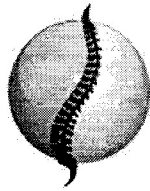


Pain Management

Wiley L. Drury (Don), M.D.  
Kate Paylo, D.O.  
Tyler Kabes, D.O.  
Arthur Davis, NP-C  
Rita Cook, NP-C  
David Curry, NP-C  
Randy Lane, PA  
Trevor Ambron, PA  
Mi Hyun Choi, NP-C



**Care Medical**  
**Spine, Pain & Rehab**  
**caremedicalcenter.com**

Chiropractic

J. Ryan Moorman, D.C.  
Daniel Day, D.C.  
Briggs Smotherman, D.C.  
Carolyn Hunter, D.C.

Physical Therapy

Flora G. Gatewood, DPT  
Laura Gwillim, P.T.  
Jonathan Howell, P.T.A.  
Zoe Chung, P.T.A.

Today you will receive a **Free Consultation** which will include:

1. Informational brochures on the treatment program
2. Educational information about the medication used
3. Tour the facility with information of treatments provided
4. Consultation with the provider to discuss your past history, current condition and future treatment option

If you wish to proceed after your free consultation, the following treatments will be provided at rates regularly charged at this office.

1. Physical Exam
2. X-Rays
3. Diagnosis & Plan of Care

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness Signature**

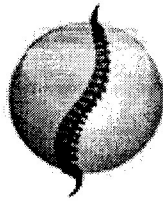
\_\_\_\_\_  
**Date**

**Valdosta Office**  
2804 N Oak St  
Valdosta, GA 31602  
229-241-8925

**Tifton Office**  
162 Virginia Ave S  
Tifton, GA 31794  
229-382-5857

**Nashville Office**  
203 W Hamilton  
Nashville, GA 31639  
229-686-2277

**Douglas Office**  
306 Shirley Ave  
Douglas, GA 31533  
912-393-3955



## Care Medical Spine, Pain & Rehab

### KNEE SURGERY PREVENTION

Care Medical Center utilizes the most advanced combination of treatment for eliminating or reducing knee pain fast...IT IS EVEN COVERED BY YOUR INSURANCE!

Keys to CMC's Knee pain Success:

- All-Natural Hyalgan (or other knee injectable medications) acts as a lubricant and shock absorber in the knee.
- Injections are visually guided by live motion x-ray unit to ensure minimal pain and maximum accuracy.
- Theraciser Rehabilitation is a unique, advanced knee rehabilitation program that maximally enhances the lubrication and shock absorbing effect of Hyalgan injections.
- Licensed Physical Therapists on site work individually with each patient for 8 weeks to improve results.
- Safe, effective, Hyalgan is an all-natural substance injected into the knee with no other side effects.

Can these injections prevent surgery?

The FDA has officially approved hyaluronic acid for use in the treatment of Arthritis of the knee. It bonds with the joint fluid naturally present in your knee to create lubrication and a cushioning layer in the knee. It reduces pain, inflammation and swelling in the joint, allowing you to do the everyday activities that you enjoy! There are no major side effects, and the best results occur when the injections are combined with Theraciser rehabilitation. Maximal accuracy with little or no pain occurs when the injections are performed under advanced live motion x-ray unit (fluoroscopy).

Are you a candidate for CMC's knee rehabilitation program?

- Are your knees very stiff in the morning?
- Do your knees hurt when going up or down stairs?
- Do you frequently take Ibuprofen or Aspirin for knee pain?
- Do the activities you enjoy cause pain around your knee?
- Have you been told that you will need knee replacement surgery?

If you have answered YES to an of these questions above, call Care Medical Center today to schedule your consultation at 229-241-8925 (Valdosta), 229-686-2277 (Nashville), 229-382-5857 (Tifton), 912-393-3955 (Douglas)!

Your knee pain can be significantly reduced, and possibly eliminated, without a lifetime dependency on oral medications. Best of all, the FDA and all major insurance companies, including Medicare, have approved you to continue.

# **Osteoarthritis Knee Program**

We offer the most advanced treatment program for eliminating or reducing knee pain fast.

## **Keys to CMC's Knee Pain Success**

- \* All-Natural Hyaluronic Acid acts as a lubricant and shock absorber in the knee.
- \* Injections are visually guided by live motion X-ray unit to ensure minimal pain and maximum accuracy.
- \* The Osteoarthritis Knee Rehab Program is a unique, advanced knee rehabilitation program that maximally enhances the lubrication and shock absorbing effect of Hyalgan/Supartz injections.
- \* Licensed Physical Therapists on site work individually with each patient for 8 weeks to improve results. Care Medical is the only center certified by the OsteoArthritis Centers of America for Rehabilitation of the knee.
- \* Safe, Effective, Hyaluronic Acid is an all-natural substance injected into the knee with no major side effects.

## **Can Viscosupplementation (Hyalgan or Supartz) Injections Prevent Surgery?**

The FDA has officially approved Hyaluronic Acid (viscosupplementation) for use in the treatment of Arthritis of the knee. The all natural medication bonds with the fluid inside the knee and coats the joint surface acting as a lubricant and shock absorber. It reduces pain, inflammation and swelling in the joint, allowing you to do the everyday activities that you enjoy! There are no major side effects, and the best results occur when the viscosupplementation injections are combined with specialized Physical Therapy Rehabilitation. Maximal accuracy with little or no pain occurs when the injections are performed under an advanced live motion X-ray unit (fluoroscopy). **This unique treatment combination is ONLY found at CARE MEDICAL CENTER.**

## **Are you a candidate for CMC's knee rehabilitation program?**

- \* Are your knees very stiff in the morning?
- \* Do your knees hurt when going up or down stairs?
- \* Do you frequently take Ibuprofen or aspirin for knee pain?
- \* Do the activities you enjoy cause pain around your knees?
- \* Have you been told that you will need knee replacement surgery?

**If you answered YES to any of the questions above, call Care Medical Center today to schedule your private consultation at 229-241-8925 (Valdosta), 912-393-3955 (Douglas), 229-686-2277 (Nashville), or 229-382-5857 (Tifton).**

**Your knee pain can be significantly reduced, and possibly eliminated, without a lifetime dependency on medications. Freedom From Pain is just a phone call away!**

**[www.caremedicalcenter.com](http://www.caremedicalcenter.com)**

### **Pain Management**

**Wiley L. "Don" Drury, M.D.**

Interventional Pain Management  
Anesthesiology

**Kate E. Paylo, D.O.**

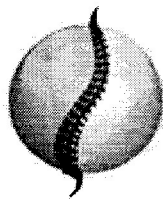
Interventional Pain Management  
Physical Medicine & Rehabilitation

**James H. Campagna, M.D.**

Interventional Pain Management  
Anesthesiology

**Arthur Davis, NP-C**

**Rita Cook, NP-C**



## **Care Medical**

### **Spine, Pain & Rehab**

### **Chiropractic**

**J. Ryan Moorman, D.C.**

**Briggs Smotherman, D.C.**

**Daniel S. Day, D.C.**

### **Physical Therapy**

**Josh Rhue, D.P.T.**

**Laura Gwillim, M.P.T.**

**Ginger Gatewood, D.P.T.**

**Stephen Sutton, P.T.**

**Jon Howell, P.T.A.**

**Rebecca Adams, P.T.A.**

**Zoe Chung, P.T.A.**

We offer these services to improve your health:

1. **Balance Testing:** An in office computerized 7-minute test done as a preventative measure against falls. Do you have a history of weakness, instability, dizziness, balance problems, a history of falls, used a support device in the last year or have medications that have caused weakness, dizziness, or instability?

**YES/NO**

2. **Braces and Supports:** Braces/supports are designed to provide extra support during times of activity and to reduce pain. You do not have to wear them all the time, only when you do activities that cause pain. This includes knee braces, back braces, therapeutic neck braces and wrist braces. Does your pain prevent you from the activities you enjoy, and would you like to know more about us fitting you for a brace?

**YES/NO**

3. **Trigger Point Therapy:** A trigger point is the injection of a small amount of local anesthetic (and/or anti-inflammatory medication) into the muscle where the tension and muscle spasm are located. Many patients will show an immediate improvement in pain, reduced spasms, and improved mobility. Treatments are scheduled once weekly for 5 weeks in addition to your other treatment. Do you have tension, muscle spasms or feel tight in any areas of your neck, shoulders or back?

**YES/NO**

If you would like to improve your health with any of these services, please ask our staff for more information for a consultation.



# Care Medical Center

## Patient Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Referred By: \_\_\_\_\_

SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex: Male/Female

Chief Complaint: \_\_\_\_\_

### **Accident Information:**

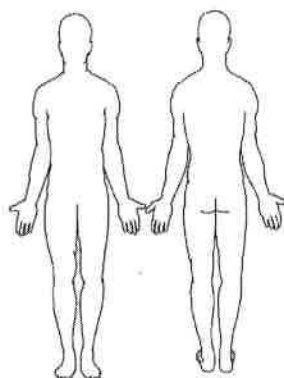
Is your condition due to an accident? ☐ Illness ☐ Other \_\_\_\_\_

Did your accident occur while at work? ☐ Yes ☐ No Were you involved in an automobile accident? ☐ Yes ☐ No

Date \_\_\_\_\_ Time \_\_\_\_\_ Injury reported to employer ☐ Yes ☐ No Name of Supervisor: \_\_\_\_\_

### **Location:**

- ☐ Head
- ☐ Neck
- ☐ Shoulder
- ☐ Arm
- ☐ Back
- ☐ Thorax
- ☐ Elbow
- ☐ Wrist
- ☐ Hip
- ☐ Knee
- ☐ Ankle
- ☐ Foot



### **Quality:**

- ☐ Achy
- ☐ Dull
- ☐ Sharp
- ☐ Stabbing
- ☐ Throbbing
- ☐ Radiating
- ☐ Burning
- ☐ Itching
- ☐ Numb
- ☐ Pins & Needles

### **Time of Day:**

- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ Bedtime
- ☐ All the time
- ☐ Varies

### **Modifying Factors:**

	Increase	Decrease
Standing	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Up Stairs	<input type="checkbox"/>	<input type="checkbox"/>
Down Stairs	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>
Coughing	<input type="checkbox"/>	<input type="checkbox"/>
Touch	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>
Movement	<input type="checkbox"/>	<input type="checkbox"/>

### **Neurological Signs & Symptoms:**

- ☐ Bowel Dysfunction
- ☐ Bladder Dysfunction
- ☐ Motor Loss
- ☐ Sensory Loss
- ☐ Radiation to Arm
- ☐ Radiation to Leg

### **Numerical Pain Scale:**



<b><u>Medications:</u></b> 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	<b><u>Dosage:</u></b> 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	<b><u>Allergies:</u></b> 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	<b><u>Primary Care Physician:</u></b> Name: _____ Address: _____ Phone: _____ <b><u>Imaging HX:</u></b> What? When? Where? Who ordered it?
<b><u>Family Hx:</u></b> <input type="checkbox"/> Heart Disease <input type="checkbox"/> High BP <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer Type: _____ <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Bleeding Tendency <input type="checkbox"/> Diabetes <input type="checkbox"/> Arthritis Type: _____ Other:	<b><u>Social Hx:</u></b> <b><u>Marital Status:</u></b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <b><u>Alcohol:</u></b> <input type="checkbox"/> Never <input type="checkbox"/> 0-1 / Week <input type="checkbox"/> 1-5 / Week <input type="checkbox"/> Other: _____ <b><u>Tobacco:</u></b> <input type="checkbox"/> Never <input type="checkbox"/> Quit <input type="checkbox"/> When? _____ Packs per day _____ Years Smoked _____ <b><u>Illegal Drugs?</u></b> Y or N <b><u>Occupation:</u></b> _____	<b><u>Medical Hx:</u></b> <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Thyroid <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> GI Disorder <input type="checkbox"/> Hepatitis <input type="checkbox"/> Kidney Disorder <input type="checkbox"/> Cancer <input type="checkbox"/> Ulcer <input type="checkbox"/> Seizure <input type="checkbox"/> Asthma <input type="checkbox"/> Mental Illness <input type="checkbox"/> Infections <input type="checkbox"/> Anemia <input type="checkbox"/> Pregnancy  Other:	<b><u>Surgical Hx:</u></b> <input type="checkbox"/> Appendectomy <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Inguinal Hernia <input type="checkbox"/> Ventral Hernia <input type="checkbox"/> Umbilical Hernia <input type="checkbox"/> Cholecystectomy <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Cesarean Section <input type="checkbox"/> CABG <input type="checkbox"/> Coronary Stent <input type="checkbox"/> Carotid <input type="checkbox"/> Endarterectomy <input type="checkbox"/> Angioplasty <input type="checkbox"/> Vascular Bypass <input type="checkbox"/> Craniotomy <input type="checkbox"/> Total Hip <input type="checkbox"/> Total Knee <input type="checkbox"/> Rotator Cuff <input type="checkbox"/> Carpal Tunnel <input type="checkbox"/> Release <input type="checkbox"/> Adverse RXN <input type="checkbox"/> Anesthesia <input type="checkbox"/> Lumbar <input type="checkbox"/> Laminectomy <input type="checkbox"/> Cervical Fusion <input type="checkbox"/> Arthroscopy <input type="checkbox"/> Ganglion <input type="checkbox"/> Mastectomy <input type="checkbox"/> Prostatectomy
<b>OTHER DOCTORS SEEN FOR THIS CONDITION:</b> MD <input type="checkbox"/> DC <input type="checkbox"/> DO <input type="checkbox"/> DDS <input type="checkbox"/> _____ _____ _____ _____ _____ _____			

# INFORMED CONSENT FOR TREATMENT

Thereby request and consent to the treatment of medical care, physical therapy, and/or chiropractic adjustments. This includes various modes of physical therapy, chiropractic, diagnostic x-rays, and possible medication and/or injections prescribed to me (or to the other patient named below, for whom I am legally responsible). I request to be treated by the doctors named below and/or other licensed doctors who now or in the future treat me while employed by, working, or associated with or serving as back-up for the doctors named below, including those working at Care Medical Center.

I have had an opportunity to discuss the nature and purpose of chiropractic adjustments and other procedures with the doctors named below and/or with other office or clinic personnel.

I understand and am informed that, as in the practice of medicine, chiropractic, and physical therapy, there are some risks to treating, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains.

I also understand that there are risks to taking medication, including, but not limited to, rash, diarrhea, nausea, low-grade fever, dry mouth, restlessness, night sweats, increased heart rate, and depression as prescribed by the medical doctor.

I do not expect the doctors to be able to anticipate and explain all risks and complications, and I wish to rely on the doctors to exercise judgment during the course of the procedure, which the doctors feel at the time, based upon the facts, then known, is in my best interests.

I have read or have read the above consent to me. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and future condition(s) for which I seek treatment.

## TO BE COMPLETED BY PATIENT

Patient Name \_\_\_\_\_ Signature of Patient \_\_\_\_\_

Date Signed \_\_\_\_\_ Witness of Patient's Signature \_\_\_\_\_

## TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient Name \_\_\_\_\_ Signature of Patient \_\_\_\_\_

Date Signed \_\_\_\_\_ Signature of Representative \_\_\_\_\_

Relationship/Authority of Representative \_\_\_\_\_

Translated by \_\_\_\_\_

## TO BE COMPLETED BY DOCTOR OR STAFF

Date \_\_\_\_\_

CLINIC/OFFICE: CARE MEDICAL CENTER

ADDRESS: \_\_\_\_\_

NAME OF DOCTOR'S TREATING THIS PATIENT: \_\_\_\_\_

<u>Medical:</u>	Kate Paylo, DO, Tambrea Ellison, MD, Inderpal Singh, MD, Wiley L. Drury, MD
<u>Chiropractic:</u>	Ryan Moorman, DC, Daniel Day, DC, Briggs Smotherman, DC
<u>Physical Therapy:</u>	Joshua Rhue, DPT, Ginger Gatewood, DPT, Laura Gwillim, P.T., Jonathan Howell, PTA., Zoe Chung, PTA, Kimberly Lamb, PTA, Amanda King, PTA, Steven Sutton, PT, Marissa Clark, PTA

# Care Medical Center

## Office Financial Policy

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and will enable you to place your family under care.

**1. If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may be at most \$100 at any time, or care may be terminated. Our payment plans make care an affordable part of your family's budget.

**2. If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may be at most \$100, or care may be terminated. Our payment plans make care an affordable part of your family's budget.

You are considered a cash patient until you bring in your complete insurance information, and we qualify and accept your insurance coverage.

Our fees are considered usual, customary, and reasonable by most companies and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

**3. Payment Options:** An affordable payment plan will be given at your report of findings. We offer payment by cash, check, post-dated check, credit card, or by care credit.

If you are a Medicare patient and your schedule of visits is once per month or longer, you will not be eligible for an insurance assignment. Charges for services rendered will be due as they are rendered.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Finance Counselor: \_\_\_\_\_

Date: \_\_\_\_\_

Front Desk: \_\_\_\_\_

Date: \_\_\_\_\_

For your convenience, you can keep your credit card on file with us. (OPTIONAL)

Card # \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Name as it appears on the card: \_\_\_\_\_

CVC on back of card: \_\_\_\_\_





**Care Medical**  
**Spine, Pain & Rehab**

## PRIVACY ACT OF 1974

The Privacy Act of 1974, 5 U.S.C. 552a, prohibits disclosures of records contained in a system of records maintained by a federal agency (or its contractors) without the written request or consent of the individual to whom the record pertains. This general rule is subject to various statutory exceptions. In addition to the disclosure of information for other purposes compatible with the purpose for which the information was collected by identifying the disclosure as "routine use" and publishing notice of it in the Federal Register. The Act applies to all federal agencies and certain federal contractors who operate Privacy Act systems of records on behalf of federal agencies—some federal agencies and contractors of federal statutes and regulations. For example, if the privacy regulation permits a disclosure, but the disclosure is not permitted under the Privacy Act, the federal agency may not make the disclosure. If, however, the Privacy Act allows a federal agency the discretion to make a routine use disclosure, but the privacy regulation prohibits the disclosure, the federal agency means not making the disclosure.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

[www.caremedicalcenter.com](http://www.caremedicalcenter.com)

**Valdosta Office**

2804 N Oak St  
Valdosta, GA 31602  
T: (229) 241-8925

**Tifton Office**

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Tifton, GA 31794  
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203 W Hamilton  
Nashville, GA 31639  
T: (229) 686-2277

**Douglas Office**

306 Shirley Ave  
Douglas, GA 31533  
T: (912) 393-3955

# HIPPA Notice of Privacy Practices

## Care Medical Center

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out our treatment, payment, or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and any information that relates to your past, present, or future physical or mental health condition and related healthcare services.

### **1. Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that is involved in your care and treatment for the purpose of providing healthcare services to you, paying your healthcare bills, supporting the operation of the physician's practice, and any other use required by law.

**TREATMENT:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**PAYMENT:** Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. We may use or disclose your protected health information in the following situations without your authorization. These situations included as Required by Law, Public Health Issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Defense of professional liability claims asserted by patients, Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make the disclosure to you and, when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT. UNLESS REQUIRED BY LAW.**

You may revoke this authorization at any time, in writing, except to the extent that this practice has taken action in reliance on the use of disclosure indicated in the authorization.

## 2. YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request restrictions on your protected health information. This means you may ask not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also ask that any portion of your protected health information not be shared with family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your doctor is not required to agree to a restriction that you may request. If your doctor believes it is in your best interest to permit the use and disclosure of your protected health information, it will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to have your doctor amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made of any of your protected health information.

We reserve the right to change the terms of this notice and will let you know by mail of any changes. You then have the right to object or withdraw as provided in this notice.

## COMPLAINTS

You may make a complaint to our office or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our privacy officer at (229) 241-8925 of your complaint. We will not retaliate against you for filing a complaint.

Signature \_\_\_\_\_ Date \_\_\_\_\_



PATIENT NAME

DOB

**WESTERN ONTARIO AND  
MCMASTER OSTEOARTHRITIS INDEX (WOMAC)**

Please circle the appropriate rating for each item.

RATE YOUR PAIN WHEN...	NONE	SLIGHT	MODERATE	SEVERE	EXTREME
Walking	0	1	2	3	4
Climbing stairs	0	1	2	3	4
Sleeping at night	0	1	2	3	4
Resting	0	1	2	3	4
Standing	0	1	2	3	4

RATE YOUR STIFFNESS IN THE...	NONE	SLIGHT	MODERATE	SEVERE	EXTREME
Morning	0	1	2	3	4
Evening	0	1	2	3	4

RATE YOUR DIFFICULTY WHEN...	NONE	SLIGHT	MODERATE	SEVERE	EXTREME
Descending stairs	0	1	2	3	4
Ascending stairs	0	1	2	3	4
Rising from sitting	0	1	2	3	4
Standing	0	1	2	3	4
Bending to floor	0	1	2	3	4
Walking on even floor	0	1	2	3	4
Getting in/out of car	0	1	2	3	4
Going shopping	0	1	2	3	4
Putting on socks	0	1	2	3	4
Rising from bed	0	1	2	3	4
Taking off socks	0	1	2	3	4
Lying in bed	0	1	2	3	4
Getting in/out of bath	0	1	2	3	4
Sitting	0	1	2	3	4
Getting on/off toilet	0	1	2	3	4
Doing light domestic duties (cooking, dusting)	0	1	2	3	4
Doing heavy domestic duties (moving furniture)	0	1	2	3	4

PATIENT SIGNATURE	DATE
REVIEWED BY PHYSICAL THERAPIST	DATE

HOSPITAL USE  
ONLY

TOTAL

HOSPITAL USE  
ONLY

TOTAL

HOSPITAL USE  
ONLY

TOTAL

WOMAC  
TOTAL  
SCORE /96**Care Medical**  
Spine & Therapy Center

# Care Medical Center

## AUTHORIZATION FOR RELEASE OF INFORMATION OR INDIVIDUAL ACCESS TO INFORMATION

I hereby authorize Care Medical Center to: ☐ release ☐ obtain medical information of:

\_\_\_\_\_  
(Patient's Full Name)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_

I request only the following information to be released/obtained:

- ☐ Emergency Report ☐ Laboratory ☐ Pathology Report ☐ Itemized Billing Statement ☐ Discharge Summary  
☐ Radiology Reports ☐ MRI CD/Reports ☐ Pain Management  
☐ History and Physical ☐ X-Rays Reports ☐ Other (specify) \_\_\_\_\_

Date(s) of Treatment: \_\_\_\_\_

Requested from: Physician/Institution/Agency: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_

ATTENTION: Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "Confidential". I permit the release of all information indicated above including test results and/or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases.

I understand that neither Care Medical Center nor any of its affiliated health care providers can make me sign this Authorization as a condition of getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. This does not apply to the billing of medical claims. I agree that I have received a signed copy of this Authorization if I choose to do it.

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will Expire ninety (90) days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I need to mail, fax, or bring the letter to the address or fax number noted at the top of this page.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's death certificate if the patient did not expire in the facility the information is being requested from.

The health care provider is neither required nor prohibited by law from engaging in private conversations regarding the patient's above- referenced care. The decision to enter into any such conversation is that of the health care provider. However, disclosure that exceeds the scope of this authorization may subject the health care provider to civil liability. This Authorization, contrary to the notice above, shall remain in effect until the underlying claim is finally resolved. Therefore, you may receive a supplemental request for documents. Provided you have an original authorization allowing you to provide records to the party making the supplemental request, a written request for supplemental documents is sufficient, and no additional authorization is required.

Note: Records will be mailed to the above address unless otherwise noted below.

\_\_\_\_\_  
Signature of Patient/Legal Guardian/Personal Representative Date

\_\_\_\_\_  
If someone else signs on behalf of the patient, state the relationship to the Patient.

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

Note: if the above address is not the patient's, please complete the following:

Patient Address: \_\_\_\_\_

\_\_\_\_\_  
Initial if a patient will pick up copies at Care Medical Center.