



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 7<sup>th</sup> 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 #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Policy Holder's Social Security #: \_\_\_\_\_ Insurance phone: \_\_\_\_\_

### Secondary Insurance Information

Secondary Insurance Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Policy Holder's Social Security #: \_\_\_\_\_ 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 check 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 responsible 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 24 hours of advanced notification 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 \$25.00 fee will be charged for the first missed follow-up appointment. A \$50 fee will be charged for the second missed follow-up appointment. A \$75 fee will be charged for the third and all subsequent missed follow-up appointments. A \$100 fee 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 not allowed to accept cash or money orders from self-pay patients. Therefore, your payment must be made using a 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: \_\_\_\_\_



Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

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**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:**

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

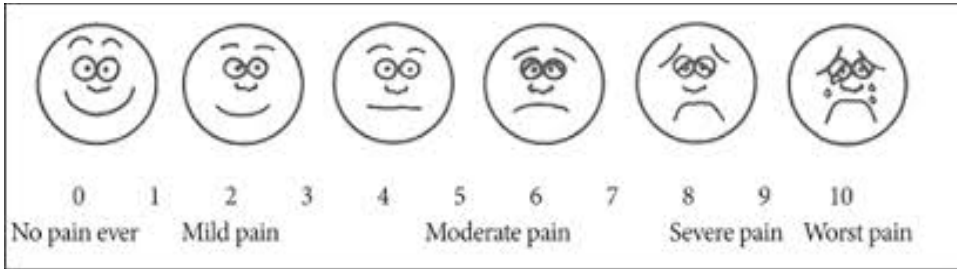
Cardiac:	<input type="checkbox"/> Abnormal EKG	<input type="checkbox"/> Congestive failure	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Murmur
	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> High blood pressure		
Endocrine/ Hematological:	<input type="checkbox"/>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

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**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
  - Narcotic pain meds
  - Topical Creams/Patches
  - 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:** \_\_\_\_\_

# 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. Feeling tired or having little energy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. Poor appetite or overeating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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 mark 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.