Cincinnati Comprehensive Pain Center, LLC.

2818 Mack Rd. Fairfield, Ohio 45014 Phone 513.900.0750 Fax 513.816.7631

Patient Intake Form

Date: _____

Last Name: _____ First Name: _____ Middle: _____

Date of birth: _____ SSN: _____

Street address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work: _____ Cell: _____

Marital status: _____ Religious Preference: _____ Race: _____

Referring physician: _____ Phone : _____

Primary care physician: _____ Phone: _____

Health Insurance Carrier:

1 _____ ID# _____

2 _____ ID# _____

NO Show Policy

Late Policy

If a patient is late for an appointment we ask that you call and let us know you are on your way. However, if you are more than 20 ***minutes late*** we may have to reschedule your appointment.

Cancellation of Appointment(s) / No-Shows

Patients wanting to cancel an appointment are asked to call the office 48 hours in advance. The charge for not canceling within 48 hour notice is

1- New Patient Visit or a Follow up is **$50.00**

2- Office Procedure is **$100.00**

3- **SCS Trial is $250.00**

Which will be charged to your account and is not payable by any insurance company. Patients who "No-Show" with no previous notification three times for scheduled appointments may be discharged from the practice.

□ I have been informed of and understand the CCPC No Show/ Late Cancellation Policy. I understand that a no-show or late cancellation will result in a **Charge** that is not covered by any insurance. I understand that three consecutive no show or late Cancellations may result in dismissal from the Clinic.

Signature of Patient / Guardian: _____ Date:

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AUTHORIZATION AND AGREEMENT OF MEDICAL TREATMENT
INSURANCE BENEFITS AND FINANCIAL RESPONSIBILITY

The undersigned hereby makes the following Acknowledgements and Agreements regarding medical treatment, insurance benefits, financial responsibility and release of information to be provided by Cincinnati Comprehensive Pain Center, (CCPC) LLC. or associates or assistants to the patient whose name appears below.

CONSENT FOR EXAMINATION: I understand that medical treatment may be necessary for the patient by Cincinnati Comprehensive Pain Center, LLC. or associates or assistants.
I understand the examination procedures will be explained to me and I shall consent to the rapid, partial or complete medical examination of the part(s) of my body I show to the examiner. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow-up examinations to check abnormalities found and treated, lies with me and not with the physician. I hereby release my examiner from all responsibility in connection with this examination.

CONSENT FOR TREATMENT: I understand that medical treatment is necessary for the patient by Cincinnati Comprehensive Pain Center, LLC. or associates or assistants. I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the physician. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments.

INSURANCE BENEFITS: As a courtesy to patients of Cincinnati Comprehensive Pain Center, LLC. acceptable insurance claims will be processed. I hereby authorize my insurance benefits to be paid directly to Cincinnati Comprehensive Pain Center, LLC. I am financially responsible for all office visit charges, which are payable at time of service, all deductibles, coinsurance (copay), and non-covered and/or disallowed services by Insurance Carriers, I.E. Medicare, Blue Cross Blue Shield, Medicaid, Private Insurance or Workers' Compensation. If it becomes necessary to refer this account to a collection agency, I agree to pay collection costs, court costs and reasonable attorney fees.

NO INSURANCE BENEFITS: For patients with NO insurance, I acknowledge I am financially responsible for all charges for services and payment is expected at time of service unless arrangements are made in advance for a payment plan. Patients are encouraged to discuss fees with the finance department of the practice prior to any major medical or surgical procedure.

RELEASE OF INFORMATION: I hereby authorize Cincinnati Comprehensive Pain Center, LLC. to release any information in the course of my examination or treatment as may be needed to process my insurance claims and to inform my private physician as to my course of treatment.

I have read the above Acknowledgments and Agreements and fully understand the same.

PATIENT'S NAME (Print) _____

SIGNATURE OF PATIENT OR GUARDIAN: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____

WITNESS: _____ **DATE:** _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:

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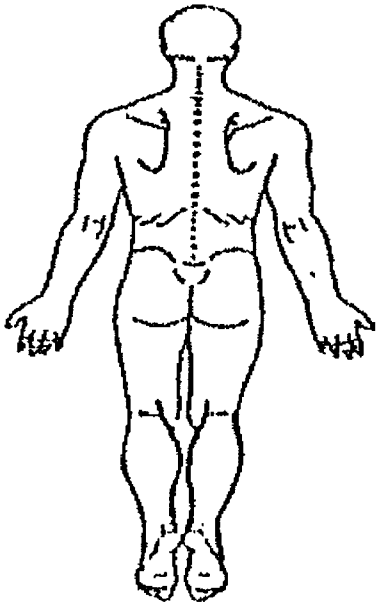
Patient Pain Inventory

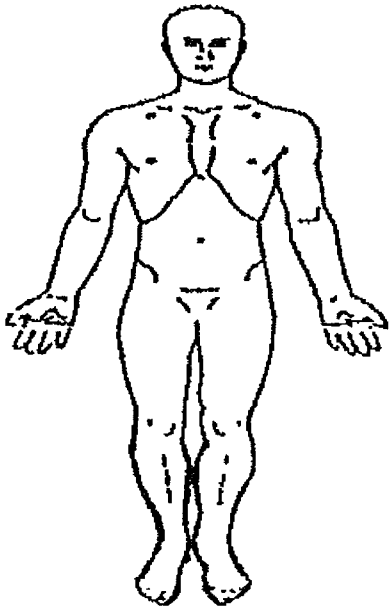
First Name_____MI____Last Name_____Date of Birth_____

Race: □ American Indian □ Alaska Native □ Black or African American □ Bi-Racial
□White/Caucasian □Middle Eastern

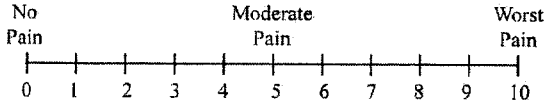
1. Through our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today? **Yes** **No**

2. On the diagram, shade in the area where you feel pain. Put an X on the area that hurts the most

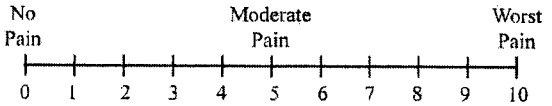




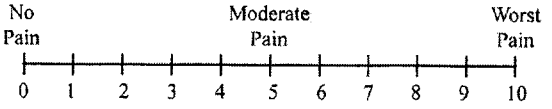
3. Please circle the WORST pain level in the last 24hrs:



4. Please circle the LEAST pain level in the last 24hrs:



5. Please circle the AVERAGE pain level:



6.

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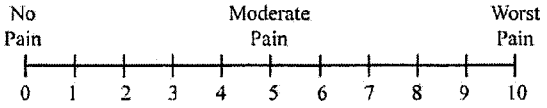
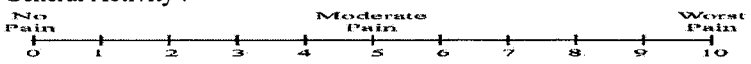
7. Please circle the pain level RIGHT NOW:

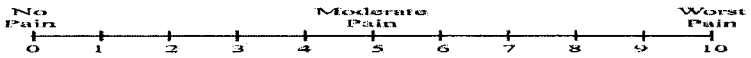


8. Please circle number indicating how much the pain has interfered with your:

a. General Activity :

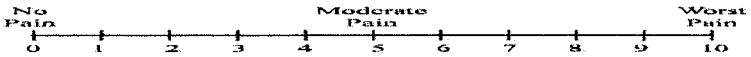


b. Mood :

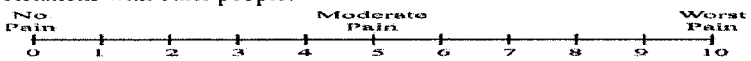


c. Walking Ability :

d. Normal Work:

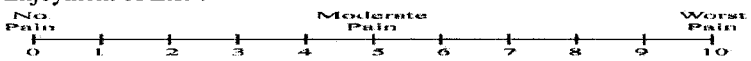


e. Relations with other people:



f. Sleep:

g. Enjoyment of Life :



9. Please circle any that apply to describe your pain:

Constant	Intermittent	Throbbing	Shooting
Stabbing	Sharp	Cramping	Crushing
Burning	Tingling	Dull	Tender
Radiating	Squeezing	Tightness	Aching

10. **What goals do you want to achieve with therapy?** _____

_____