CLEAVER MEDICAL GROUP
THE CENTER FOR INTERVENTIONAL PAIN MANAGEMENT

SERVICES

Cleaver Medical Group offers management for acute, chronic, and cancer pain. A wide range of interventional procedures to help control pain are available, including epidural steroid injections, nerve blocks, radiofrequency procedures, and spinal cord stimulators. Medication management, physical therapy, and psychological support are also commonly recommended as part of the treatment plan. After one of our physicians has completed a comprehensive assessment of your pain, a personalized care plan will be developed for you.

PATIENT INFORMATION

Name_____

Date of Birth_____Age_____ Male ☐ Female ☐

Address_____City/Zip_____

Home Phone_____Cell Phone_____ Email _____

Marital Status_____SSN # _____

Emergency Contact_____Phone #: _____

Name of physician who referred you_____Phone_____

Name of your primary care physician _____

List of all physicians you currently see _____

Allergies _____

☐ Latex ☐ Contrast Dye ☐ Shellfish ☐ Iodine ☐ Adhesive

Pharmacy

_____

Current Medications & Over the Counter Medications/Vitamins

Medication Name & Strength	Frequency	Why do you take this medication?

Immunizations: Please circle Yes or No if you are currently vaccinated with the immunizations listed below.

Flu Vaccine - YES NO Pneumonia Vaccine - YES NO COVID Vaccine: YES NO

Do you have health care proxy in the event you are unable to make your own medical decisions? YES NO
Designee:_____ Designee Best Phone Number: _____
Do you have a living will? YES NO
Which of the following statements best reflects your wishes on advanced care recommendations?

- Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
- Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.
- Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

PAST MEDICAL HISTORY

- ☐ Anemia/Blood Disorder/Aneurysm
- ☐ Anxiety Disorder
- ☐ Arrhythmia of Heart
- ☐ Asthma
- ☐ Barrett's Esophagus
- ☐ Blood Clots/Pulmonary Embolism
- ☐ Bowel or Urinary Problems
- ☐ Cancer: Specify: _____
- ☐ Complex Regional Pain Syndrome
- ☐ COPD
- ☐ Depression (including post-partum)
- ☐ Diabetes
- ☐ Dialysis
- ☐ Fibromyalgia
- ☐ GERD
- ☐ GI Problems (IBS/Crohn's)
- ☐ Head Trauma & Injury
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines
- ☐ Myocardial Infraction (Heart Attack)
- ☐ Nerve Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Psoriatic Arthritis
- ☐ Rectal Bleeding
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Stroke/CVA/TIA
- ☐ Thyroid Disease
- ☐ Vision Loss
- ☐ Other: _____

SURGICAL HISTORY

- ☐ Prostate Surgery
- ☐ EGD
- ☐ Gastric Bypass
- ☐ Colonoscopy
- ☐ Colon Surgery
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ Breast Removal (Mastectomy) (Left / Right / Bilateral)
- ☐ Hernia Repair
- ☐ Shoulder Surgery (Left / Right / Bilateral)
- ☐ Hip Surgery (Left / Right / Bilateral)
- ☐ Knee Surgery (Left / Right / Bilateral)
- ☐ Heart Bypass Surgery/Cardiac Stents
- ☐ Back Surgery
- ☐ Neck Surgery
- ☐ Transplant Surgery
- ☐ Other:

PAST VACCINE HISTORY

- ☐ Pneumonia Vaccine
- ☐ Flu Vaccine
- ☐ Shingles Vaccine
- ☐ TDAP
- ☐ COVID Vaccine

FAMILY HISTORY

FATHER	MOTHER
☐ Heart Disease	☐ Heart Disease
☐ Stroke/CVA	☐ Stroke/CVA
☐ Cancer: Type: _____	☐ Cancer: Type: _____
☐ Neurological Conditions	☐ Neurological Conditions
☐ Diabetes	☐ Diabetes
☐ Other:	☐ Other:

SOCIAL HISTORY

Are you currently employed? (Circle) **Full-Time** **Part-Time** **Retired** **Disabled** **Not working** **Student**
If you are working, describe your job. _____
Are you receiving Workers Compensation or disability benefits? (Circle) **Yes** **No**
What is the highest level of education you have completed?_____
Do you use tobacco in any form? (Circle) **Yes** **No**
If yes, what kind? How much per day? For how long? _____
Do you drink alcoholic beverages? If yes, what kind? **Beer** **Liquor** **Wine** How often? _____
Do you use marijuana/THC and/or any illicit drugs (i.e., cocaine, heroin, methamphetamine's)? (Circle) **Yes** **No**
If so, what: _____ How often? _____
Do you use CBD oil or any derivative of CBD? (Circle) **Yes** **No** If so, how often? _____

REVIEW OF SYSTEMS (Check all that apply)

Constitutional Symptoms

Good general health ☐ Yes
Recent weight change ☐ Yes

Musculoskeletal
Joint pain ☐ Yes
Joint stiffness or swelling ☐ Yes
Weakness of muscles or joints ☐ Yes

Respiratory
Shortness of breath ☐ Yes
On home oxygen_____Liters ☐ Yes

Neurologic
Weakness in limbs (Arms / Legs) ☐ Yes
Difficulty with balance ☐ Yes
Dizzy or fainting spells ☐ Yes

Endocrine
Unusually tired or sluggish ☐ Yes
Unusually jumpy or nervous ☐ Yes

Genitourinary
Difficulty with urination ☐ Yes

Gastrointestinal
Change in bowel habits ☐ Yes
Nausea and/or vomiting ☐ Yes

Cardiac
Fluttering/palpitations of the heart ☐ Yes
Chest pain or pressure ☐ Yes
Swelling of the feet or ankles ☐ Yes

Obstructive Sleep Apnea
Loud snoring ☐ Yes
Wake up choking or gasping for air ☐ Yes
Restless sleep ☐ Yes
Recurrent awakenings or insomnia ☐ Yes

Reproductive
Sexual difficulty ☐ Yes

PAIN HISTORY

When did your problems with pain first begin? _____

_____

How did your pain first begin? (Accident, job related, fall, etc.)? _____

_____

Describe your pain problem. _____

How would you describe your pain? (Circle)

acute / burning / chronic / aching / sharp / dull / radiating / severe / constant / gait instability

catching / stiffness / swelling / weakness / numbness / tingling / resolving

Describe the pattern of your pain. (When it is worse, is it constant, intermittent, etc.) _____

_____

What are your realistic goals for the treatment of your pain? _____

_____

Have you ever been hospitalized for treatment of your pain? Yes No
If yes, explain. _____

_____

Have you ever been treated and/or currently being treated by another pain clinic in the past? Yes No
If yes, list the clinic, dates, and doctors:

_____

_____

Are you involved in any legal action or are you considering legal action regarding your pain problem? Yes No

If yes, describe the status and type of legal action

_____

_____

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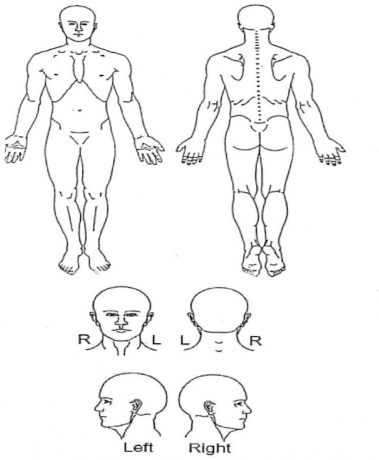
Circle the levels of your pain from the following:

0 = No Pain 10 = Worst Pain Imaginable

Present level of pain	0	1	2	3	4	5	6	7	8	9	10
Worst level of pain	0	1	2	3	4	5	6	7	8	9	10

Please share in any area where you feel pain or numbness. Circle on body diagram below.



How is your pain affected by the following activities?

	Relieves Pain	Worsens Pain	No Change in Pain
Exercise	☐	☐	☐
Heat pack	☐	☐	☐
Ice pack	☐	☐	☐
Massage	☐	☐	☐
Tens Unit	☐	☐	☐

Do you perform exercises or stretching as prescribed by a doctor or therapist? Yes No

What treatments have you received for the management for your pain?

	Helpful	Not Helpful	Dates
Acupuncture	☐	☐	_____
Any Implanted Device or Pump	☐	☐	_____
Chiropractic	☐	☐	_____
Counseling	☐	☐	_____
Epidural Injections	☐	☐	_____
Herbal/Natural Remedies	☐	☐	_____
Homeopathy (OMT)	☐	☐	_____
Massage Therapy	☐	☐	_____
Nerve Block	☐	☐	_____
Neuromuscular Stimulator/Spinal Cord Stimulator	☐	☐	_____
Physical Therapy	☐	☐	_____
Steroid Injection	☐	☐	_____
TENS Unit			_____
Trigger Point Injections			_____
Other: _____			_____

List any radiology procedures performed in the last two years pertaining to your current areas of pain:
Please bring any and all imaging reports to your future appointment for review.

Test	Body Part	Date	Facility
Plain X-Ray	_____	_____	_____
MRI	_____	_____	_____
CT Scan	_____	_____	_____
EMG	_____	_____	_____
Ultrasound	_____	_____	_____

The following are some questions given to all patients at the Pain Management Center who areon or be considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment.

CAGE-AID Questionnaire

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

PSYCHOLOGICAL HISTORY

List any past or current psychological problems, including depression or anxiety that have required medical treatment or hospitalization. Please list dates, location of treatment and physician.

Have you ever used and/or abused drugs, alcohol, or other illicit substances (currently or in the past)?

(Circle One) Yes No If yes, please list them.

Have you ever been hospitalized or treated for a substance abuse problem?

(Circle One) Yes No If yes, please list dates, location of treatments, and physician.

Have you ever attempted or seriously considered suicide or harming yourself?

(Circle One) Yes No

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Patient Name: _____ DOB: _____

Today's Date: _____

Please answer all of the following questions listed below. There are no right or wrong answers.
Please answer the questions using the scoring measures below.

SOAPP-R	Never (0)	Seldom (1)	Sometimes (2)	Often (3)	Very Often (4)
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with doctors?					
4. How often have you felt that things are so overwhelming that you can't handle them?					
5. How often is there tension in your home?					
6. How often have you counted your pain pills to see how many are remaining?					
7. How often have you been concerned that others will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication					
12. How often have others expresses concern over your use of pain medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you ran out of medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended AA or NA meeting?					
20. How often have you been in an argument that was so out of control someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medication from your family and friends?					
24. How often have you been treated for alcohol or drug problem?					

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY

- ☐ I can tolerate the pain I have without having to use pain killers
- ☐ The pain is bad but I manage without taking pain killers
- ☐ Pain killers give complete relief from pain
- ☐ Pain killers give moderate relief from pain
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)

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

3. LIFTING

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

4. WALKING

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than one mile
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

5. SITTING

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour
- ☐ Pain prevents me from sitting more than ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

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 for more than one hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

7. SLEEPING

- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using medication
- ☐ Even when I take medication, I have less than 6 hrs sleep
- ☐ Even when I take medication, I have less than 4 hrs sleep
- ☐ Even when I take medication, I have less than 2 hrs sleep
- ☐ Pain prevents me from sleeping at all

8. SOCIAL LIFE

- ☐ My social life is normal and gives 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, i.e. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

9. TRAVELLING

- ☐ 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 necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOMEMAKING

- ☐ My normal homemaking/ job activities do not cause pain.
- ☐ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

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NO SHOW/MISSED APPOINTMENT POLICY

We, at Cleaver Medical Group, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 770-800-3455.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder email, call and/or text to you are made/attempted prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinician's at Cleaver Medical Group and whenever possible, we like to fill canceled spaces to shorten the waiting period for our patients.

2. If less than a **24-hour cancellation "Same Day"** is given this will be documented as a "No-Show" appointment.

3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

4. If you arrive 15 minutes late for your scheduled appointment you will be considered a "No-Show"

5. If you "No-Show" a regular office visit appointment with Cleaver Medical Group, we will apply a **$50.00 "No-Show"** fee to your account.

6. If you "No-Show" a surgery/procedure, we will apply a **$250.00 "No-Show"** fee to your account. These fees will have to be paid in full before we schedule you for any additional appointments.

7. If you have 3 "No-Show " appointments within a twelve (12) month period, you will be subject to dismissal from our practice. *** You will be notified by letter if the dismissal was approved. ***

I have read and understand Cleaver Medical Group's No-Show Appointment Policy and understand my responsibility to plan appointments accordingly and notify Cleaver Medical Group appropriately if I have difficulty keeping my scheduled appointments.

_____ _____ _____
Patient Name Date of Birth Date

_____ _____
Patient Signature Date

_____ _____
Staff Signature Date

CLEAVER
MEDICAL GROUP

Patient Financial Responsibility

Thank you for choosing Cleaver Medical Group for your medical care. We appreciate that you have entrusted us with your healthcare, and we are committed to providing you with the best patient care possible.

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. In order to achieve this, we offer the following information regarding our insurance and financial policies.

Patients or their legal representatives are ultimately responsible for all charges for services rendered. All services rendered to minor patients will be the responsibility of the accompanying adult, custodial parent or legal guardian.

Your insurance is a contract between you and your insurer. It is your responsibility to know and understand the terms, guidelines and limitations of your plan. It is also your responsibility to advise us of any changes in your insurance, your address or your employer. Cleaver Medical Group is contractually obligated to collect applicable co-payments at the time of services are rendered. We are also obligated to collect any deductible and/or co-insurance amounts deemed patient responsibility by your insurance company.

Medicare & Contracted Insurance Plans
If you are on traditional Medicare or are a member of a health plan that we participate with, we will submit your claim to your insurance company. Our staff will verify your benefits and collect any co-payment, co-insurance and/or deductible at the time services are rendered as required by your insurance company. You will be billed in full for any services that your health plan deems as “not a benefit” or a “non-covered service”.

Secondary/Supplemental Insurance Plans
We are happy to file secondary and supplemental claims as a courtesy. In the case of non-contracted secondary carriers, the balance will become the patient’s responsibility.

Non-Contracted Insurance Plan
If we do not participate with your insurance plan, payment in full will be required at the time of service. Our billing department will file a claim to your insurance company as a courtesy upon your request.

Self-Pay
Self-Pay (Uninsured) patients will be expected to pay in full at the time of service for all services rendered.

Minors
A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements. If this is a custodial parent, we can submit the charges to another parent’s insurance, however, the parent presenting the child for care will be billed for the balance not covered by the insurance. Any patient over 18 will be responsible for all charges incurred.

Missed Appointments
Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations must be made 24 hours in advance of the scheduled appointment or we reserve the right to assess a fee.

Medical Records
Copies of medical records are provided to another healthcare provider at no charge. Any additional medical records requests and/or completion of forms (i.e. disability, life insurance, cancer policies, etc.) are subject to processing fees. Please be advised that medical records requests require time to be processed and cannot be provided same day requested.

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Collection Fees
Statements are sent out monthly for patients with personal balances. Payment is due upon receipt of the statement. If you are unable to pay the balance in full, please contact our billing department at 770.800.3455 option 6. Personal balances over 120 days old will be sent to our collection agency. In the event an account is turned over to an outside collection agency, patients will be responsible for any collection fees including courts costs, attorney fees and collection agency charges.

Returned Check Fee
A $25.00 fee will be added to your account balance in addition to the amount of the check returned for insufficient funds. This total must be paid by cash or credit card within 14 days.

Procedure Deposit
Patients who are scheduled for a procedure are expected to pay the estimated out of pocket amount at time of service. This amount will consist of any applicable co-payments, co-insurance or any remaining deductible amounts. Out staff will contact your insurance company and provide you with an estimated out of pocket amount based on your plan benefits.

If you are unable to pay the total of the estimated amount at time of service, our billing staff will assist you in setting up a payment plan if deemed necessary. You will be required to make some type of payment towards your estimated amount prior to your procedure.

Pathology Fees (Dermatology only)
Cleaver Medical Group has a pathologist that performs the interpretation of our patients' biopsy specimens. Fees associated with this service are separate from the procedure performed by your treating provider.

Depending upon specific factors, your provider may send the specimen to an outside lab for slide processing and interpretation. In those instances, patients or their insurance will receive a bill from the outside lab.

Cosmetic Services
Patients are financially responsible for all cosmetic procedures at the time of service. This office does not bill insurance companies for cosmetic procedures.

Please be aware that you may receive a statement from other entities such as anesthesia, lab, pathology, etc. Any questions that you have regarding those charges will need to be directed to those respective offices. Cleaver Medical Group does not process the billing for these services.

By signing this form, you agree that you have read and understand your financial responsibility.

Patients Name: _____ DOB: _____

_____ _____
(Signature of Patient or Guardian) **Date**

For Office Use Only:

SIGNED COPY TO CHART Staff Initials: _____ Date: _____

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