CINCINNATI PAIN PHYSICIANS, LLC (CPP)

ACKNOWLEDGEMENT OF

RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of CPP's Notice of Privacy Practices. The Notice describes who my health information may be used or disclosed to. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice by calling CPP, by visiting CPP's website at www.cincypain.com, or by requesting one at CPP's offices.

The person listed below has the authority to confirm, make or change an appointment and we can also release emergency medical information to them if necessary.

Please note: no one except the patient can pick up medical records of any sort. The patient must be present and show ID. If you are the POA (power of attorney) for the patient, you must show the POA paperwork to receive printed medical records.

The name listed below should be your emergency contact or POA….Please fill out completely.

Name:_____

Relationship to Patient:_____

Address:_____

Telephone:_____

☐ ***OKAY TO RELEASE MEDICAL (emergency) INFORMATION***

☐ ***THIS PERSON ABOVE IS MY P.O.A.***
(Must turn in POA paperwork for this to be valid in chart)

PATIENT SIGNATURE: _____ ***DOB:*** _____

Date: _____

****Please furnish a copy of any conservator/guardianship papers with this form. (POA forms)***

PLEASE READ ALL INFORMATION CAREFULLY

I wish to be contacted in the follow manner (check all that apply)

Home Telephone _____ ☐ OK to leave message with detailed information ☐ Leave message with call back information ONLY Cell Phone _____ ☐ OK to leave message with detailed information ☐ Leave message with call back information ONLY	Work Telephone _____ ☐ OK to leave message with detailed information ☐ Leave message with call back information ONLY Written Communication ☐ OK to mail to my home address ☐ OK to mail to my work/office address ☐ OK to fax to Email address _____

Your PHI **CAN BE RELEASED** to the following family/friends

Please list only family or friends, NOT physicians

Privacy Statement Agreement:

_____ I received a copy of the Privacy Practice from Cincinnati Pain Physicians. My signature constitutes acceptance of the packet. I understand if I would like to make changes to my specific medical information, I must do so in writing.

_____ I was offered a copy of the Privacy Practice from Cincinnati Pain Physicians but declined it.

_____ The patient was offered the Privacy Practice from Cincinnati Pain Physicians; they declined/accepted but refused to sign because: _____

Patient Signature_____ Date _____

Print Name_____ Birth Date_____

This form will need to be completed every calendar year. Please complete the following forms to the best of your ability so that we can assist in your continual monitored care. If you have any questions regarding these forms, please ask.

WELCOME TO CINCINNATI PAIN PHYSICIANS

Dr. Gururau Sudarshan

NEW PATIENT INTAKE FORM

Today's Date: _____ Referring Physician Name: _____

Name: _____ DOB: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____

Preferred Primary Phone Number: _____Home ☐ Cell ☐ Work ☐ Relative ☐

Primary Insurance Payer: (Ex: Medicare, Humana, BCBS, etc.) _____

Plan: (HMO, PPO, HSA, etc.) _____ ID#: _____ Group#: _____

MUST FILL THIS OUT: Policy Holder: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Policy Holder Name: _____ **DOB:** _____

Secondary Insurance Payer: (Ex: Medicaid, Medicare, etc.) _____

Plan: (HMO, PPO, etc.) _____ ID#: _____ Group#: _____

MUST FILL THIS OUT: Policy Holder: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Policy Holder Name: _____ DOB: _____

Workers Compensation Claim – BWC Claim #: _____ Date of Injury: _____

Workers Comp Company_____

Agent Name/MCO: _____ Employer: _____

Allowed DX codes: _____MCO Phone Number: _____

THIS SHEET IS FOR BILLING AND INSURANCE PURPOSES

I certify that the above information regarding my insurance is accurate, complete and true. This information must be updated and correct for billing purposes. It is the duty of the patient to inform the office when your insurance changes. CPP reserves the right to verify and check the validity of insurance at any time. I hereby assign all medical and surgical benefits, to which I am entitled to CINCINNATI PAIN PHYSICIANS. This assignment remains in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. I consent to the release of information by CINCINNAI PAIN PHYSICIANS and my health insurance and/or payer to CINCINNATI PAIN PHYSICIANS and its employees/representatives to facilitate peer review and of my treatment including utilization and quality management. I understand that I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE.** I understand that my medical insurance is a contract between myself and the insurance company and/or my employer. CINCINNATI PAIN PHYSICIANS is not a party said to contract. I understand that I am responsible for legal and/or collection fees necessary to settle my account, should it become delinquent**

Patient Name: _____ Date: _____

Patient Signature: _____

PHARMACY INFORMATION:

PHARMACY INFORMATION

For the ease of filling your medications, we ask that you choose **one Pharmacy** to fill at. This allows for seamless communication verbally and through our medical records system regarding your medications.

If at any point, your preferred pharmacy location changes, you must let us know. If you do not tell us, it can cause delay in ordering or picking up your medications.

Pharmacy Name: _____Phone Number: _____

Address: _____ City/State: _____

Zip Code: _____

***We do need ALL of the above information completed. ***

THIS SHEET IS FOR ON-GOING MEDICAL DOCUMENTATION NEEDS FOR CPP

Please circle and fill in your answers…

Have you had your Pneumonia vaccine for last calendar year (2019)? Yes No

If Yes, when: _____

Have you had a Flu shot for last calendar year (2019)? Yes No

If Yes, when: _____

Have you had the opportunity to receive the COVID-19 vaccine? Yes No

If Yes, when: 1ST DOSE_____

2ND DOSE _____

FOR US TO ENSURE THAT YOU ARE TAKEN CARE OF IN THE MOST EFFICIENT MANNER,

PLEASE MAKE SURE YOU LET US KNOW THE FOLLOWING:

NAME: _____ DOB: _____

WHAT MEDICATIONS ARE YOU CURRENTLY PRESCRIBED? (do you have a list?)

_____ _____

_____ _____

_____ _____

WHAT ALLERGIES DO YOU HAVE?

_____ _____

_____ _____

HAVE YOU HAD A MRI, CAT SCAN OR XRAY OF THE FOLLOWING? ☐ **YES** ☐ **NO**

☐ **Cervical Spine** ☐ **Thoracic Spine** ☐ **Lumbar Spine**
☐ **Other: _____ _____**
Location: _____

HAVE YOU EVER HAD AN INJECTION FOR YOUR PAIN? ☐ **YES** ☐ **No**

☐ **Epidural Injection** ☐ **Joint Injection**
☐ **Other: _____**

HAVE YOU HAD ANY PAST SURGERIES? (list below) ☐**YES** ☐**NO**

_____ _____

_____ _____

SEE NEXT PAGE

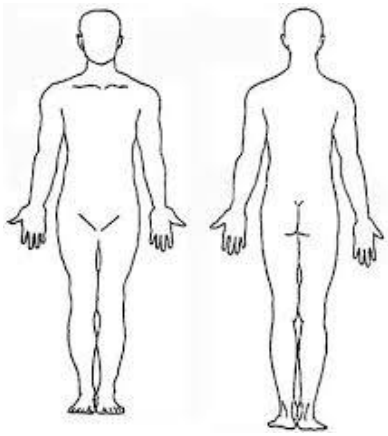
REASON FOR YOUR PAIN? (circle)

Fall Trauma Surgery N/A

WHEN: _____

MARK YOUR PAIN AREAS THAT YOU ARE SEEKING TREATMENT FOR:

R L L R



ANTERIOR POSTERIOR

ARE YOUR SYMPTOMS AGGRAVATED BY? (circle)

Walking Standing Sitting Bending Twisting Lying down

DOES YOUR PAIN GET BETTER BY? (circle)

Ice Heat Rest Medications Massage Stretching

HOW WOULD YOU DESCRIBE YOUR PAIN? (circle)

Sharp Stabbing Aching Tingling