NEW PATIENT CONSULTATION INFORMATION

In order for us to see you promptly please arrive at the time and date below with the following paperwork completed and any X-ray films/discs from the past year. Arrival at this time will allow us to prepare your electronic chart for consultation and to see you in a timely manner. We may opt to reschedule your consultation if you do not have these items at your scheduled arrival time.

Please bring these completed forms to your appointment scheduled:

____________________________________ at ______________ with Dr. Kenneth Bartholomew

In addition to the attached forms, please bring the following items with you to your appointment:

- ✓ All X-Ray, MRI, CT, Discogram, Myelogram Reports AND Films
- ✓ A list of all medications you are currently taking
- ✓ Any additional medical records pertaining to your pain that we might not have received prior to your visit
- ✓ Insurance Card(s)
- ✓ Insurance co-pay in the form of cash, check, money order (Payable to Cumberland Pain Associates) or Visa/Mastercard/Discover/American Express.
- ✓ If your insurance requires a referral (Healthspring & Tricare), please have your primary care physician fax it to us prior to your appointment. Our fax number is 615.860.2420.

If you are unable to keep this appointment please provide our office with at least 48 hours notice.

Please note that a New Patient Consultation is to develop treatment recommendations and does not imply acceptance of the patient for continued care.

CUMBERLAND PAIN ASSOCIATES, PLC

PATIENT INFORMATION:
Patient Name ______________________________ Social Security No. ________________

Address ______________________ City ______________ State _______ Zip _________

Home # ______________ Work # ______________ Mobile # ______________

Date of Birth ______________ Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Other

EMPLOYER INFORMATION:
Employer ______________________________ Employer Phone No. ________________

Address ______________________ City ______________ State _______ Zip _________

Referred by ____

RESPONSIBLE PARTY INFORMATION (If other than patient):
Name ______________________________ Social Security No. ________________

Address ______________________ City ______________ State _______ Zip _________

Home # ______________ Work # ______________ Mobile # ______________

Date of Birth ______________ Sex: ☐ Male ☐ Female Relationship ________________

INSURANCE INFORMATION:
Primary ______________________________ Phone No. ________________

Member's Name ______________________________ Relation to Patient ________________

Member's Employer ______________________________ Employer Phone No. ________________

Member's ID No. ______________ Group No. ______________ Plan No. ______________

Secondary ______________________________ Phone No. ________________

Member's Name ______________________________ Relation to Patient ________________

Member's Employer ______________________________ Employer Phone No. ________________

Member's ID No. ______________ Group No. ______________ Plan No. ______________

EMERGENCY CONTACT:
Name ______________________________ Relation to Patient ________________

Home # ______________ Work # ______________ Mobile # ______________

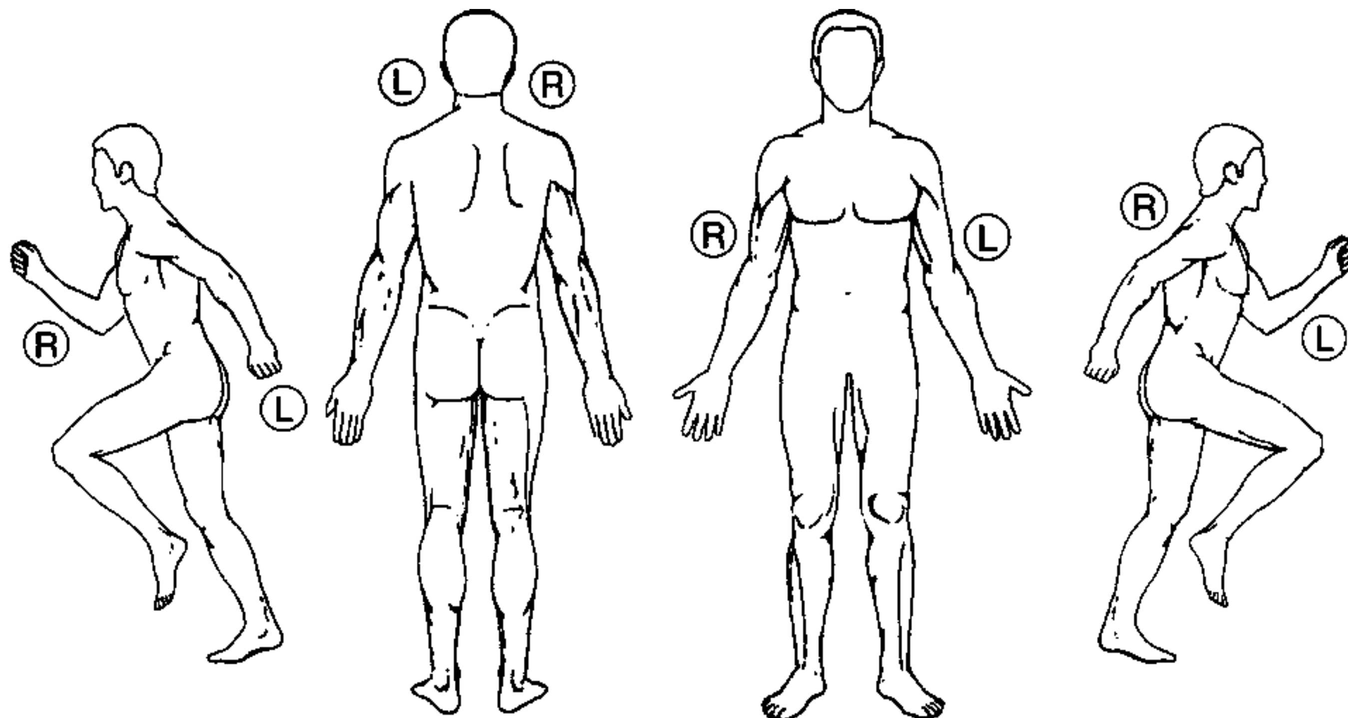
I authorize my insurance company to pay benefits directly to CUMBERLAND PAIN ASSOCIATES, PLC. I hereby consent to the release of medical information necessary to process any insurance claims and to any other physician for the continuation of my medical care. I accept personal responsibility for any and all services in which I have been proven ineligible for medical benefits. I understand that a photocopy of this release is as valid as the original.

______________________________ ______________________________
Signature of Patient or Legal Guardian if under 18 years of age Date of Signature

NAME ______________________________________ SSN ________________________ DATE__________________

Pain Self – Analysis Questionnaire

In the diagrams below, SHADE in all areas of pain:



When and how did your pain problem begin?

Circle the number that best describes the following:

	No pain									Worst pain Imaginable	
• Your pain at its worst during the past month:	0	1	2	3	4	5	6	7	8	9	10
• Your pain at its least during the past month:	0	1	2	3	4	5	6	7	8	9	10
• Your pain's average on a daily basis:	0	1	2	3	4	5	6	7	8	9	10

Is your pain from an accident? ☐ No ☐ Yes If so, provide your date of injury. ____________________

Is your pain work related? ☐ No ☐ Yes If so, provide your date of injury. ____________________

Pain is at its worst (circle): In the morning In the evening Throughout the day When being active

Pain is improved with (circle): Heat Ice Rest Pain Medication Nothing

Pain is worsened by (circle): Bending Twisting Lifting Standing Walking Riding in a car Loud Noises Bright light Exposure to heat Exposure to cold

Circle the words in each column that best describes your pain:

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
Flickering	Dull	Pricking	Nagging	Pinching	Annoying	Punishing
Quivering	Sore	Boring	Nauseating	Pressing	Troublesome	Grueling
Pulsing	Hurting	Drilling	Agonizing	Gnawing	Miserable	Cruel
Throbbing	Aching	Stabbing	Dreadful	Cramping	Intense	Vicious
Beating	Heavy	Lancinating	Torturing	Crushing	Unbearable	Killing

Column 8	Column 9	Column 10	Column 11	Column 12	Column 13	Column 14
Tight	Hot	Tender	Tingling	Spreading	Fearful	Sharp
Numb	Burning	Taut	Itchy	Radiating	Frightful	Cutting
Drawing	Scalding	Rasping	Smarting	Penetrating	Terrifying	Lacerating
Squeezing	Searing	Splitting	Stinging	Piercing		
Tearing						

Column 15	Column 16	Column 17	Column 18	Column 19	Column 20
Tugging	Cool	Jumping	Sickening	Wretched	Tiring
Pulling	Cold	Flashing	Suffocating	Blinding	Exhausting
Wrenching	Freezing	Shooting			

Which of the following pain treatments have you had done:

☐ Nerve Blocks Was it effective? ☐ Yes ☐ No Date of treatment ________________
☐ Epidural Injections Was it effective? ☐ Yes ☐ No Date of treatment ________________
☐ Physical Therapy Was it effective? ☐ Yes ☐ No Date of treatment ________________
☐ Acupuncture Was it effective? ☐ Yes ☐ No Date of treatment ________________
☐ Psychological Counseling Was it effective? ☐ Yes ☐ No Date of treatment ________________
☐ Other Was it effective? ☐ Yes ☐ No Date of treatment ________________

What surgeries have you had for your pain? Were they successful?

What physicians have you seen for your pain? What did they do?

What pain medications have you taken?

Which of the following tests have been performed:

☐ EMG Date of test ______________ Results ______________________________________

☐ CT Scan Date of test ______________ Results ______________________________________

☐ MRI Date of test ______________ Results ______________________________________

☐ X – Rays Date of test ______________ Results ______________________________________

How much does your pain interfere with the following:

1 – Not at All 2 – A little bit 3 – Moderately 4 – Severely 5 – Completely

Normal work routine	1	2	3	4	5
Performing household chores	1	2	3	4	5
Yard work or shopping	1	2	3	4	5
Socializing with friends	1	2	3	4	5
Recreation and hobbies	1	2	3	4	5
Having sexual relations	1	2	3	4	5
Physical exercise	1	2	3	4	5
Enjoyment of life	1	2	3	4	5

Circle the following that apply:

Appetite change Feeling of guilt Felt depressed

Lack of concentration Decreased interest in hobbies Considered suicide

The future looks bleak Felt anxious

Are you awakened by pain? ☐ No ☐ Yes, how often ______________________________________

How many hours of sleep do you normally get per evening?

☐ 1 to 2 hours ☐ 7 to 8 hours
☐ 3 to 4 hours ☐ 9 to 10 hours
☐ 5 to 6 hours ☐ More than 10 hours

Do you currently, or have you in the past, used drugs or alcohol? ☐ No ☐ Yes

Are there any substance abuse issues in the household? ☐ No ☐ Yes

Are there any lawsuits or claims pending in your case? ☐ No ☐ Yes

With whom do you live? ____

HEALTH HISTORY
(Confidential)

Name ______________________________ Today's Date ______________

Age ________ Date of Birth ______________ Date of last physical examination ______________________

SYMPTOMS Check (√) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE, JOINT, BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO – URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Other

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap smear
- ☐ Bleeding between period
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Mammogram
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

____
Date of Last Menstrual Period

____
Date of Last Pap Smear

____
If pregnant, when are you due?

CONDITIONS Check (√) symptoms you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Pollo
- ☐ Prostate problem
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

MEDICATIONS List all medications you are currently taking	**ALLERGIES** To medications or substances

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√), if your blood relatives had any of the following: Disease	Relationship to you
Father					☐ Arthritis, Gout	
Mother					☐ Asthma, Hay Fever	
Brothers					☐ Cancer	
					☐ Chemical Dependency	
					☐ Diabetes	
					☐ Heart Disease, Strokes	
Sister					☐ High Blood Pressure	
					☐ Kidney Disease	
					☐ Tuberculosis	
					☐ Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates. ______________________

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (√) which substances you use and describe how much.

☐ Caffeine	
☐ Tobacco	
☐ Drugs	
☐ Other	
☐ Other	
☐ Other	

OCCUPATIONAL CONCERNS Check (√) if your work exposes you to the following:

☐ Stress
☐ Hazardous Substances
☐ Heavy Lifting
☐ Other

Your occupation:

I certify that the information contained in the previous six pages is correct to the best of my knowledge. I will not hold Cumberland Pain Management, PLC or any members its staff responsible for any errors or omissions that I may have made in the completion of these forms.

______________________ ______________________
Signature Date

______________________ ______________________
Reviewed by Date

Authorization to Release Medical Records and Information

Patient Name: ____

Patient Address: ____

Date of Birth: _______________________ Social Security Number: _____________________

I authorize the release of all of my medical records to Cumberland Pain Associates, PLC for the purpose of further medical care. These records include, but are not limited to, office and operative notes, diagnostic tests, and laboratory results. **Please fax the requested information to (615) 860-2420.**

I understand the following:

1. I may revoke this authorization, in writing, at anytime. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
2. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
3. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
4. The information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information unless stated below.
5. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____________________________________ _______________________________

Signature of Patient or Legally Authorized Representative Date

_____________________________________ _______________________________

Printed Name of Patient or Legally Authorized Representative Relationship to Patient

_____________________________________ _______________________________

Witness Signature Date

CUMBERLAND PAIN ASSOCIATES, PLC

The purpose of this form is to obtain authorization for use or disclosure of protected health information. Please complete ONLY the sections that apply to the requested disclosure.

Patient Authorization for Use/Disclosure of Health Care Information

Patient's Name: ____

Date of birth: ________________________ SSN: ________________________

I request and authorize Cumberland Pain Associates, PLC to release health care information of the patient named above to:

Name: ______________________ Relation to patient: ______________________

Name: ______________________ Relation to patient: ______________________

Name: ______________________ Relation to patient: ______________________

Name: ______________________ Relation to patient: ______________________

This request and authorization applies to:

__________ All health care information

__________ Other: ____

THIS AUTHORIZATION EXPIRES ON: ______________________________

OR WHEN THE FOLLOWING EVENT OCCURS: ______________________________

______________________________ ______________________________

Patient Signature Date Signed

I may revoke this authorization to the extent allowed by law. If I do, I understand that Cumberland Pain Associates, PLC may have already released information about me after I gave permission. I know that revoking this authorization would not prohibit any release of information by Cumberland Pain Associates, PLC in reliance on my original authorization.

There are two ways to revoke this authorization. I can:

1) Sign and date a form available from Cumberland Pain Associates, PLC called "Revocation of Authorization for Use and Disclosure of Health Care Information";

Or

2) Write a letter to Cumberland Pain Associates, PLC. If I write a letter to Cumberland Pain Associates, PLC, it must say that I want to revoke my authorization to disclose the patient's health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative for health care) must sign and date the letter.

Once Cumberland Pain Associates, PLC gives out the information that I want released, I know that Cumberland Pain Associates, PLC has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

CUMBERLAND PAIN ASSOCIATES, PLC

FINANCIAL POLICY

The following is a general description of our financial policy and how it relates to you as our patient. It outlines what we expect from you, and summarizes what you can expect from our billing service. We employ a standard fee schedule that applies to all patients, without bias based on insurance or lack there of. We will do our best to provide you with an accurate estimate of costs associated with your treatment, upon your written request. Please feel free to ask any questions you might have concerning your financial situation with our practice.

<u>INSURANCE</u>

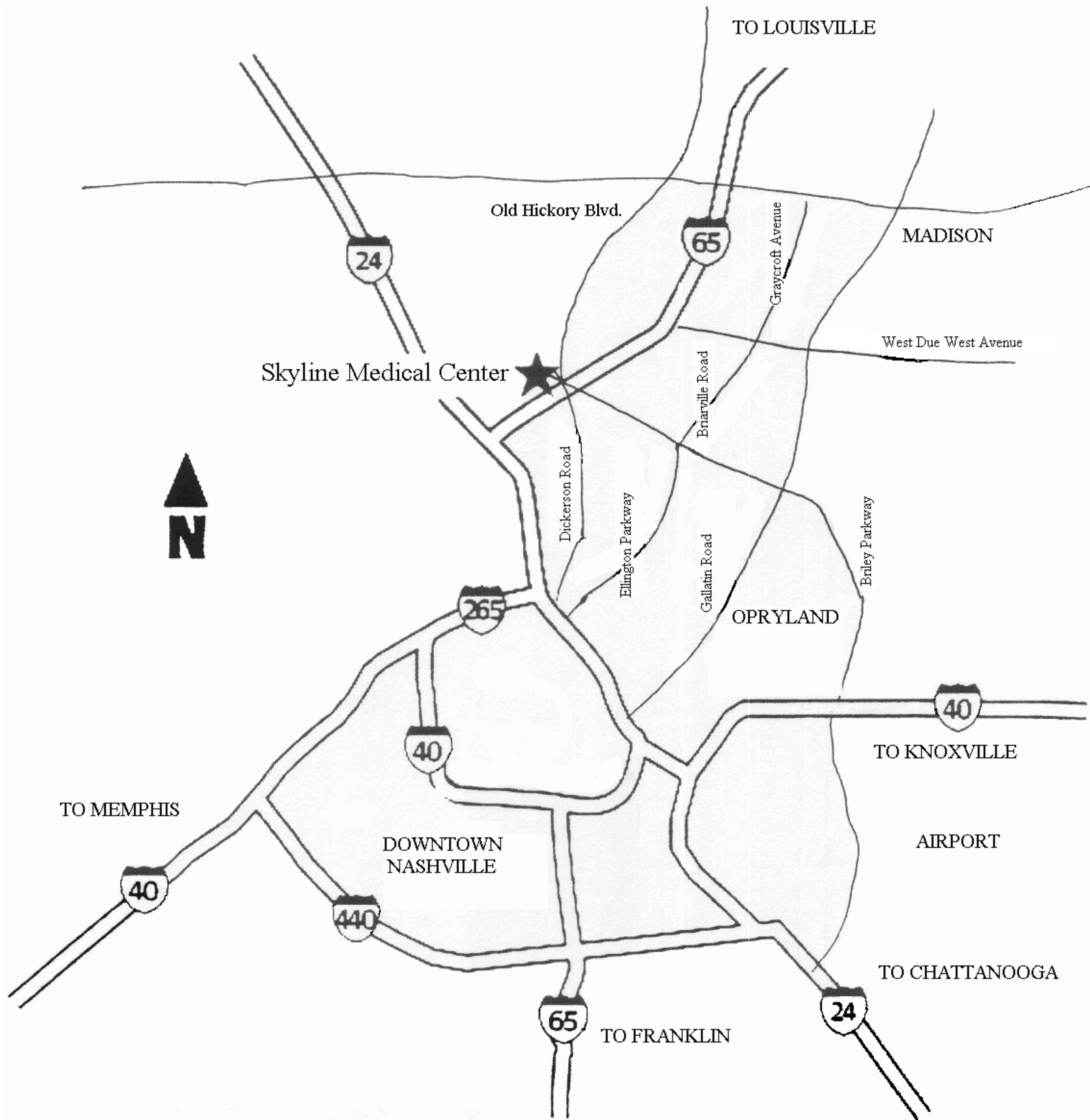
- Your insurance is a contract between you and your insurance company.
- Insurance is your benefit.
- As a courtesy, we will file your insurance.
- Your deductible and co-pay portion is due on the day of service.
- If you do not have your co-payment, we are not required to see you. We may elect to see you, but there will be a $25.00 charge to send a bill for the co-payment.
- If your insurance requires a referral, it is your responsibility to make sure you have a referral. If you do not have a referral, you will NOT be seen.
- If your insurance is not paid within 60 days, your balance becomes your responsibility and payment is expected at that time.
- Any balance remaining after 60 days will be charged interest at 18% APR.
- Failure to make payment in full, or establish a payment plan with our office after 60 days will result in your account being turned over to our collection agency.
- You will be responsible for all collection costs and reasonable legal costs in addition to the amount originally owed.
- We gladly accept cash, money orders, or checks made payable to Cumberland Pain Associates, PLC.
- Returned checks will be charged a $25 fee.

I, the undersigned, understand the financial policies of Cumberland Pain Associates, PLC and agree to abide by the plan I have signed. In addition, I understand and agree to the following:

- To pay the amount charged by Dr. Bartholomew for all professional treatment and services to the undersigned.
- **I understand that I am financially responsible for any and all charges whether or not they are covered by insurance. In the event that I do not pay as outlined above and collection efforts become necessary, I will pay all costs of collection and reasonable legal fees in addition the amount originally owed.**

________________________________		________________________________	
Signature of Patient	Date	Signature of Witness	Date

CUMBERLAND PAIN ASSOCIATES, PLC



SKYLINE MEDICAL CENTER DRIVING DIRECTIONS

To Skyline From I-65 Southbound: Take Exit 90B (Dickerson Pike / Briley Parkway / Opryland). Veer right on the exit ramp. Turn right onto Dickerson Pike. Skyline Medical Center is on the right.

To Skyline From I-65 Northbound: Take Exit 90A (Dickerson Pike / Briley Parkway). Ramp will circle around. Turn right onto Dickerson Pike. Skyline Medical Center is ½ mile on right (2nd traffic light).