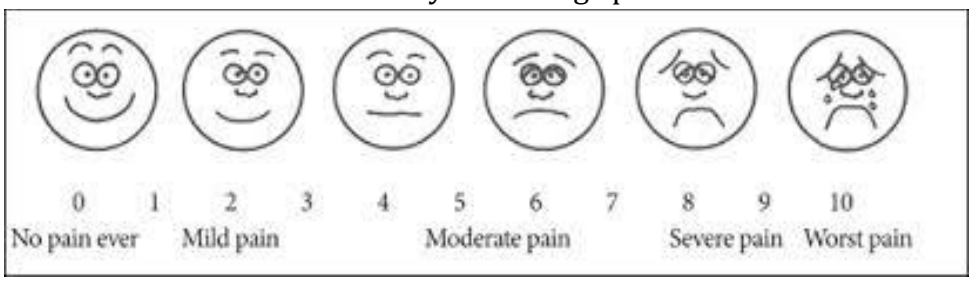
Review of Systems (Please check all that you are currently experiencing):

Cardiac:	☐ Abnormal EKG ☐ Irregular heartbeat	☐ Congestive failure ☐ High blood pressure	☐ Chest pain	☐ Murmur
Endocrine/ Hematological:	☐ Abnormal blood sugars	☐ Bruising easily	☐ Bleeding	
Gastrointestinal:	☐ Bowel control loss ☐ Chronic nausea	☐ Appetite loss ☐ Heartburn	☐ Constipation	☐ Diarrhea
General:	☐ Night sweats	☐ Weight loss ☐ Weight gain	☐ Fevers	☐ Fatigue
Genitourinary:	☐ Painful urination ☐ Bladder control loss	☐ Irregular bleeding ☐ Enlarged prostate	☐ Testicular pain ☐ Blood in urine	☐ Pregnancy
Head:	☐ Teeth/gum problems ☐ Headaches	☐ Hearing loss ☐ Facial pain	☐ Vision loss	☐ Sinusitis
Musculoskeletal:	☐ Joint pain	☐ Muscle spasms	☐ Neck pain	☐ Back pain
Neurological:	☐ Vertigo/dizziness ☐ Seizures	☐ Drowsiness ☐ Weakness	☐ Blackouts ☐ Numbness	☐ Tremors
Psychiatric:	☐ Depression	☐ Panic attacks	☐ Anxiety	☐ Insomnia
Respiratory:	☐ Shortness of breath ☐ Home oxygen use	☐ Chronic cough ☐ Sleep apnea	☐ Wheezing	☐ C-Pap
Skin:	☐ Rash			
Vascular:	☐ Poor circulation	☐ Current clot	☐ Swelling in legs	

Interventional Pain Center Conservative Therapies Questionnaire

Patient's Name:_____Date of Birth: _____Today's Date: _____

Please circle a number below that describes your average pain level:



Please indicate those activities that INCREASE your pain: (check all that apply)

- ☐ Work
- ☐ Activities around the Home
- ☐ Physical activities
- ☐ Physical Therapy
- ☐ Travel
- ☐ Walking
- ☐ Standing
- ☐ Sitting
- ☐ Resting (Breaks in activity)
- ☐ Bending
- ☐ Lying flat or on affected side
- ☐ Medications
- ☐ Sleep-related factors
- ☐ other_____

Please indicate those activities that DECREASE your pain: (check all that apply)

- ☐ Walking
- ☐ Standing
- ☐ Sitting
- ☐ Resting (Breaks in activity)
- ☐ Sleeping
- ☐ Bending
- ☐ Lying flat
- ☐ Elevating the affected area
- ☐ Non-weight bearing
- ☐ Using a brace for support
- ☐ Application of heat &/or cold compresses
- ☐ Injections
- ☐ Physical therapy
- ☐ Relaxation exercises
- ☐ Medications
- ☐ Positional changes
- ☐ Massage Therapy
- ☐ other_____

Do you take any of the following anticoagulants? (check all that apply)

- ☐ Coumadin (Warfarin)
- ☐ Aspirin
- ☐ Heparin
- ☐ Plavix (Clopidogrel)
- ☐ Eliquis (Apixaban)
- ☐ Xarelto (Rivaroxaban)
- ☐ Brilinta (Ticagrelor)
- ☐ Fragmin (Dalteparin)
- ☐ Lovenox (Enoxaparin)
- ☐ Ardeparin (Normiflo)
- ☐ Orgaran (Danaparoid)
- ☐ other_____

Have you tried any of these conservative therapies:

- ☐ Acupressure
- ☐ Acupuncture
- ☐ Chiropractors
- ☐ Injections to the affected area
- ☐ Physical or Occupational Therapy
- ☐ Home Exercise Program
- ☐ Application of Heat &/or Ice
- ☐ Massage therapy
- ☐ Medication therapy
    - o Narcotic pain meds
    - o Topical Creams/Patches
    - o Nerve Pain Meds (Gabapentin, Lyrica, Duloxetine/Cymbalta)
- ☐ Nerve stimulation / TENS
- ☐ Relaxation
- ☐ Psychotherapy
- ☐ Surgery
- ☐ Biofeedback
- ☐ other_____

Have you tried the following NSAIDS to help relieve your pain:

- ☐ Ibuprofen
- ☐ Aleve
- ☐ Advil
- ☐ Naproxen
- ☐ Celecoxib (Celebrex)
- ☐ Toradol
- ☐ Indocin (Indomethacin)
- ☐ Meloxicam (Mobic)
- ☐ other_____

Patient Signature: _____

TN

Patient name: _____

Date of birth: _____

Screening, Brief Intervention, and Referral to Treatment Survey

SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and drugs.[1] The following questionnaire is one SBIRT tool that can be used in the prior authorization process for opioid prescriptions for TennCare members.

Please begin with the brief PRE-SCREEN SURVEY below.

Are you currently in recovery for alcohol or substance use? ☐Yes ☐No

Alcohol: One drink =

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	○	○

For any "1 OR MORE" response to the PRE-SCREEN, administer the *CAGE-AID SURVEY.

*If patient did not answer "1 or more" then the CAGE-AID SURVEY does not need to be administered.

In the last three months, have you felt you should cut down or stop drinking or using drugs? ☐Yes ☐No

In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs? ☐Yes ☐No

In the last three months, have you felt guilty or bad about how much you drink or use drugs? ☐Yes ☐No

In the last three months,have you been waking up wanting to have an alcoholic drink or use drugs? ☐Yes ☐No

If any answer is "Yes", it may indicate a possible substance use disorder and a need for further medical discussion and/or referral to treatment.

[1]For more information or education visit: https://www.integration.samhsa.gov/clinical-practice/sbirt

CAGE-AID SURVEY adapted from SBIRT Training: https://www.sbirttraining.com/node/525

PRE-SCREEN SURVEY adapted from SBIRT Oregon: http://www.sbirtoregon.org/

Screening Tools

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

1: Patient Health Questionnaire – (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several Days**	**More than half the days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

add columns 0 + _____ + _____ + _____

Total Score _____

If your total score is 5 or above, you may be suffering from clinical depression. We recommend you discuss this with your primary care physician.

2: Smoking Status

Please Circle the answer that describes you best

Current Every day Smoker	Current Some day Smoker	Former Smoker	Never Smoker	Heavy Tobacco	Light Tobacco

3: Fall Risk Assessment (For patients 65 and older)

Please Circle your answer next to each question

Have you fallen in the last 6 months?	Yes | No
Do you have neuropathy or weakness in your legs?	Yes | No
Do you use a cane or walker?	Yes | No

If you circled yes to any of the above, we recommend you discuss falls prevention with your primary care physician and consider physical therapy.

4: Blood Pressure and BMI

We recommended all our patients have their blood pressure and weight regularly monitored by their primary care physician.