New Patient Intake

Welcome to our office. We are committed to providing the most comprehensive rehabilitation to decrease pain while improving your mobility and overall quality of life. Please assist us by providing the following information to the best of your ability. All information is confidential and is released only with your consent. Please feel free to ask us any questions you may have.

Today's Date: _________________

Patient Information

Your Name: ____

DOB: ___________________ **Age:** _________ **Gender:** ❑ Male ❑ Female

Address: ____

City/State/Zip: ____

Preferred Phone: _________________________________ ❑ Home ❑ Cell ❑ Work

Secondary Phone: ________________________________ ❑ Home ❑ Cell ❑ Work

Social Security #: ___________-______-_____________ **Driver's License #/State:** _____________________

Email address: ____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed Other: ____________________

Race: ❑ American Indian ❑ Asian or Pacific Islander ❑ Black ❑ White ❑ Refuse to report ❑ Other

Primary Language: ❑ English ❑ Spanish ❑ Other **Ethnicity:** ❑ Hispanic ❑ Non-Hispanic

Employment Status

❑ Employed ❑ Unemployed ❑ Retired ❑ Disabled Employer: ________________________________

Phone: _____________________________________ Occupation: __________________________________

Referral and Physician Relationships

Who is your primary care physician? ____________________________________ Phone: __________________

Who can we thank for referring you to our clinic? ____

If you were not referred, how did you hear about us? ❑ Insurance company ❑ PCP ❑ Family ❑ Friend ❑ Yelp

❑ www.choicepain.com ❑ Facebook ❑ Google ❑ Other website: ______________________

Emergency Contact

Name: ____________________________ Phone: _________________________ Relationship: _____________

Preferred Pharmacy

Pharmacy Name: ____ Phone: _________________________

Address: ____ City/State/Zip: ___________________________

Primary Insurance

Primary Insurance Company and Plan: ______________________________

Medicare Patients Only: ❑ Medicare Cigna Health Springs ❑ Medicare Kaiser: ❑ Other__________

Policy ID #: ____________________ Group #: ____________________

Claims Address: ______________________________

City/State/Zip: ____________________ Phone: ______________

Insurance Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Complete this box if you are *not* the policy holder for your primary insurance

Policy Holder Name: ____________________ DOB: ______________

Social Security #: ________-_____-________ Phone: ______________

Address: ____________________ City/State/Zip: ______________

Policy Holder Gender: ❑ Male ❑ Female Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary Insurance

Secondary Insurance Company and Plan: ______________________________

Policy ID #: ____________________ Group #: ____________________

Claims Address: ______________________________

City/State/Zip: ____________________ Phone: ______________

Insurance Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Complete this box if you are *not* the policy holder for your secondary insurance

Policy Holder Name: ____________________ DOB: ______________

Social Security #: ________-_____-________ Phone: ______________

Address: ____________________ City/State/Zip: ______________

Policy Holder Gender: ❑ Male ❑ Female Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

* WORK ACCIDENT OR MOTOR VEHICLE ACCIDENT?

❑ Yes If yes, **PLEASE NOTIFY FRONT DESK** ❑ No

Consent for Treatment

I certify that the above information is accurate, complete, and true.

I authorize Choice Pain & Rehabilitation Center and its associates, assistants, and other health care providers it may deem necessary to treat my condition. I understand that no warrant or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

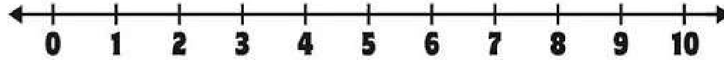
Patient Signature: ______________________________ Date: ______________

MEDICAL / CLINICAL HISTORY

Your Name: ____ DOB: __________________________

Primary reason for today's visit: _________________________________ Height: _________ Weight: ________lbs

Pain Scale with Descriptions



Use the pain scale described below to rate your pain for the questions below:

0-Pain free
1-Very minor annoyance, occasional minor twinges
2-Minor annoyance, occasional strong twinges
3-Annoying enough to be a distraction
4-Can be ignored if you are really involved in your work/task, but still distracting
5-Cannot be ignored for more than 30 minutes
6-Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7-Makes it difficult to concentrate, interferes with sleep, but you can still function with effort 8-Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain
9-Unable to speak, crying or moaning uncontrollably, near delirium 10-Unconcious, pain makes you pass out

What number on the pain scale (0-10) best describes your pain **right now**?

What number on the pain scale (0-10) best describes your **worst pain**?

What number on the pain scale (0-10) best describes your **least pain**?

What number on the pain scale (0-10) best describes your **average pain over the last month**?

Where is your worst area of pain located? ____

PEG Scale

Please answer to the best of your ability in order to provide the best care possible, we rely on its accuracy and its completeness.

1) What number on the pain scale (0-10) best describes your pain on average in the past week? _________

2) What number on the pain scale (0-10) best describes how, during the past week, pain has interfered with your enjoyment of life? _________

3) What number on the pain scale (0-10) best describes how, during the past week, pain has interfered with your general activity? _________

Pain Location

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

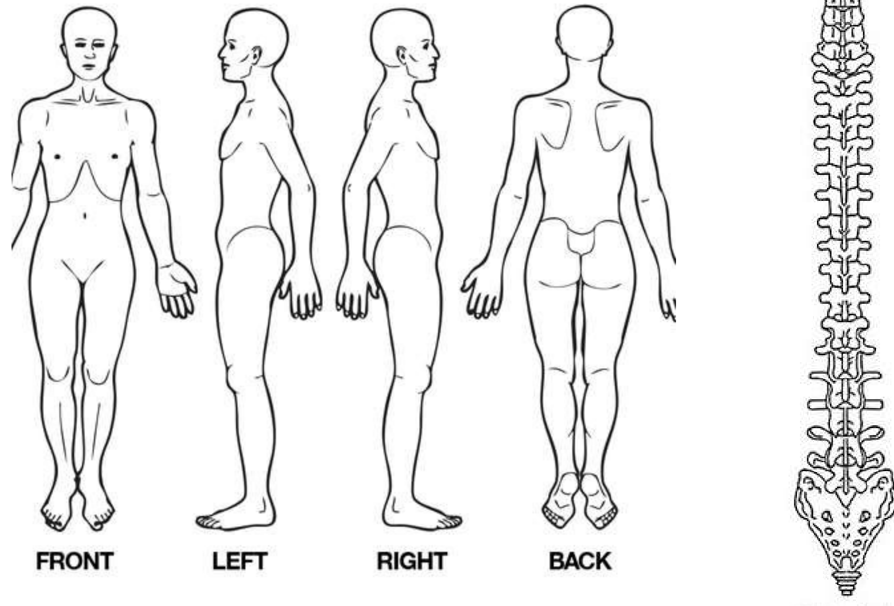
"A" = Aching

"B" = Burning

"N" = Numbness

"P" = Pins and needles

"S" = Stabbing



Approximately when did this pain begin? ______________________________

What caused your current pain episode? ______________________________

Is your pain the result of a Motor Vehicle Accident or Personal Injury? ❑ Yes Accident Date_________ ❑ No

Are you presently involved in a lawsuit related to your pain? ❑ Yes ❑ No

If "yes" please explain on the lines below.

____

____

How did your current episode begin? ❑ Gradually ❑ Suddenly

Since your pain began, has it changed? ❑ Decreased ❑ Increased ❑ Remained the same

What is your functional goal(s)? ______________________________

Pain Scale with Descriptions

Check the words that best describe your pain below:

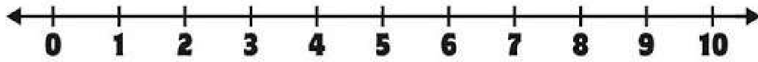
❑Sharp	❑Throbbing	❑Tender	❑Nagging	❑Shooting	❑Cramping
❑Exhausting	❑Miserable	❑Gnawing	❑Unbearable	❑ Aching	❑Tingling
❑Burning	❑Stabbing	❑Numb	❑Penetrating	❑Spasming	❑Dull

Pain Frequency

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

When is your pain at its worst? ❑ Morning ❑ During the day ❑ Evenings ❑ Middle of the night

How has pain interfered with your daily life?



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4-Can be ignored if you are really involved in your work/task, but still distracting
5-Cannot be ignored for more than 30 minutes
6-Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7-Makes it difficult to concentrate, interferes with sleep, but you can still function with effort 8-Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain
9-Unable to speak, crying or moaning uncontrollably, near delirium 10-Unconcious, pain makes you pass out

What number on the pain scale (0-10)

Mood	______	Driving	______
Walking ability	______	Going downstairs	______
Normal work routine	______	Going up stairs	______
Relations with other people	______	Increased activity	______
Sleep	______	Lifting objects	______
Enjoyment of life	______	Lying flat	______
Ability of concentrate	______	Movement	______
Appetite	______	Sitting	______
Bending	______	Prolonged sitting	______
Change in weather	______	Standing	______
Coughing/sneezing	______	Prolonged standing	______

In the past six months have you developed any new:

❑Headaches	❑Dizziness	❑Sharp	❑Nausea	❑Urinary incontinence	❑Rashes
❑Vision problems	❑Fever/ Chills	❑Exhausting	❑Stomach pain	❑Chronic fatigue	❑Swollen joints
❑Hearing problems	❑Constipation	❑Erection problem	❑Diarrhea	❑Night sweats	❑Chest pain

❑ I HAVE **NOT** RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIONS.

Diagnostic Tests and Imaging

Mark all the following tests you have had that are related to your current pain complaints:

❑ MRI of the ___________________________ Date: ____________________ Facility: ___________________

❑ X-ray of the __________________________ Date: ____________________ Facility: ___________________

❑ CT of the ____________________________ Date: ____________________ Facility: ___________________

❑ EMG/NVC study of the _________________ Date: ____________________ Facility: ___________________

❑ Ultrasound of the ______________________Date: ____________________ Facility: ___________________

❑ Other diagnostic testing: ____

❑ I HAVE **NOT** HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT COMPLAINTS.

Pain Treatment History

Mark all the following pain treatments you have undergone prior to today's visit:

❑ Chiropractic ❑ Neurosurgeon (spine) ❑ Pain Management ❑ Physical/Occupational Therapy

❑ Rheumatology ❑ Discogram - (circle all levels that apply) Cervical / Thoracic / Lumbar

❑ Epidural Steroid Injection - (circle all levels that apply) Cervical / Thoracic / Lumbar

❑ Joint Injection – Joint(s) ____

❑ Medial Branch Blocks or Facet Injections - (circle all levels that apply) Cervical / Thoracic / Lumbar

❑ Nerve Blocks – Area/Nerve(s) ____

❑ Radiofrequency Ablation - (circle all levels that apply) Cervical / Thoracic / Lumbar

❑ Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant – Which Company ________________

❑ Trigger Point Injection – Where ____

❑ Vertebroplasty / Kyphoplasty – Level(s) ____

❑Back Brace- When/Where did you receive it? ____

❑Knee Brace- When/Where did you receive it? ____

❑Tens Unit- When/Where did you receive it? ____

❑ I HAVE **NOT** HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS

Current Medications

Are you currently taking any aspirin, blood thinners or anticoagulants? ❑ Yes ❑ No

If yes, which ones? ❑ Coumadin ❑ Plavix ❑ Lovenox ❑ Aggrenox ❑ Other: _________________________

Please list *all* medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency

Allergies

Do you have any known drug allergies? ❑ Yes ❑ No

If so, please list all medications you are allergic to:

Medication Name Allergic Reaction Type

____

____

____

____

Previous Medications Tried

Mark all the following medications you have previously tried.

Over the Counter medications: ❑ Aspirin ❑ Acetaminophen/Tylenol ❑ Advil/Motrin/Ibuprofen ❑ Aleve/Naproxen ❑ Excedrin

Prescription Anti-Inflammatories: ❑ Ibuprofen ❑ Naproxen ❑ Diclofenac/Voltaren ❑ Meloxicam/Mobic ❑ Celecoxib/Celebrex ❑ Ketorolac/Toradol ❑ Etodolac ❑ Indomethacin ❑ Piroxicam

Muscle Relaxers: ❑ Flexeril/Cyclobenzaprine ❑ Robaxin/Methocarbamol ❑ Tizanidine/Zanaflex ❑ Soma/Carisoprodol ❑ Baclofen ❑ Skelaxin/Metaxalone ❑ Orphenadrine/Norflex ❑ Lorzone/Chlorzoxazone

Nerve Pain Medications: ❑ Gabapentin/Neurontin ❑ Pregabalin/Lyrica ❑ Duloxetine/Cymbalta ❑ Amitriptyline/Elavil ❑ Nortriptyline/Pamelor ❑ Oxcarbazepine/Trileptal ❑ Topiramate/Topamax

Opiates:

Short Acting: ❑ Tramadol/Ultram ❑ Tylenol w/ Codeine ❑ Hydrocodone/Vicodin

❑ Oxycodone/Percocet ❑ Dilaudid/Hydromorphone ❑ Immediate Release Morphine ❑ Opana IR

Extended Release: ❑ Butrans Patch ❑ Fentanyl/Duragesic Patches ❑ MS Contin/Morphabond/Morphine ER ❑ OxyContin ❑ Opana ER ❑ Methadone

Opiate Induced Constipation: ❑ MiraLAX ❑ Docusate ❑ Senokot ❑ Colace ❑ Movantik ❑ Amitiza ❑ Linzess ❑ Relistor

Medical History/Problem List

Mark all conditions/diseases that **YOU** have been **DIAGNOISED** with:

❑Diabetes ❑Hypertension ❑Heart disease ❑Stroke ❑Mental Illness ❑Cancer

❑Other______________________________________ If none, check the box: ❑None

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type or other pertinent details:

Abdominal Surgery		**Joint Surgery**	
❑ Gallbladder removal	____________	❑ Hip	____________
❑ Appendectomy	____________	❑ Knee	____________
❑ Other	____________	❑ Shoulder	____________
Female Surgeries		**Spine/Back Surgery**	
❑ Caesarean section	____________	❑ Discectomy (levels)	____________
❑ Hysterectomy	____________	❑ Laminectomy	____________
❑ Laparoscopy	____________	❑ Spinal Fusion (levels)	____________
❑ Ovarian	____________	❑ Other	____________
❑ Other	____________	❑ Other	____________
Heart Surgery		**Other Common Surgeries**	
❑ Aneurysm repair	____________	❑ Hemorrhoid surgery	____________
❑ Stent placement	____________	❑ Hernia repair	____________
❑ Valve replacement	____________	❑ Thyroidectomy	____________
❑ Other	____________	❑ Tonsillectomy	____________

Please list any surgeries and dates

❑ I HAVE NOT HAD ANY SURGICAL PROCEDURE DONE

Hospitalizations

Please list any recent hospitalizations:

Month/Year	Reason	Hospital

❑ I HAVE **NOT** HAD ANY RECENT HOSPITALIZATIONS

Family History

Have any of your family had the following?

	If yes, who?			If yes, who?	
❑Diabetes	______________	❑Deceased	❑Mental illness	______________	❑Deceased
❑Hypertension	______________	❑Deceased	❑Cancer	______________	❑Deceased
❑Heart disease	______________	❑Deceased	❑Drug Abuse	______________	❑Deceased
❑Stroke	______________	❑Deceased	❑Alcohol Abuse	______________	❑Deceased
❑Other	______________	❑ Deceased	❑Other	______________	❑Deceased

❑ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY ❑ I AM ADOPTED (No Medical History)

Social History

Alcohol Use: ❑ Current Alcoholism ❑ Daily Limited Use ❑ Drinks Alcohol Socially
❑ History of Alcoholism ❑ Never Drinks Alcohol

If you are a current drinker, how many drinks per week? ❑ 1-3 ❑ 4-6 ❑ 7-9 ❑ 10-12 ❑ 13+

Tobacco Use: ❑ Current Tobacco User ❑ Former Tobacco User ❑ Never Used Tobacco If you are a current smoker, how many cigarettes do you smoke a day?

❑ 5 or less ❑ 6-10 ❑ 11-20 ❑ 21-30 ❑ 31 or more

Illegal Drug Use: ❑ Current Illegal Drug Use ❑ Current Marijuana Use ❑ Denies Any Illegal Drug Use
❑ Current Use of Someone Else's Prescription Medications ❑ Former Illegal Drug Use
If you currently or formally use illegal drugs, which one (s)?: ____ Do you have a Medical Marijuana card? ❑ Yes ❑ No

Have you filed for disability? ❑ Yes ❑ No

Medical History and Authorization to Proceed with Treatment

I certify that the above medical/clinical history information is accurate, complete, and true. I authorize Specialty Pain Management to proceed as indicated in above consents.

Patient Name: ____ DOB: ______________________

Patient Signature: ____ Date: _____________________

PATIENT HISTORY INDEX (ORT)

Patient Name: ____ DOB: ________________

Date: ________________

Mark each box that applies	Yes	No
Do your <u>PARENTS or SIBLINGS</u> or anyone in the family have a history of substance abuse?		
Alcohol		
Illegal drugs		
Rx drugs		
Do <u>YOU</u> have a history of substance abuse?		
Alcohol		
Illegal drugs		
Rx drugs		
Are you between the age of 16 – 45 years		
History of preadolescent sexual abuse		
Psychological disease		
ADD, OCD, bipolar, schizophrenia		
Depression		

☐ If none of this applies, please check here.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

Financial Agreement, Cancellation Policy & Notice of Privacy Practices

PLEASE READ THE FOLLOWING AGREEMENT. IT EXPLAINS YOUR FINANCIAL OBLIGATIONS WHILE UNDER OUR CARE, OUR POLICIES REGARDING CANCELLATIONS AND NOTICE OF PRIVACY PRACTICES.

ALL MEDICARE PATIENTS MUST SIGN THE FOLLOWING STATEMENT: I request that payment under the medical insurance program be made on my behalf to Choice Pain & Rehabilitation Center, LLC for any services furnished me by its physician(s) and/or practitioners. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Name: ____ Signature: _________________________________

Insurance Co-Payments

In accordance with my insurance contract, I understand that **co-payments are due at time of service**.

Deductible

If my insurance deductible has not been met, I understand that outstanding deductible amounts will be collected at the time of service unless other payment arrangements have been made.

Co-insurance

I understand that co - insurance amounts may be collected at time of service, and at the time interventional procedures are scheduled.

Private Pay

Established patients with Choice Pain & Rehabilitation Center, LLC only: If I have no insurance coverage, or insurance with which Choice Pain & Rehabilitation Center, LLC does not participate, or Choice Pain & Rehabilitation Center, LLC is unable to verify current insurance coverage, I understand **full payment of $350 is expected at time of service**.

Verification of Benefits and Non-Covered Services

Insurance policies are individualized per patient plan. Choice Pain & Rehabilitation Center, LLC may provide services that my insurance plan excludes. I understand that it is my responsibility to verify coverage benefits and exclusions. I understand that all non-covered services are my responsibility.

Notice to Medicare Patients

If we are unable to verify from Medicare that there is automatic submission of claims to the secondary insurance carrier, you may be responsible for secondary insurance balances at the time of service and at the time interventional procedures are scheduled.

Refund Policy

I understand that amounts collected from me (including co-payments, co-insurance, and deductibles) are based on information received by Choice Pain & Rehabilitation Center, LLC from my insurance carrier. Refunds are to be requested from your insurance company. Choice Pain & Rehabilitation Center, LLC is not responsible for reimbursements.

Collections

I understand that once an account is placed in a collection status, all future services must be paid in full at time of service (no checks accepted). If my account is placed into collections, I will be responsible for all collection and interest costs.

Financial Agreement, Cancellation Policy & Notice of Privacy Practices Continues:

Medical Records

We are happy to provide you with copies of your medical records upon request. However, because of time restrictions, please allow up to 30 business days to fulfill this request. Please note there is a 0.76 cent per page charge for personal use, however, medical records sent to another medical provider will be done free of charge.

Other Forms

We will respond (at the provider's discretion) to requests for the completion of certain medical forms (FMLA, Short Term Disability & **Temporary** Disability Parking Permit) assuming the patient is in good standing and has been active with the Choice Pain & Rehabilitation Center, LLC for six (6) months consecutively. Other forms not listed may be considered for completion. The fee is $10 per page. Payment must be made upfront. **Please allow up to 14 business days to fulfill this request.**

Notice of Privacy Practices

I have been given the option to review Choice Pain & Rehabilitation Center, LLC "Notice of Privacy Practices" that explains how my personal health information will be used. I am also aware that I may request a copy of the "Notice of Privacy Practices" at any time.

I HAVE READ AND AGREE TO ABIDE BY THIS FINANCIAL AGREEMENT, CANCELLATION POLICY AND NOTICE OF PRIVACY PRACTICES. By signing this, you are indicating that you understand and agree to the terms of service explained above.

Name: ____ DOB: ________________________

Signature: ____ Date: ________________________

Office Policies and Procedures

PLEASE READ AND **INITIAL** ALL SECTIONS BELOW:

_______ **1).** A cordial and cooperative tone will facilitate communication with our staff and providers Choice Pain & Rehabilitation Center, LLC has a very strict **ZERO** tolerance for abusive and aggressive behavior toward its staff; we do not permit patients to swear at our staff, nor be rude, aggressive, belligerent or disruptive. Thank you for remaining calm and friendly.

_______ **2).** All patients with pain perceive their symptoms to be special and urgent. We acknowledge that you may be experiencing physical and emotional distress. However, all the patients referred to this clinic feel this same urgency to obtain treatment. Extra-special consideration cannot routinely be granted in scheduling your visits and treatments due to time, space, and staff limitations. Please know that we will do everything possible to serve you in a timely and effective manner within our limitations. Occasionally, a medical emergency arises which may delay the day's schedule – we appreciate your patience in these situations.

_______ **3).** Chronic pain is **NOT** considered to be a medical emergency. Therefore, emergency access to our clinic is rarely indicated. You may be referred back to your primary care physician or to an emergency facility if we cannot accommodate your urgent needs. Please do not wait until the last minute to seek care for an escalating problem.

_______ **4).** Arriving late for your appointment is very disruptive and makes it nearly impossible to maintain our commitment to serve you in a timely manner. Therefore, our office has a 15-minute late policy. If you arrive 15 minutes after your scheduled appointment, we will usually not be able to see you that day. We will reschedule your appointment for the next available time. Arriving late on a routine basis for your scheduled appointments may be reason for dismissal from our clinic. ***THERE ARE NO EXCEPTIONS***. Out of courtesy, if you are running late please call the office to confirm we are still able to see you. ***PLEASE REMEMBER THAT ANY LEEWAY IS A COURTESY AND NOT A GUARANTEE.*** We make every effort to give reminder calls for upcoming appointments,

but it is ultimately the patients' responsibility to keep all scheduled appointments or give appropriate notice for rescheduling or cancelling.
I ACKNOWLEDGE THAT IF I HAVE 3 OR MORE "NO SHOW" OR "LATE CANCELLATIONS" FOR ANY SERVICE, I MAY BE REFERRED FOR TREATMENT TO ANOTHER CLINIC.

_______ **5).** Missed appointments will be rescheduled at the next available time. We will not refill medications in the interim, so try not to miss your scheduled appointment. Missing several appointments may be reason for dismissal from our clinic.

_______ **6).** When you call our clinic, you may be routed to a voice mailbox. Please leave your message. We listen to our messages daily and will return your call within 24-48 business hours. **Multiple phone calls on the same day for the same problem are very disruptive** and may cause delay in a call back. If you do this, you will be given a warning to desist. If this behavior continues, you may be dismissed from our clinic.

_______ **7).** If narcotics or other potent medications to treat your pain are prescribed, you will be asked to enter into a formal narcotic agreement that outlines rules, risks, and conditions of continued access to these medications. Please remember, it is up to the physician's discretion if opiate medications are prescribed on the first visit.

_______ **8).** Lost or stolen medication will **NOT** be replaced with a new prescription. ***THERE ARE NO EXCEPTIONS***. Pain medication should be taken as directed as we do **NOT** provide early refills. Medication changes are addressed during scheduled office visits.

_______ **9).** Obtaining pain medications elsewhere without our specific written or verbal approval may be considered a sign of possible narcotic addiction and may be reason for dismissal from our clinic.

_______ **10). For female patients only:** To the best of my knowledge, I am **NOT** pregnant. If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is MY responsibility to inform my physician immediately if I become pregnant. If I am pregnant or am uncertain, **I WILL NOTIFY MY PHYSICIAN IMMEDIATELY**. All the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and **DO NOT** hold my physician liable for injuries to the embryo/fetus/ baby.

Following these guidelines is important for continued success in managing your pain. If our clinic guidelines are unacceptable to you, you may choose to seek care from another source more suited to your desires. Thank, you for your understanding. We consider it a privilege to serve you. We look forward to a happy and productive working relationship.

Patient Name: ____ DOB: ____________________________

Signature: ____ Date: ____________________________

Your choice for quality care

Tristan Shockley, MD
Chukwuma O. Onyewu, MD
Ronald Shin, DO
LaShelle Dixon, NP
Bruce Abraham, PA
Tel (240) 786-1001

BALTIMORE REGION
6615 Reisterstown Rd Suite 302 **Pikesville**, MD 21215 Fax: (410) 580-2037
1005 North Point Blvd Suite 722 **Dundalk**, MD 21224 Fax: (240) 770-0453
7106 Ridge Rd Suite 100 **Rosedale**, MD 21237 Fax: (443) 868-7185
1001 Pine Heights Suite 200 **Catonsville**, MD 21229 Fax: (410) 501-5699

Authorization to Release Healthcare Information

Patient Name: ____________________
Previous/Maiden Name: ____________________
Authorized Representative Name: ____________________
Date of Birth: ____________________
Social Security: ____________________

I request and authorize (Location/Doctor) ____________________
to release healthcare information of the patient names above to Choice Pain & Rehabilitation Center LLC via mail/ secure fax/ or secure email.

I understand that my health information will be handled confidentially in compliance with all applicable federal laws.

This request/ authorization applies to:

❏ All healthcare information
❏Healthcare information relating to the following ____________________
❏ Healthcare information relating to the following condition: ____________________
❏ Healthcare information during the period from dates ____________________
❏ Other: ____________________

____ ________________
(Patient/ Authorized Representative Signature/Legal Guardian) (Date Signed)

This authorization expires 90 days after it is signed.