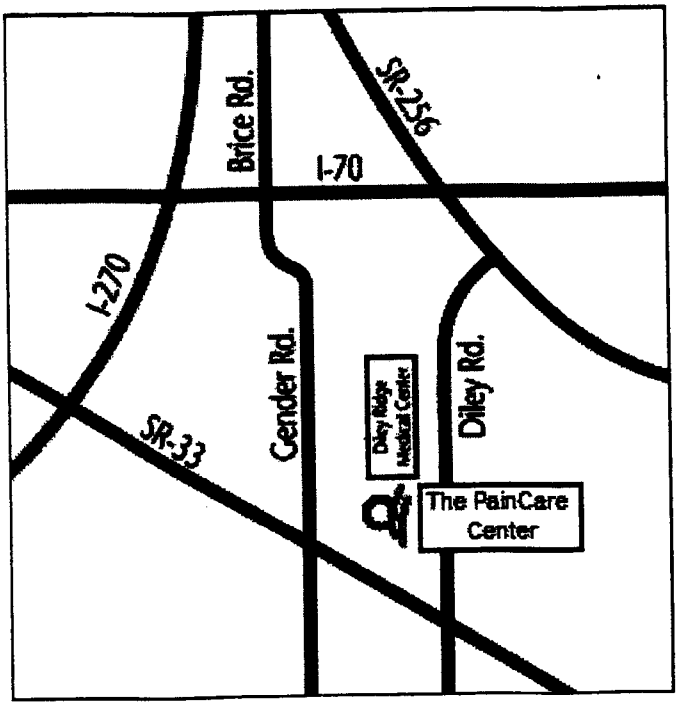
THE PainCare
CENTER

614.FOR.PAIN
740.653.HURT

Martin J. Andrews, M.D
Board certified in Pain Management and Anesthesiology

Initial Visit Package

- PLEASE FILL OUT ATTACHED PAPERWORK AND BRING TO APPOINTMENT
- HAVE A CURRENT INSURANCE CARD AND COPAY
- IF INJECTIONS ARE INDICATED, YOU WILL NEED A DRIVER



Your Appointment is in:

The Diley Ridge Medical Office Building

7901 Diley Road, Suite 130

Canal Winchester, OH 43110

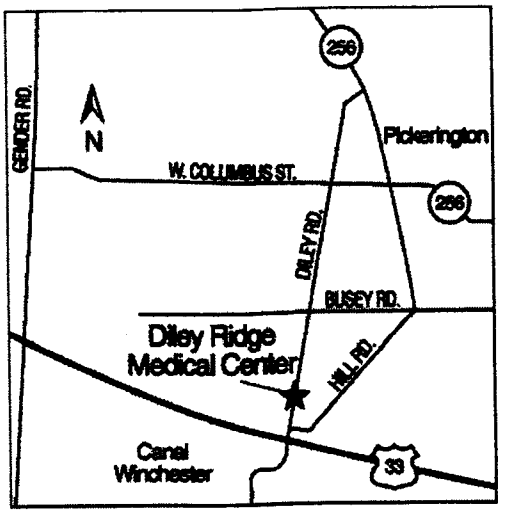
With Dr. Martin J. Andrews, M.D.

Date: _____

Time: _____

Phone: 614.FOR.PAIN

740.653.HURT

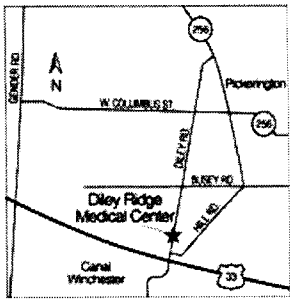


- Should you need to reschedule, a 24 hour notice is appreciated. You should expect a reminder call one day before your appointment
- Please fill out all patient information sheets prior to your appointment. If you are unable to do this, please show up 15 minutes before your appointment to complete them.

Fairfield Pain Management Inc.

"The PainCare Center"

7901 Diley Road Suite 130
Canal Winchester, Ohio 43110
614-833-1700 (ph) 614-833-1701 (fax)
www.pccohio.com



Appointment Date: _____

Appointment Time: _____

Dear Patient: **Chart#:** _____

Welcome to Fairfield Pain Management (FPM). We appreciate the confidence and trust you have placed in us by scheduling an appointment, and we look forward to seeing you. Our philosophy is to help you best manage your chronic pain symptoms. We shall make every effort to see that your experience with our clinic is as comfortable as possible.

At your initial appointment, Dr. Andrews and his staff will take a complete medical history. A treatment plan will be suggested by Dr. Andrews. This plan will include in-office procedure options. Many insurance companies do allow for a patient to undergo an in-office procedure on the initial visit without requiring prior authorization. **Patients whose insurance companies provide for this option and who wish to elect to take this treatment option must bring a secondary driver with you at the time of service.**

Due to the amount of time that our staff may need to spend with you at your initial consultation, we cannot allow children under the age of 16 years to accompany you into the treatment areas. Please bring a responsible adult along to watch children during your appointment. If this is not possible, we will need to reschedule your appointment to a more appropriate time.

All insurance company policies are different. It is advisable that you become familiar with your particular insurance coverage. **You will be asked to show a staff member your insurance card and government issued photo ID. Please bring both documents to each visit with our office. If a specialist office co-payment is due at the time of service, and we ask that you bring this with you to all of your appointments.**

Please arrive 15 minutes prior to your initial scheduled appointment time. We will make every effort to maintain our schedule and yours. Please assist us by being punctual. If you are unable to keep your appointment, we ask that you give us at least 48 hour notice.

If you have any questions about FPM and/or the conditions we treat, please visit our website at **www.pccohio.com**. To view full animation of the procedures we offer, click on the "Procedure Videos" tab on the upper right side of the main website page.

Thank you for choosing us. We welcome any questions or concerns you may have, and we look forward to seeing you.

Sincerely,

Martin J. Andrews, M.D.

Board Certified,
American Board of Pain Medicine
American Board of Anesthesiology

Meaningful Use Intake Form

Please take a minute to complete this form to assist us in updating our records. Thank you.

Patient Information

Name (Please print): _____

Date of Birth: _____ Sex (circle one): M F Race: _____

Ethnicity (circle one or leave blank): Hispanic/Latino Not Hispanic/Latino

Preferred language: _____

Have you had a colonoscopy? (circle one): Yes No If yes, year? _____

Were you in a hospital, skilled nursing facility, emergency room, or other setting of care before your visit today (circle one): No Yes: Hospital Skilled Nursing Facility ER Other

Contact Information

Home phone: _____ Cell phone: _____ Work Phone: _____

E-mail address: _____

Note: Your e-mail address could be used by the practice to notify you on how to access information and for specific reminders. It will not be used for two-way communication regarding your medical care. Please contact our offices if you have any questions or concerns related to your medical care.

Preferred method of contact (circle one): Home phone Cell Phone Work Phone Email Mail

Emergency Contact Name: _____ Relationship: _____

Phone number: _____ Alternative Number: _____

Preferred Pharmacy Information

Note: You are now required to have one pharmacy of record. We are required to transmit certain prescriptions we are able to transmit directly to your pharmacy. Some prescriptions may not be transmitted by Ohio law. You are required to select one and only one pharmacy where your prescriptions are to be sent. We have currently selected the pharmacy to use on our system as the most recent location where you last filled a prescription written by Dr. Andrews. Any changes to this pharmacy designation must be requested in writing. In addition, you are limited to changing your pharmacy of record to 2 times over a 12 month period unless the pharmacy closes, you move or your insurance is no longer accepted at that location.

Pharmacy Name: _____

Pharmacy Address: _____

City: _____ Zip Code: _____

Patient Signature: _____ Date: _____

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NEW PATIENT EVALUATION FORM

INITIAL PATIENT DATA BASE In order to help us provide the best possible care for you at Fairfield Pain Management, we ask for your cooperation in providing the following information. Please bring this form with you to your first appointment.

GENERAL INFORMATION Date form completed: ____/____/_____

Patient Name: Date of birth: ____/____/_____

Height: ft. in. Weight: Age:

Referred By: Family Physician:

Date onset of pain: ____/____/_____ Cause of pain:

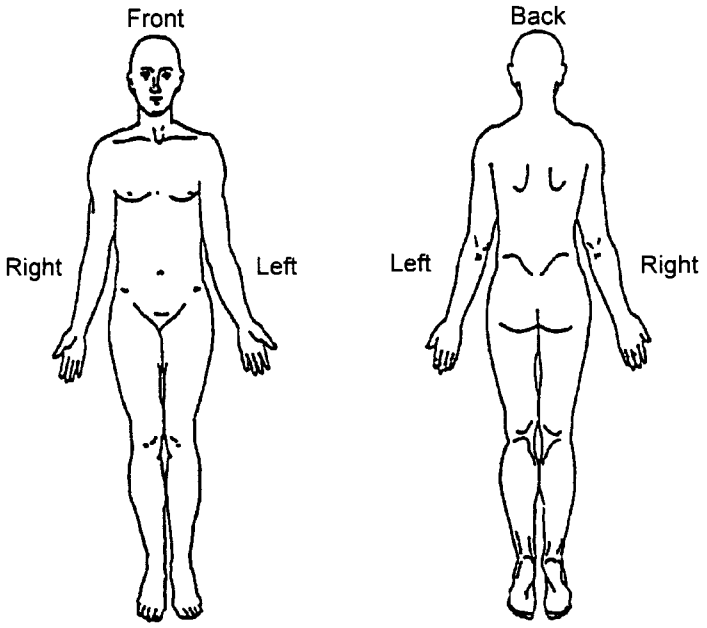
Was this injury: ☐ At Work ☐ Auto Accident ☐ Other ☐ After Surgery

Onset of pain: ☐ Sudden ☐ Gradual

On a scale of 1-10 your pain is at its worst: Pain at its best: Pain right at this moment:

0 = no hurt | 1-2 hurts a little bit | 3-4 hurts a little more | 5-6 hurts even more | 7-8 hurts a whole lot | 9-10 hurts the worst

LOCATION OF YOUR PAIN
On the picture, color in all your areas of pain.



Associated with (check all that apply):
- ☐ Numbness/Tingling
- ☐ Night Pain
- ☐ Weakness
- ☐ Loss of Control of Bowel
- ☐ Loss of Control of Bladder
- ☐ Fever/Chills
- ☐ Sexual Dysfunction
- ☐ Unexplained Weight Loss

How many pounds:

Fairfield Pain Management Inc.

Patient Name: Date of birth: ____/____/____

COMPLETE THIS BOX ONLY IF YOU WERE INVOLVED IN AN AUTO ACCIDENT

Were you wearing a seat belt? ☐ Yes ☐ No
Were you the passenger? ☐ Yes ☐ No
Were you the driver? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No If yes, for how long?
Briefly describe the accident:
How much damage was done to your vehicle? $
How long after the incident did the pain occur?
When did you first seek medical attention? ____ / ____/ _____
Did you experience pain in the same location previous to this accident? ☐ Yes ☐ No If yes, explain:

COMPLETE THIS BOX ONLY IF YOU WERE INVOLVED IN A WORK INJURY

Describe injury:
How long after the incident did the pain occur?
When did you first seek medical attention? ____ / ____/ _____
Have you had the pain in the same location prior to your work injury? ☐ Yes ☐ No If yes, explain:
Is your current injury through your current employer? ☐ Yes ☐ No
If it is not through your current employer, please list the name of the employer that it is through, along with a phone number.
Employer name: Phone:

SYMPTOMS The questions below refer only to the area of pain that you are coming to our clinic for at this time.

My pain is: ☐ Mild ☐ Mild-Moderate ☐ Moderate ☐ Moderate-Severe ☐ Severe

Check the boxes that best describe what your pain feels like.

☐ Throbbing	☐ Shooting	☐ Stabbing	☐ Burning	☐ Sharp	☐ Tingling
☐ Numb	☐ Tender	☐ Pressure	☐ Deep	☐ Aching	☐ Cramping
☐ Heaviness	☐ Diffuse	☐ Dull	☐ Gnawing	☐ Localized	☐ Superficial

What makes your pain worse?

☐ Bending	☐ Coughing	☐ Daily Activities	☐ Driving	☐ Everything	☐ First Steps
☐ Going Downstairs	☐ Going Upstairs	☐ Kneeling	☐ Lifting	☐ Lying Down	☐ Neck Movement
☐ Nothing	☐ Reaching	☐ Sitting	☐ Sneezing	☐ Squatting	☐ Standing
☐ Stretching	☐ Twisting	☐ Weather Changes	☐ Walking		☐ Work Activities
☐ Other, Explain					

The pain is: ☐ At Rest ☐ Continuous ☐ In the Night ☐ In the Morning ☐ Intermittent ☐ On Activity ☐ Spontaneous

Does your pain make you: (check all that apply)			***Does your pain interfere with any of the following***		
☐ Depressed	☐ Angry	☐ Frustrated	☐ Sleep	☐ Daily Activities	☐ Work
☐ Helpless/Hopeless					

Fairfield Pain Management Inc.

Patient Name:

Date of birth: ____/____/____

Please check any previous treatments for current pain:

☐ No Prior Modalities ☐ Acupuncture ☐ Biofeedback ☐ Hypnosis ☐ Manipulation/Chiropractor
☐ Physical Therapy ☐ Traction ☐ Work Hardening ☐ Herbal Remedies ☐ Tens Unit
☐ Injections ☐ Counseling

List any tests for your pain

☐ X-ray ☐ CT scan ☐ MRI ☐ Mylogram ☐ Bone Scan ☐ EMG ☐ Blood Tests

PAST MEDICAL HISTORY
Please check all that apply

☐ AIDS/HIV	☐ Aneurysm	☐ Arthritis	☐ Asthma
☐ Bleeding Disorder	☐ Cancer	☐ Chem. Dependency	☐ CA Colon
☐ CA Lung	☐ CA Breast	☐ CA Prostate	☐ CA Cervical
☐ COPD	☐ Depression	☐ Diabetes	☐ Fibromyalgia
☐ Heart Attack	☐ Heart Disease	☐ Hepatitis	☐ Hypercholesterolemia
☐ Hypertension	☐ Hypothyroidism	☐ Jaundice	☐ Kidney Disease
☐ Liver Disease	☐ Murmur	☐ Osteoarthritis	☐ Pacemaker
☐ Peptic Ulcer Disease	☐ Peripheral Neuropathy	☐ Peripheral Vascular Disease	☐ Post-op Nausea/Vomiting
☐ Reflux	☐ Rheumatic Fever	☐ Seizure Disorder	☐ Sleep Apnea
☐ Stroke	☐ Other, please list:		

PAST SURGICAL HISTORY
List all previous surgeries:

DATE (MONTH/YEAR)	PROCEDURE

Fairfield Pain Management Inc.

Patient Name: Date of birth: ____/____/____

FAMILY HISTORY

Check if any of your BLOOD relatives have had any of the following:

DISEASE	RELATIONSHIP TO YOU
Asthma	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, stroke	
High Blood Pressure	
Kidney Disease	
Neurologic Condition	
Bleeding disorder	
Other, please list	

SOCIAL HISTORY

Educational Background

☐ None ☐ Home-Schooling ☐ Elementary School ☐ High School ☐ College Graduate
☐ GED ☐ Grad School ☐ Some College ☐ Trade School ☐ Technical School
☐ Post-College ☐ Medical School ☐ Law School

CHECK APPROPRIATE ANSWERS:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

How many children do you have? ____

Do you use tobacco? ☐ Current ☐ Former ☐ Never ☐ Unknown

Type: ____ Units/day: ____ Years used: ____ Pack Years: ____

Ever tried to quit? ☐ Yes ☐ No Year quit: ____ Longest tobacco free: ____

Relapse reason: ____ Passive smoke exposure? ☐ Yes ☐ No

Smoker Status (Meaningful Use)

☐ Current Every Day Smoker ☐ Smoker, Current Status Unknown ☐ Former Smoker
☐ Current Some Day Smoker ☐ Never Smoker ☐ Unknown if Ever Smoked

Do you drink alcohol? ☐ Yes ☐ No ☐ Former

How frequently do you drink alcohol?

☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Occasionally ☐ Rarely ☐ Socially ☐ Never

Do you use recreational drugs? ☐ Yes ☐ No ☐ Former

☐ Never ☐ Rarely ☐ Occasionally ☐ Often

What: ____ How often: ____

Exercise?

☐ Never ☐ Rarely ☐ Occasionally ☐ Often ☐ 2-3 Times/Week ☐ 3-4 Times/Week ☐ Daily

Fairfield Pain Management Inc.

Patient Name:

Date of birth: ____/____/_____

WORK HISTORY

Are you employed? ☐ Yes ☐ No

Occupation:

If yes, where:

Are you on worker's compensation? ☐ Yes ☐ No

Is your employer contesting? ☐ Yes ☐ No

Do you have an attorney? ☐ Yes ☐ No

If yes, attorney name:

When did you last work? ____/____/_____

Are you currently working? ☐ Yes ☐ No

Do you have work restrictions? ☐ Yes ☐ No

Would you return to work with restrictions? ☐ Yes ☐ No

Have you missed work because of your pain? ☐ Yes ☐ No

Do you want to go back to work? ☐ Yes ☐ No

Do you want permanent disability? ☐ Yes ☐ No

PSYCHOLOGICAL HISTORY

Have you ever been treated for emotional/behavioral disorder? ☐ Yes ☐ No

Have you ever been treated for depression? ☐ Yes ☐ No

If yes, when:

Do you currently have ACTIVE suicidal thoughts? ☐ Yes ☐ No

Do you have a history of suicidal attempts? ☐ Yes ☐ No

Do you have a history of drug abuse? ☐ Yes ☐ No

Do you have a history of alcohol abuse? ☐ Yes ☐ No

Fairfield Pain Management Inc.

Patient Name: | | | | | | | | | | | | | | | | | | | | | | | |

Date of birth: ____/____/_____

ALLERGIES

ALLERGY	REACTION

MEDICATION HISTORY

Pharmacy Name: _____ Phone#: _____

Please provide a list of current prescription medication and over the counter medication:

MEDICATION NAME	DOSE	FREQUENCY	PHARMACY

Have you taken any medications in the past for your current pain problem, even if they didn't work? ☐ Yes ☐ No

If yes, please list (be sure to include any nonprescription medications such as Tylenol, Bengay, etc.)

NAME	WHY STOPPED

I, the undersigned, have completed this form to the best of knowledge. The information that I have provided is true and accurate to the best of my knowledge. I understand that this information is used in the care and treatment plan while under the care of all physicians and staff of Fairfield Pain Management.

Patient/Guardian Signature _____ Date: ____/____/_____

Fairfield Pain Management Inc.

Patient Name: | | | | | | | | | | | | | | | | | | | | | | | | |

Date of birth: ____/____/_____

Please review the following list and check any that apply to you.

CONSTITUTIONAL
□ *Normal* □ *Abnormal*

Weight Loss Amount: ☐
Weight Gain Amount: ☐
Fever □ No □ Yes
Chills □ No □ Yes
Insomnia □ No □ Yes
Fatigue □ No □ Yes

EYES
□ *Normal* □ *Abnormal*

Vision □ Normal □ Abnormal
Dryness □ No □ Yes
Pain □ No □ Yes

ENT
□ *Normal* □ *Abnormal*

Ears
Hearing Loss □ No □ Yes
Tinnitus □ No □ Yes
(ringing in ears)
Vertigo □ No □ Yes
Dizziness □ No □ Yes

Nose
Nasal Congestion □ No □ Yes
Facial Pain □ No □ Yes
Decreased Smell □ No □ Yes
Epistaxis □ No □ Yes
(nose bleeds)

Throat
Sore Throat □ No □ Yes
Dysphagia □ No □ Yes
(difficulty swallowing)

RESPIRATORY
□ *Normal* □ *Abnormal*

Shortness of Breath □ No □ Yes
Cough □ No □ Yes
Sputum □ No □ Yes
Hemoptysis □ No □ Yes
(bloody sputum)
Wheezing □ No □ Yes
Chest Pain □ No □ Yes
Snoring □ No □ Yes

MUSKULOSKELETAL
□ *Normal* □ *Abnormal*

Joint Pain □ No □ Yes
Neck Pain □ No □ Yes
Mid Back Pain □ No □ Yes
Low Back Pain □ No □ Yes
Weakness □ No □ Yes

NEURO
□ *Normal* □ *Abnormal*

Headache □ No □ Yes
Fainting □ No □ Yes
Seizures □ No □ Yes
Paralysis □ No □ Yes
Uncoordinated □ No □ Yes
(Clumsiness)
Memory Loss □ No □ Yes
Numbness □ No □ Yes

PSYCHIATRIC
□ *Normal* □ *Abnormal*

Depression □ No □ Yes
Anxiety □ No □ Yes
Suicidal □ No □ Yes
Hallucinations □ No □ Yes

GENITOURINARY
□ *Normal* □ *Abnormal*

Incontinence □ No □ Yes
Dysuria □ No □ Yes
(pain w/urination)
Urgency □ No □ Yes
Hematuria □ No □ Yes
(blood in urine)
Erectile Dysfunction □ No □ Yes
Loss of Sexual Drive □ No □ Yes

ALLERGIC/IMMUNOLOGIC
□ *Normal* □ *Abnormal*

Food Allergies □ No □ Yes
Environmental Allergies □ No □ Yes

HEMATOLOGIC/LYMPHATIC
□ *Normal* □ *Abnormal*

Easy Bruising □ No □ Yes
Easy Bleeding □ No □ Yes
Lymphadenopathy □ No □ Yes
(swollen glands)

SKIN/DERMATOLOGIC
□ *Normal* □ *Abnormal*

Rash □ No □ Yes
Dryness □ No □ Yes
Alopecia □ No □ Yes
(hair loss)
Nail Changes □ No □ Yes
Color Changes □ No □ Yes

GASTROINTESTINAL
□ *Normal* □ *Abnormal*

Dysphagia □ No □ Yes
(difficulty swallowing)
Heartburn □ No □ Yes
Abdominal Pain □ No □ Yes
Vomiting □ No □ Yes
Diarrhea □ No □ Yes
Constipation □ No □ Yes
Fecal Incontinence □ No □ Yes
Bloody Stool □ No □ Yes
Nausea □ No □ Yes

ENDOCRINOLOGY
□ *Normal* □ *Abnormal*

Intolerance to heat □ No □ Yes
Intolerance to cold □ No □ Yes
Diaphoresis □ No □ Yes

CARDIOVASCULAR
□ *Normal* □ *Abnormal*

Chest Pain □ No □ Yes
Shortness of Breath □ No □ Yes
Palpitations □ No □ Yes
Ankle Swelling □ No □ Yes
Claudication □ No □ Yes

Fairfield Pain Management Inc.

Patient Name:

Date of birth: ____/____/____

Please complete this questionnaire. It has been designed to give us information as to how your pain has affected your ability to manage in everyday life. **Please answer every section**. Mark only ONE number in each section that most closely describes you today.

Section 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 - Personal Care

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself, but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help, but can manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on the table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can walk only using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 - Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want, but it gives me extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 1/2 hour.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 - Sleeping

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain, I have less than 6 hours of sleep.
- ☐ Because of pain, I have less than 4 hours of sleep.
- ☐ Because of pain, I have less than 2 hours of sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 - Sex Life (if applicable)

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal, but causes some extra pain.
- ☐ My sex life is nearly normal, but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9 - Social Life

- ☐ My social life is normal and causes me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., sports, etc.)
- ☐ Pain has restricted my social life and I don't go out often.
- ☐ Pain has restricted my social life to home.
- ☐ I have no social life because of pain.

Section 10 - Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere, but it gives me extra pain.
- ☐ Pain is bad, but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to short journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

Patient signature: Total:

Date: ____/____/_____

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Patient Name: _____ _____
Last First M.I. Today's Date

( ) _____ ( ) _____
Home Telephone Cell Phone

Home Address: _____ Mailing Address: _____
Street Street

_____ _____
City State Zip City State Zip

DOB: _____ Age ____ ☐M ☐F SS# _____ ☐Married ☐Single ☐Divorced ☐Widowed ☐Other
Sex Check Marital Status

Employer: _____ ( ) _____
Name Telephone

_____ _____
Address Occupation

Responsible Party: _____ _____ ( ) _____
Name Relationship Telephone

Emergency Contact:
Spouse/Next of Kin: _____ _____ ( ) _____
Name Relationship Telephone

Referring Physician: _____ Primary Care Physician: _____

Primary Ins: _____ Telephone:( )

Subscriber Name: _____ DOB: _____

Subscriber Employer: _____ Group #: _____ Policy #: _____

Secondary Ins: _____ Telephone:( )

Subscriber Name: _____ DOB:: _____

Subscriber Employer: _____ Group #: _____ Policy #: _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to The PainCare Center. I also authorize agents of any hospital, treatment center or previous physician to furnish The PainCare Center copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or report related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within The PainCare Center.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to The PainCare Center. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to The PainCare Center.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payors; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with The PainCare Center.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

_____ _____
Patient Signature Date/Time AM or PM (*circle one*)

_____ _____
Responsible Party Signature Relationship Date/Time AM or PM (*circle one*)

PHYSICIAN: _____
ACCT REF: _____ LOC: _____
FOR OFFICE USE ONLY

EMPLOYEE INITIALS
_____

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Canal Winchester, Ohio 43110
614-833-1700 (ph) 614-833-1701 (fax)
www.pccohio.com

Patient Financial Statement of Information

Thank you for choosing Fairfield Pain Management as your pain provider. Fairfield Pain Management is a caring organization that is committed to providing patients with innovative pain management services. We are committed to providing you with quality and compassionate health care.

Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have and sign in the space provided. A copy will be provided to you upon request.

Insurance and Billing

- As your provider, please remember that our relationship is with you and not your insurance company. Your benefit coverage is a contract between you and your insurance carrier. Please be aware that not all medical services are covered benefits under all insurance contracts. We encourage you to be familiar with your insurance benefits and limitations. If you have any questions about your insurance coverage, please contact your insurance carrier directly.

- Dr. Martin Andrews is a "Preferred Provider" for many insurance plans. It is your responsibility to check with your insurance carrier to ensure that Dr. Martin Andrews participate with your insurance network. If Dr. Martin Andrews is not in your carrier's network, you may incur higher patient responsibility amounts. As a preliminary evaluation, we may have verified your coverage using the health care insurance information provided by your referring physician prior to your visit. If this coverage has changed, please provide us with updated insurance coverage information.

- As a service to you, our office will bill your health insurance company. Providing us with accurate information at the time services are rendered will facilitate in the timely filing of claims. Changes in your information should be reported to our office in a timely manner. Your cooperation in keeping your account information current is greatly appreciated.

- You will receive a bill for our services. Patient payments can be applied to outstanding balances for professional services or for the facility fees, as determined by the organization.

- If you undergo urine toxicology testing, you may receive an invoice from FPM for the test. In addition, many of our lab results are also sent to a confirmatory lab for additional information on the quantitative results of the specimen. If your test is sent to a confirmatory lab, you will receive a separate bill for their services.

Co-payments, Co-insurance and Deductibles

All copayments, coinsurance and deductibles are due at the time of service.

Co-payments are a flat fee paid each time a medical service is accessed and must be paid before any policy benefit is payable by an insurance company. Co-payments usually range from $5.00 to $75.00 depending on your coverage.

Co-insurance is a percentage of the allowed charge that the patient pays after the deductible has been satisfied.

Deductibles are amounts which must be paid out of pocket before an insurance carrier will pay any expenses. The deductible must be paid by the patient before the benefits of the insurance policy can apply.

Dr. Martin Andrews is in network with most insurance companies, and the insurance company will require that we collect these fees per the terms of your health care contract. Failure to pay any amounts due, including past due balances, will result in your appointment being rescheduled or other collection activity. Please speak with one of our office staff if you need assistance with the payments of these balances. For your convenience, we accept cash, checks, debit or credit cards (MasterCard, Visa, Discover and American Express). A fee of $25.00 will be charged for all returned checks.

Referrals/Authorizations

Many of the services we provide require referrals, authorization and pre-authorization. Your insurance company may require documentation prior to authorizing services and we will do our best to comply in a timely fashion with their requests. This process can take time. We appreciate your patience while we work with your insurance company. We reserve the right to refuse or reschedule services to any patient who does not have a valid referral in our office at the time of their appointment.

Non-Payment

If your account is over 120 days past due, your account will be referred to our outside collection agency. This may include listing your information with the credit bureau. Your account will also be reviewed for possible discharge from care.

You may see balances on your statement(s) that are related to previous services performed at Fairfield Pain Management. Please be advised that these balances must be paid immediately. You may pay by by phoning payment into the office at 614-833-1701 or by mailing in payment.

I have read and understand the above credit/payment policy.

I hereby authorize Fairfield Pain Management to file claims on my behalf and for payment to be rendered directly to Fairfield Pain Management for benefits otherwise payable to me by any third party. The above authorization is in effect permanently or until canceled by myself in writing.

Patient Signature: _____ Date: _____

Fairfield Pain Management Inc.

"The PainCare Center"

7901 Diley Road Suite 130
Canal Winchester, Ohio 43110
614-833-1700 (ph) 614-833-1701 (fax)
www.pccohio.com

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.

FAIRFIELD MANAGEMENT,

Fairfield Pain Management ("FPM") is committed to ensuring that your health information is kept private in accordance with federal and state law. This information is called "protected health information" or "PHI." This Notice covers the privacy practices of all health care professionals, employees and staff at our clinicWe will abide by the terms of the Notice.

We are required by law to maintain the privacy of your PHI and to provide you with this Notice. We are also required to notify you following a breach of your unsecured health information.

This Notice is effective as of September 01, 2012. We reserve the right to make changes to this Notice as permitted by law. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. Each version of the Notice will have an effective date listed on the first page. If we change this Notice, you can access the revised Notice using these options:

From the FPM website (www.pccohio.com); or

From the receptionist at our office.

If you want more information about the privacy practices of FPM, please contact the Fairfield Pain Management in writing at 7901 Diley Road, Suite 130, Canal Winchester, OH 43110, by phone at 614-833-1700.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION: *The following categories describe the ways that we may use and disclose your PHI without your written authorization:*

Treatment. We will use PHI about you to provide you with medical treatment or services. We will disclose your PHI to other health care professionals so that they can evaluate your health, diagnose your medical conditions and provide your treatment. For example, results of laboratory tests and procedures will be available in your medical record to health professionals who may need the information to provide you with treatment.

Payment. We may use and disclose your PHI to obtain payment for the services we provide to you. For example, we may disclose your PHI to seek payment from your insurance company, or from another third party. We may need to give your insurance company information about a procedure you underwent so that your insurance company will pay for the procedure We may also inform your insurance company about a treatment you are going to receive so that we obtain prior approval for the treatment, or in order to find out if your insurance company will cover the treatment.

Health Care Operations. We may use and disclose your PHI in order to conduct certain of our business activities, which are called health care operations. These uses and disclosures are necessary to run our business and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, necessary credentialing, and for other essential activities. We may also disclose your health information to third party "business associates" that perform various services on our behalf, such as transcription, billing and collection services. In these cases, we will enter into a written agreement with the business associate to ensure they protect the privacy of your health information.

OTHER WAYS WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION: *The following categories describe other ways we may use and disclose your PHI without your written authorization.*

Family Members and Friends for Care and Payment and Notification If you verbally agree to the use or disclosure and in certain other situations, we may make the following uses and disclosures of your PHI. We may disclose certain PHI to a family member, friend, or anyone else whom you identify as involved in your health care or who helps pay for your health care. In such cases, the PHI we disclose would be limited to the portion of the PHI that is relevant to that person's involvement in your care or payment for your care. We may also make these disclosures after your death as authorized by Wisconsin law unless doing so is inconsistent with any prior expressed preference. We may use or disclose your PHI to notify or assist in notifying a family member, personal representative, or any other person responsible for your care regarding your location, general condition, or death. In an emergency situation or in the event of your incapacity, we may exercise our professional judgment to determine whether a disclosure to a particular person is in your best interest.

Disaster Relief Efforts. We may disclose your PHI to organizations for the purpose of disaster relief efforts in accordance with the law.

Required by Law. We may disclose your PHI when required by law to do so.

Public Health Reporting. We may disclose your PHI to public health agencies as authorized by law. For example, we may report certain communicable diseases to the state's public health department.

Reporting Victims of Abuse or Neglect. If we reasonably believe you have been a victim of abuse or neglect, we may disclose your PHI to a government authority in accordance with law.

Health Care Oversight. We may disclose your PHI to authorities and agencies for oversight activities allowed by law, including audits, investigations, inspections, licensure and disciplinary actions, or civil, administrative and criminal proceedings, as necessary for oversight of the health care system, government programs and civil rights laws.

Legal Proceedings. We may disclose your PHI pursuant to a court order if you are involved in a legal proceeding. Under most circumstances when the request is made through a subpoena, a discovery request, or involves another type of administrative order, your authorization will be obtained before disclosure is permitted.

Law Enforcement. We may disclose your PHI to a law enforcement official for certain specific purposes, such as reporting certain types of injuries.

Deceased Persons. We may disclose your PHI to coroners, medical examiners or funeral directors so that they can carry out their duties.

Research. Under certain circumstances, we may disclose your PHI to researchers who are conducting a specific research project. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your PHI without your authorization.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI if we believe it is necessary to prevent a serious and imminent threat to the health or safety of a person or to the public.

Military, National Security, or Incarceration/Law Enforcement Custody. If you are or were involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your PHI to the proper authorities so they may carry out their duties under the law

Workers' Compensation. We may disclose your PHI as necessary to comply with laws related to workers' compensation or other similar programs.

Please be aware that Ohio law and other federal laws may have additional requirements that we must follow, or may be more restrictive than HIPAA on how we use and disclose your PHI. If there are specific more restrictive requirements, even for some of the purposes listed above, we may not disclose your PHI without your written permission as required by such laws. For example, we will not disclose your HIV test results without obtaining your written permission, except as permitted by Ohio law. We may also be required by Ohio and or federal law to obtain your written permission to use and disclose your information related to treatment for a mental illness, developmental disability or alcohol or drug abuse.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION
Disclosure of your PHI or its use for any purpose other than those listed above requires your specific written authorization. Some examples include:

- Psychotherapy Notes: We usually do not maintain psychotherapy notes about you. If we do, we will only use and disclose them with your written authorization except in limited situations.
- Marketing: We may only use and disclose your health information for marketing purposes with your written authorization This would include making treatment communications to you when we receive a financial benefit for doing so.
- ~~Sale of Your Health Information~~: We will not sell your health information without your written authorization.

If you change your mind after authorizing a use or disclosure of your PHI, you may withdraw your permission by revoking the authorization However, your decision to revoke the authorization will not affect or undo any use or disclosure of your PHI that occurred before you notified us of your decision, or any actions that we have taken based upon your authorization. To revoke an authorization, you must notify us in writing at Fairfield Pain Management, 7901 Diley Road, Suite 130, Canal Winchester, OH 43110.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

YOUR PROTECTED HEALTH INFORMATION RIGHTS
As an APM patient, you have the following rights regarding the PHI we maintain about you:

Right to Inspect and Copy. You have the right to inspect and receive a copy of your PHI. We may charge you a fee as authorized by law to meet your request. To inspect and copy your health information, you must make your request in writing. Please contact our our office by phone at 614-833-1700 to obtain a request form. You may request access to your medical information in a certain electronic form and format, if readily producible, or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit such a copy to any person or entity you designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy. If you wish to make such requests, please contact our office by phone at 614-833-1700.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. You have a right to request that we amend or correct your PHI that you believe is incorrect or incomplete. For example, if your date of birth is incorrect, you may request that the information be corrected. To request a correction or amendment to your PHI, you must make your request in writing to Fairfield Pain Management, 7901 Diley Road, Suite 130, Canal Winchester, OH 43110 and provide a reason for your request. You have the right to request an amendment for as long as the information is kept by or for us. Under certain circumstances we may deny your request. If your request is denied, we will provide you with information about our denial and how you can file a written statement of disagreement with us that will become part of your medical record.

Right to Request Restrictions on Certain Uses and Disclosures. You have the right to request restrictions on how your PHI is used or disclosed for treatment, payment or health care operations activities. However, we are not required to agree to your requested restriction, unless that restriction is regarding disclosure of PHI to your health insurance company and: (1) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (2) the PHI pertains solely to a health care item or service for which you or another person (other than your health insurance company) paid for in full. If you would like to make a request for a restriction, you must submit your request in writing to our office at Fairfield Pain Management, 7901 Diley Road, Suite 130, Canal Winchester, OH 43110. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

The Right to Request Confidential Communications. You have the right to request that we communicate your PHI to you in a certain manner or at a certain location. For example, you may wish to receive information about your health status through a written letter sent to a private address. We will grant reasonable requests. We will not ask you the reason for your request. To request confidential communications, you must make your request in writing. You may obtain a request form by contacting our office at 614-833-1700.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures we make of your PHI. Please note that certain disclosures need not be included in the accounting we provide to you. To request an accounting of disclosures, you must submit your request in writing to our Medical Records Department. Your request must state a time period which may not go back further than 09/01/2012. You will not be charged for this accounting, unless you request more than one accounting per year, in which case we may charge you a reasonable cost-based fee for providing the additional accounting(s). We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of Notice. You have the right to receive a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. A paper copy of this Notice can be obtained from the receptionist at any FPM site or surgery center and is also available at our website at www.pccohio.com.

Complaints. You have the right to file a complaint if you believe your privacy rights have been violated. If you would like to file a complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: Fairfield Pain Management, 7901 Diley Road, Suite 130, Canal Winchester, OH 43110 or by contacting us at 614-833-1700.

You have the right to complain to the United States Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

CONTACT INFORMATION, QUESTIONS OR CONCERNS If you have questions or concerns about your privacy rights, or the information contained in this Notice, please contact us at Fairfield Pain Management in writing at 7901 Diley Road, Suite 130, Canal Winchester, OH 43110 or by phone at 614-833-1700.