W. C. PAIN MANAGEMENT

MISSION STATEMENT

To provide quality medical care to adolescents and adults in the need of a pain evaluation;

To use our skills and the resources available to us, to provide some measure of pain control; to work together with each patient in regards to their plan of care.

NEW PATIENT WELCOME PACKET

W.C. PAIN MANAGEMENT INC.

1574 Henthorne Drive, Suite C
Maumee, OH 43537
Ph: (419) 794-1170
Fax: (419) 794-1171
www.wcpainmanagement.com

WELCOME LETTER

Dear **POTENTIAL PATIENT**

Thank you for your interest in our pain management facility!

At this practice, we feel that there must be a partnership between patient and physician for the optimization of your pain control. Our goal is to help you manage your pain better and improve your daily function, social, and work activities.

Once you have completed the forms, **please return them to the office as soon as possible**. You may do so via mail, fax, or personally dropping them off. The faster you return this completed packet, the faster it will be for us to schedule your initial appointment.

Your appointment **will be scheduled as soon as we receive your referral, completed forms and our pain physician has reviewed your information.**

As a pain specialty practice, we use several different approaches to managing your pain including medications, physical therapy, injections, blocks, counseling and/or psychiatry. In addition, we now offer a pharmacogenetics testing that helps to determine which pain medications may be best suited for you.

Therefore you must understand that your treatment plan may change from that of your Primary Care Physician or referring physician and will be based on the pain medicine physician's evaluation, radiologic studies, behavior and evidence based guidelines. **Your current medications may be discontinued**.

Please allow 1 to 2 hours for your initial appointment with our pain physician. **You should arrive at least 15 minutes prior to your appointment.**

Please notify us if you need to reschedule at least 48 hours prior to your appointment so that we can use your spot for another patient (please see office policy).

If you have any questions, please feel free to call us at **(419) 794-1170**.

Sincerely,

W.C. Pain Management

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MEDICATION AGREEMENT STATEMENT

Patient Name: _____ DOB: _____

As a pain specialty practice, we use several different approaches to managing your pain including medications, physical therapy, injections, blocks, counseling and/or psychiatry.

Therefore you must understand that your current treatment plan from your Primary Care Physician or referring physician may be changed.

Your new pain care plan will be based on the pain doctor's evaluation, radiologic studies, behavior and evidence based guidelines. **Our goal is to help you manage your pain better and improve** your daily function, social and/or work activities.

Your current medications may be discontinued or prescribed in a limited dose and quantity.

Our pain physician will review your referral information.

If you agree to this, please call the office to be scheduled.

A signed copy of this will be placed in your chart if you become a patient in this practice.

No change or refill of opioid medications will be done over the phone.

Please, do NOT discuss whether or not you will receive Opioid medication at your appointment with the staff. This needs to be discussed with your physician.

As always, remember to be courteous to the staff and physician(s).

Signature of patient Date

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PAIN TREATMENT AGREEMENT

Patient Name: _____ DOB: _____

At this practice, Wee Care! and feel that there must be a partnership between patient and physician for the optimization of your pain control. Our goal is to help you manage your pain better and improve your daily function, social, and work activities.

As a pain specialty practice, we use several different approaches to managing your pain including medications, physical therapy referral, injections, blocks, counseling and/or psychiatry referral. In addition, we may offer pharmacogenetics testing that can help to determine which pain medications may be best suited for you.

Therefore you must understand that your treatment plan may change from that of your Primary Care Physician or referring physician and will be based on the pain medicine physician's evaluation, radiologic studies, behavior and evidence based guidelines. Your current medications may be discontinued or reduced.

By agreeing to be a part of this practice, you must understand that you are here to be evaluated by a Pain Medicine Specialist and that you have a right to comprehensive pain management.

Our pain management specialist (physician) may put you on a trial period of opioids (narcotic medication) to help manage your pain. This is a serious decision and should not be taken lightly.

Expected Benefits

- Better control of Pain condition(s).
- Better functioning in workplace/school and home/social environment.

Possible Complications

I understand that the possible problems and/or complications associated with chronic use of opioid medication(s) may include:

- **Physical Dependence**: It may develop and I will need mental supervision to safely come off the medication(s). I understand that if I run out of my medication(s) too soon or stop it suddenly that I could experience withdrawal symptoms, which can be uncomfortable.
- **Psychological Dependence:** Some patients become "psychologically" dependent on this type of medication. If overuse or amounts are increased by me without physician supervision, this can be harmful. This would be a reason to taper and discontinue treatment.
- **Addiction:** Addiction implies the abuse of a drug, and is defined by certain behaviors, including energy and time focused on obtaining medication, along with a decline of normal family and work functions.
- **Allergic reactions, overdose, and/or fatal complications.**

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- **Breathing problems especially when combined with other sedative medications.**
- **Drowsiness, dizziness and/or confusion**
- **Impaired judgment and inability to operate machines or drive motor vehicles which may lead to fall or motor vehicle accidents.**
- **Nausea, vomiting and/or constipation.**
- **Development of tolerance with prolonged use.**

Guidelines to Avoid Complications:

1) **I will not use illegal substances, street drugs or abuse alcohol while taking controlled medications and will not take opioids prescribed for other people or friends/family members**.

2) I will not be involved in the sale, illegal possession, diversion, or transport of controlled substances like opioids (narcotics), sleeping pills, nerve pills or marijuana.

3) I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication

4) I agree to comply with random drug screening tests, including blood alcohol levels, when requested by my physician. Refusal may result in you not being accepted into the practice.

5) I agree to obtain **ALL** of **my prescriptions for opioids and other pain medications** from one physician or only at the W. C. Pain Management and to take medications as prescribed by my doctors.
I will fill **ALL of my prescriptions at the following Pharmacy:**
Name: _____; Ph: _____
Fax: _____ Address: _____

6) In an acute emergency requiring a prescription for opioids, such as an **ER visit**, Dental appointment, or an inpatient admission, another provider may prescribe medications for me. However, if this occurs**, I agree to notify this office at (419) 794-1170 within 24 to 72 hours of the receipt of the prescription.**

7) Overdose on this medication may cause death by stopping my breathing; this can be reversed by Naloxone or emergency medical personnel if they know I have taken narcotic pain killers.

8) I understand that my doctor may consult with the pharmacist, pharmacy, or any other pharmaceutical monitoring establishments.

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9) I understand that **NO** allowances will be made for lost prescriptions, sample medications, or any problems I may have with transportation or dates of pick up. I agree to keep my medication in a safe and secure place. Stolen prescriptions must be reported to the police before a replacement can be considered. A police report will be requested.

10) **The dosage of any medication must remain exactly what was agreed upon at my last visit or conversation with my physician.**

11) I agree to attend the required follow up visits with my physician regarding pain control and to keep all scheduled clinic appointments.

12) I agree that no change in medication dosage or refills will be granted in between appointments and that I must be re-evaluated for any adjustments in medications unless, there is a special circumstance.

13) **I also agree to participate in other chronic pain treatment modalities recommended by my doctor**.

14) I agree to allow my physician in W. C. Pain Management to communicate with other physicians and any pharmacists regarding pain management as deemed necessary.

15) **FOR FEMALES ONLY**: I certify that I am not pregnant, and I will submit to a urine pregnancy test if required prior to any procedures. I certify that I will use appropriate measures to prevent pregnancy during the course of my treatment with opioids. I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids and withdrawal can be life-threatening for a baby.
PLEASE INITIAL: _____; N/A

16) I have read and understand the possible adverse effects and dependencies associated with opioids regarding Adverse Effects.

17) If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.

18) I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be tapered and I will be referred to a drug treatment program to help with this problem.

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PAIN TREATMENT AGREEMENT

Patient Name**:** _____ DOB: _____

I have read and agree to all of the terms outlined above, and give my consent to enter into a pain treatment agreement to prevent possible misunderstandings in the future.

I understand that the physician or associate at W. C. Pain Management (WC Pain) may terminate this agreement at any time:

- If there is reason to believe that I am not complying with the terms of this agreement.
- Or believe that I have made a misrepresentation or false statement concerning my pain or my compliance with the terms of this agreement.
- If I am disrespectful or rude to the Physician or the staff.
- If I give away, sell, or misuse the Pain Medications or use other peoples' (family/friends or other) medications or illegal substances.
- If I do not follow up regularly, multiple cancellations, or as requested by my physician.
- If I am unwillingly to partner with the physician in using the safest and most appropriate therapy for my pain.

I understand that if the agreement is terminated, I will not be a patient of **W. C. Pain Management Practice** and would strongly consider treatment for chemical dependency if clinically indicated.

_____ _____/_____/_____

Patient's Signature

Or

Power of Attorney Signature

_____ _____/_____/_____

Physician or Provider

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PATIENT REGISTRATION FORM

Date: _____

PATIENT

Patient's Name: Last	First *(legal)*:	Middle Initial:	
Address:			
City:	State:	Zip:	
Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
SSN#:	Birthdate:	Age:	
Home Phone #	Cellular #	Work #	Ext:
BEST NUMBER TO CALL			
Employer:			
EMAIL ADDRESS:			

Race ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Alaskan Native-American Indian ☐ More than one race ☐ Unreported/Refused	**Ethnicity** ☐ Hispanic ☐ Non Hispanic **Preferred Language:** _____ **How would you like to get notifications?** ☐ Postal ☐ E-mail ☐ Phone	**Veteran of U.S Military** ☐ Yes ☐ No ☐ N/A **Student:** ☐ Full Time ☐ Part Time ☐ Not Attending

Preferred Local Pharmacy:

Preferred Mail Order Pharmacy:
_____

PCP (Primary Care Physician) Name: _____

Address: _____Phone #: _____

Occupation: ( ) Employed ( ) Full-time ( ) Part-time ( ) Retired ( ) Unemployed ( ) Disability
Place of Employment: _____What does your work involve:_____

Are you involved in any legal action related to your pain problem? ( ) Yes ( ) No
If yes, what is the current status of your claim? _____
_____
If no, are you considering legal action? ( ) Yes ( ) No
Do you have an active Worker's Compensation Claim? ( ) Yes ( ) No
Have you had a worker's Compensation claim in the past? ( ) *Yes ( ) No If "yes", when was it settled?
_____ Are you currently on disability? ( ) *Yes ( ) No
*If yes, please provide date disability began:_____
Are you planning on filing for disability in the next 6 months? ( ) Yes ( ) No
_____

Please present your insurance card to the receptionist so that a copy can be made for our records

Please note that it is YOUR responsibility to inform us about your primary and/or secondary insurances and to update YOUR information with your insurance carrier(s) for all claims to be processed correctly.
You are responsible for all charges unless otherwise stated.

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INSURANCE

PRIMARY Insurance: _____ ID# _____

Group # _____

Subscriber's Name: _____ DOB _____ SSN _____

Relation to Patient ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Other

Employer Name: _____ **Copay:** _____

SECONDARY Insurance _____ ID # _____

Group # _____

Subscriber's Name: _____ DOB: _____ SSN: _____

Relation to Patient ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Other **Copay:** _____

Employer Name: _____

Please complete the following information regarding financial responsibility:

FINANCE

Insured / Responsible Party (who is responsible for payment) Name Last: First (legal) Middle Initial:		
Address (if different than patient)		
City:	State:	Zip:
SSN#	Birth date:	
Phone #:	Relation to patient: ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Other	

EMERGENCY CONTACT

Name: _____

Relationship: _____

Home Phone: ( ) - Cell Phone: ( ) - Work Phone: ( ) -

Authorization for Treatment and Financial disclosure

I authorize ***W.C. Pain Management*** to release any information that may be necessary to comply with subpoenas, governmental regulations and laws. I also authorize the rendering physician at this practice to release to the following parties, any information they request from the physician: Medicaid, Medicare and/or other insurer. For physician services provided to me, I assign to ***W. C. Pain Management*** all insurance or other payments made for these services. This simply means that any insurance companies or other party obligated to pay my physician bills may pay the physician directly. I hereby authorize ***W. C. Pain Management*** to bill my insurance company for services rendered.

I understand that I am responsible for payment of all bills for any services provided by a **PHYSICIAN** at ***W. C. Pain Management.*** If I do not provide the name of an insurance company or other party obligated to pay my bills, I will provide the physician with personal credit information and cooperate with physicians in establishing plan for payment of my physician services.

Patient Signature: _____ **Date:** _____

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HEALTH HISTORY FORM

Date: _____

Patient Name: _____ **DOB:** _____

( ) Male ( ) Female Age _____ HT: _____ WT: _____

Do you have allergies to any medications? ( ) Yes ( ) No

Please list any medications to which you are allergic: _____

Please list the main reason(s) for your visit: _____

Please circle all that apply: Diabetes Hypertension Hepatitis B Hepatitis C Congestive heart failure Sleep apnea Obesity Asthma Arthritis COPD Seizures Thyroid problems Cancer Other: _____

Please list or attach all prescribed medications & the dosage that you are taking: _____

_____

_____

When did your pain problem first start (month/year): _____ Location of Pain: _____

What is the main cause of your pain?

( ) trauma (Please explain) _____

( ) MVA (Please explain) _____

( ) Work injury (Please explain) _____

( ) Other (Please explain) _____

Was the onset of symptom(s) ( ) gradual -or- ( ) sudden or result of injury? _____(please explain)

Describe the pain: ( ) Aching ( ) Burning ( ) Stinging ( ) Pressure like ( ) Sharp ( ) Stabbing
( ) Throbbing ( ) Dull ( ) Pins & Needles ( )Shooting ( ) Other _____

Does the pain radiate (move)? ( ) No ( ) Yes Where? _____

Current pain score: 0 1 2 3 4 5 6 7 8 9 10 (on a scale 0 to 10, with 0 = no pain & 10 = very severe pain)

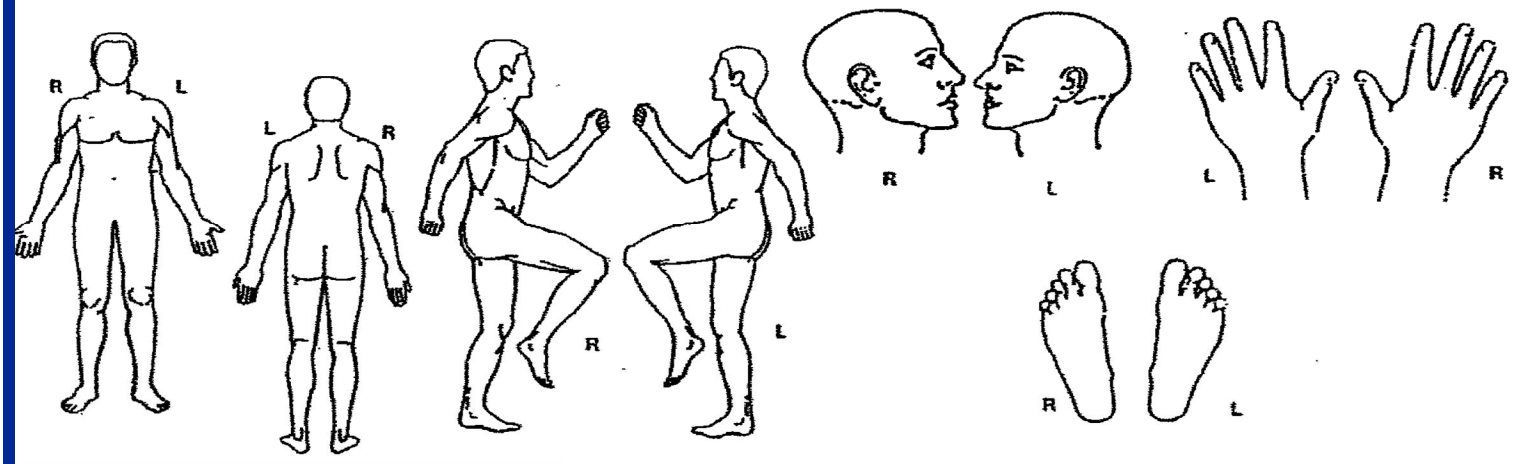
What makes your pain worse? _____What makes your pain better? _____

What have you tried to relieve the pain?_____ Have you tried heat therapy: ( ) Yes ( ) No

Have you tried Physical Therapy? ( ) Yes How many wks: _____ If yes, when (month/year)_____ ( ) No

Over the counter medications, or vitamins such as: ( ) Ibuprofen ( ) Naprosyn ( ) Aspirin ( )Vitamins ( ) other: _____

Does the pain interrupt your sleep? ( ) No ( ) Yes Number of hours of sleep nightly _____



Please shade the areas where you feel the pain.

Any interventions:

Have you been to a Pain clinic in the past (where and when):_____

If yes, have you had any procedures done? ( ) Yes ( ) No

( ) Nerve Blocks: _____( ) Steroid Injection ( ) Trigger Injection ( ) TENS unit ( ) Chiropractor ( ) Biofeedback ( ) Psychiatry Visit

Surgeries related to your pain: ( ) Yes ( ) No Where: _____ date and types of surgery:_____

surgeries:_____

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SOCIAL HISTORY

Tobacco History ( ) Never Used ( ) Currently use (# packs/day)_____ # of years smoking _____ ( ) Former User – year quit _____

Alcohol ( ) Never use ( ) Less than 2 drinks/week ( ) 3-5 drinks/week ( ) More than 5 drinks/week ( ) History of Alcohol Abuse

Social Drugs ( )Marijuana ( ) Cocaine ( ) Heroin ( ) Other _____ ( ) Never Use

Please circle all that apply: History of alcoholism history of drug use/abuse

MENTAL HISTORY

Do you have a history of depression: ( ) Yes ( ) No

Do you have anxiety? ( ) Yes ( ) No

Do you have a history of Bipolar Disease: ( ) Yes ( ) No

Do you have a history of Schizophrenia : ( ) Yes ( ) No

Do you have any suicidal history? ( ) Yes ( ) No

Please list any medications that you are currently taking for these conditions:

_____

_____

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Please print name of Patient or Personal Representative Relationship to Patient

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO US

Patient's Name: _____ Date of Birth: _____

I request and authorize my doctor: _____

(Insert name of doctor & practice)

_____

(Insert address, fax and phone number of your doctor)

To release my healthcare information to:

W. C. Pain Management, Inc.	**Phone Number: (419) 794-1170**
1574 Henthorne Dr., Suite C	**Fax : (419) 794-1171**
Maumee, OH 43537	

I authorize the release of:

1. ( ) STD Results, HIV/AIDS testing, whether negative or positive to the persons listed above. I understand that the person(s) listed about will be notified that I must give specific written Permission before the disclosure of these test results to anyone.
   Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

2. ( ) **Any records regarding drug, alcohol, and/or mental health treatment <u>or testing</u>**

3. ( ) **Last three (3) encounters and drug testing records (*** Must check boxes 1, 2 & 3)**

4. ( ) **Other**: _____

**I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

_____ _____

Signature **Date**

OFFICE USE ONLY:

Specific Information to be released:

( ) List of Allergies	( ) X-Ray Reports	( ) Physician progress Note	( ) Problem List
( ) EKG's	( ) Consultation Report	( ) Lab Reports	( ) Medication List
( ) MRI/CT report	( ) **Drug Testing Report**		

<u>Please check all that apply:</u>

- ☐ Patient
- ☐ Adult Son
- ☐ Adult Daughter
- ☐ Legally Authorized Representative
- ☐ Durable Power of Attorney for Healthcare
- ☐ Personal Representative of the Estate
- ☐ Other: _____

This authorization expires after 6 months.

Updated 6/26/2017 MG

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CONSENT TO EXAMINE & TREAT

1. I, _____, do hereby consent and authorize Dr. S. Agubosim, MD and/or such assistants or designees as may be selected by him to examine and treat me.
2. I affirm that I have the legal right to consent to this, being either, the patient, the patient's Power of Attorney (POA), or designated legal representative.
3. This consent is binding until specifically revoked by myself or another person who has the right to sign or revoke this form.
4. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of examination or treatment.

CONSENT TO DISCLOSE MY PROTECTED HEALTHCARE INFORMATION

In general, the HIPAA privacy rule gives individual the right to request a restriction on uses and disclosure of their protected health information (PHI). The undersigned hereby authorizes Wee Care Pain Management (W. C. Pain Management) and its employees/agents to contact me in the following manner (check all that apply) **PLEASE NOTE THAT THIS INFORMATION MAY BE REGARDING TEST RESULTS, APPOINTMENTS OR BILLING INQUIRIES.**

ORAL COMMUNICATION:

____ Yes, it is okay to leave a message on your phone

WRITTEN COMMUNICATION

We communicate through our patient portal or occasionally via regular mail.

I PERMIT THIS PRACTICE TO DISCLOSE MY PHI AND TO DISCLOSE THE PHI TO THE FOLLOWING INDIVIDUALS: (PLEASE BE SPECIFIC WITH WHOM YOU WANT INFORMATION GIVEN TO) WE WILL BE UNABLE TO RELEASE ANY INFORMATION TO ANYONE NOT LISTED.

Spouse _____Adult Child (Children) _____ Other _____

OTHER: Please check if this applies

__Allow Medical Students, Physician Assistant Students and Medical Assistant Students to review my protected health information (PHI) while doing rotation in this office.

I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to Wee Care Pain Management. I understand that a revocation is not effective to the extent that Wee Care Pain Management has relied on the use of discloser of the protected health information (PHI).I understand that information used or disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and may no longer by federal or state law. We Care Pain Management will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

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OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. **Please read this carefully and if you have any questions, please do not hesitate to ask a member of the staff.**

Insurance & Payments:

1. **On arrival, please sign in at the front desk and present your current insurance cards (PRIMARY AND SECONDARY**) at every visit. **You will be asked to sign and date the file copy of the card.** This is your verification of the correct insurances and consent to bill on your behalf. **IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.**
2. **According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances at the time of service.**
3. We submit to secondary insurance plans. Please provide a copy to the front desk. **YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCCOUNT.**
4. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if pre-authorization is required prior to a procedure, and what services are covered.
5. **If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit**. You can submit the bill to your insurance for re-imbursement. The payment will be sent directly to you. **For scheduled appointments, prior balances must be paid prior to the visit.**
6. **CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.** A **$10.00 service fee** will be charged in addition to your co-payment if the co-payment is not paid at time of service or by the end of the next business day.
7. **DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE IF THEY ARE CALCULATED PRIOR TO THE APPOINTMENT. OTHERWISE, THEY MUST BE PAID IMMEDIATELY ONCE THE CLAIM IS PROCESSED**.
8. Patient balances are billed immediately upon receipt of your insurance plan's explanation of benefits (EOB). **Your remittance is kindly appreciated within 10 business days of your receipt of your bill.**
9. A **$37** fee will be charged for any checks returned for insufficient funds.
10. If previous arrangements have not been made with our finance office. Any balance over 60 days may be forwarded to a collection agency.
11. **IF YOU PARTICIPATE WITH A HIGH-DEDUCTIBLE HEALTH PLAN, WE REQUIRE A COPY OF THE HEALTH SAVINGS ACCOUNT DEBIT/CREDIT CARD OR PERSONAL CREDIT CARD REMAINS ON FILE. THERE ARE ADDENDA TO THIS FINANCIAL POLICY, WHICH ARE SIGNED SEPARATELY.**
12. **Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility. Please note that we bill everyone at the full fee for non-covered services.**
13. **We accept American Express, Debit, MasterCard and Visa cards and cash. Checks are only accepted on a very limited basis and are subject to approval.**
14. **Please note that you will be asked for your insurance card at each visit.**

Appointments:

15. **We require a 48-hour notice for canceling any appointments. Otherwise, you may be charged if our contract with your insurance allows it.**
16. See our "Missed appointment policy".
17. If you are running late for your appointment, please be courteous and call the office to notify us as soon as possible at (419) 794-1170. This allows us to possibly see other patients during that time.

Forms & Medical Records:

18. **MEDICAL RECORDS RELEASE** (Please see Medical Record Copying Charges)

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19. **We did not complete Disability determination, work restrictions and Return-to-work forms. These forms should be completed by your Primary Care Physician or physician who specializes in such.**
20. **If you require a copy of medical records to support a claim for Social Security Disability or Supplemental Security Income (SSI), documentation showing that a claim has been filed, must accompany the request in order for the cost of the records to be free. This is only good for time use only.**
21. **There is a $25.00 charge for all forms completed. This includes legal documents and Payment is due when the forms are dropped off. We have a 7-10 business day turnaround time for forms. If a form is needed sooner than 7 days, there is a $5.00 *rush* fee.**

MEDICAL RECORD COPYING CHARGES

Please read this carefully and if you have any questions, please do not hesitate to ask a member of the staff.

In accordance with **Ohio Revised code 3701.74, a patient or patient representative or an authorized person who wishes to examine or copy part or all of the medical record must submit a signed, written request that is dated not more than one year before the date on which it is submitted. The request must indicate whether the copy is to be sent to the requester, the patient's physician or held for the requester at the physician's office.**

We charge the following fees:

If the request is made by the patient or the patient's personal representative:

- Three dollars ($3.00) per page for the **first 10 pages** and Fifty cents ($0.50) per pages for **pages 11** to 50, Twenty-five ($0.25) per page for **pages 51** and higher. Postal cost if mailed.

If the request is made by a person other than the patient or patient's personal representative (such as a request by an "authorized person"):

- $18 for **initial record search** and $1.20 per page for the **first 10 pages**, $0.50 per pages for **pages 11 to 50**, $0.25 per page for **pages 51** and higher. Postal cost if mailed.

The following entities are entitled to **One free copy of a medical record**: Ohio Bureau of Worker's Compensation; the Industrial Commission; the Department of Job and family Services; and the patient or patient's personal representative if the medical record is necessary to support a claim for Social Security Disability or Supplemental Security Income (SSI) and the request is accompanied by documentation that a claim has been filed.

With respect to data recorded other than on paper such as copies of X-rays, EKG strips or records on a flash drive or CD:

- A fee of two dollars ($2.00) per page in addition to cost of the flash drive or CD

OFFICE POLICY REGARDING MISSED APPOINTMENT(S)

- After the first missed appointment, **an established** patient will be reminded by phone and/or letter of our office policy. The appointment may be rescheduled.
- If a second scheduled appointment is missed the following will occur:
  - A $50 fee will be accessed for a missed office appointment if allowable per your insurance. *A 24 hour cancellation notice is required.*
  - A $75 fee will be accessed for a missed office procedure if allowable per your insurance. *A 24 hour cancellation notice is required.*
  - A 2nd missed appointment letter will be issued. The appointment may be rescheduled.
- However, if a third scheduled appointment is missed, it will be necessary to terminate our professional relationship with the patient and you may receive a termination letter will be sent.

W.C. PAIN MANAGEMENT INC.
1574 Henthorne Drive, Suite C; Maumee, OH 43537
Ph: (419) 794-1170; Fax: (419) 794-1171
www.wcpainmanagement.com

PRE-REGISTRATION POLICY

In order to better serve you, and to make your appointments more efficient, we are enforcing a new registration policy. All new patients must be pre-registered with our staff no later than 48 hours before their appointment. At the patient's request, they may come in and personally verify the registration information, or if that is inconvenient, the office can call. Patients that opt for the latter will receive contact from the office via phone, and will get your pre-registration information prior to the appointment day. When you receive the abovementioned call from the office, make sure you have the following information readily available:

Demographic Information. We want to confirm all of our information assigned to your patient record. This includes but is not limited to full name, address, phone numbers (home, cell, work), and date(s) of birth. We may also require confirmation of the patient's social security number if applicable.

All Insurance Cards. We need to know the various numbers assigned to your insurance policy. Also, if the patient is not the primary cardholder, we need other information regarding the person whose name is on the insurance card. If there are several insurances (ex. Medicare & Medicaid), we will need to know which insurance is primary and which one is secondary. It would also be greatly appreciated if you could fax us copies of the insurance card(s) prior to your appointment to avoid a delay in scheduling.

We believe that by enforcing this simple policy, that you, the patient, will be better served. This will be an easy and convenient way to decrease the wait time before the office visit, and we will be more efficient and available to care for your needs. This policy will most definitely contribute to our aspiration to uphold the highest standards of patient care for you and your family.

PHONE POLICY

- Please remember that medication refills should be requested during the time of your appointment or via the patient portal (You must give the staff your e-mail address to gain access).
- Please give the office a valid phone number and update this information regularly so that the office is able to reach you when there is a change in your appointment schedule or we need to discuss a matter with you.
- As a courtesy, please call the office back when we leave a message for you. This will ensure that you do not miss important information regarding your appointment or plan of care.
- Please do not call the office to request a change in your medication over the phone. You will need to schedule an appointment to discuss this matter with your pain doctor.
- Please do not call the office to let us know that your prescription has been stolen without filing a formal police report.
- Please do not call the office to request medical records over the phone. All requests must be completed in writing. This form is available on our website (see medical record copying fees & policies) for further details.
- **Please do not call the office multiple TIMES FOR ISSUES THAT CAN WAIT UNTIL YOUR APPOINTMENT.**

I have received the notice of privacy practices

Please Print: _____
(Name of Patient)

_____ _____
(Signature of Patient) (Date)

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