Care Medical
Spine, Pain & Rehab
caremedicalcenter.com

KNEE PAIN MANAGEMENT INFORMATION

FREE CONSULTATION & TREATMENT INFORMATION

YOUR COMPLIMENTARY CONSULTATION

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 of the facility with information of treatments provided.
4. Consultation with the provider to discuss your past history, current condition, and future treatment options.

IF YOU CHOOSE TO PROCEED

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

- Physical Exam
- X-Rays
- Diagnosis & Plan of Care

ACKNOWLEDGMENT

Print Name _____

Patient Signature _____ Date _____

Witness Signature _____ Date _____

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KNEE SURGERY PREVENTION

Care Medical Center utilizes an advanced combination of treatment for eliminating or reducing knee pain.

KEYS TO CMC'S KNEE PAIN SUCCESS

- **All-Natural Hyaluronic Acid** (or other knee injectable medications) acts as a lubricant and shock absorber in the knee.
- Injections are visually guided by live motion X-ray to help ensure minimal pain and maximum accuracy.
- Therapeutic rehabilitation is designed to enhance lubrication, mobility and shock-absorbing function.
- Licensed Physical Therapists work individually with each patient to improve function and results.
- Hyaluronic acid is a naturally occurring substance used in the knee and is generally well tolerated.

CAN THESE INJECTIONS PREVENT SURGERY?

Hyaluronic acid has been approved for use in the treatment of osteoarthritis of the knee. It combines with joint fluid to create lubrication and cushioning within the knee, helping reduce pain, inflammation and swelling and supporting everyday activity. Outcomes may be enhanced when injections are combined with a structured rehabilitation program and image guidance.

ARE YOU A CANDIDATE WITH 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 activities you enjoy cause pain around your knee?
- Have you been told that you may need knee replacement surgery?

If you answered **YES** to any of these questions, please ask our staff about a private consultation and whether this program may be appropriate for you.

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OSTEOARTHRITIS KNEE PROGRAM

We offer an advanced treatment program for eliminating or reducing knee pain.

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 to help ensure minimal pain and maximum accuracy.
- The Osteoarthritis Knee Rehab Program combines injectable treatment with specialized rehabilitation.
- Licensed Physical Therapists work individually with each patient as part of the rehabilitation program.
- Hyaluronic Acid is a naturally occurring substance used in the knee with no major systemic side effects for most patients.

Can Viscosupplementation Injections Prevent Surgery?

The FDA has approved hyaluronic acid viscosupplementation for use in osteoarthritis of the knee. The medication combines with fluid inside the knee and coats the joint surface, acting as a lubricant and shock absorber. It may reduce pain, inflammation and swelling, allowing improved participation in everyday activities. The best results may occur when injections are combined with specialized Physical Therapy Rehabilitation. Live motion X-ray (fluoroscopy) may be used to guide injection placement.

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 activities you enjoy cause pain around your knees?
- Have you been told that you may need knee replacement surgery?

If you answered YES to any of the questions above, please ask Care Medical Center staff for more information and a consultation.

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ADDITIONAL SERVICES

Ask our staff if you would like more information.

1. Balance Testing

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

YES ☐ **NO** ☐

2. Braces and Supports

Braces and supports are designed to provide extra support during activity and to help reduce pain. This may include knee braces, back braces, therapeutic neck braces and wrist braces. Does pain prevent you from activities you enjoy, and would you like to know more about being fitted for a brace?

YES ☐ **NO** ☐

3. Trigger Point Therapy

A trigger point injection places a small amount of local anesthetic and/or anti-inflammatory medication into a muscle area where tension or spasm is located. Do you have tension, muscle spasms, or tightness 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 or a consultation.

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PATIENT QUESTIONNAIRE

PLEASE COMPLETE ALL APPLICABLE SECTIONS.

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home: _____ Work: _____ Cell: _____

Email: _____ Height: _____ Weight: _____

SSN#: _____ Date of Birth: _____ Sex: Male / Female _____

Chief Complaint: _____

ACCIDENT INFORMATION

☐ Illness ☐ Other Is your condition due to an accident? ☐ Yes ☐ No

Did your accident occur while at work? ☐ Yes ☐ No Automobile accident? ☐ Yes ☐ No

Date: _____ Time: _____ Supervisor: _____

LOCATION	QUALITY	TIME OF DAY	MODIFYING FACTORS
☐ Head	☐ Achy	☐ Morning	Standing ☐ Increase ☐ Decrease
☐ Neck	☐ Dull	☐ Afternoon	Sitting ☐ Increase ☐ Decrease
☐ Shoulder	☐ Sharp	☐ Evening	Walking ☐ Increase ☐ Decrease
☐ Arm	☐ Stabbing	☐ Bedtime	Climbing ☐ Increase ☐ Decrease
☐ Back	☐ Throbbing	☐ All the time	Bending ☐ Increase ☐ Decrease
☐ Thorax	☐ Radiating	☐ Varies	Squatting ☐ Increase ☐ Decrease
☐ Elbow	☐ Burning		Stairs ☐ Increase ☐ Decrease
☐ Wrist	☐ Itching		Driving ☐ Increase ☐ Decrease
☐ Hip	☐ Numb		Coughing ☐ Increase ☐ Decrease
☐ Knee	☐ Pins & Needles		Touch ☐ Increase ☐ Decrease
☐ Ankle			Sneezing ☐ Increase ☐ Decrease
☐ Foot			Movement ☐ Increase ☐ Decrease

NEUROLOGICAL SIGNS & SYMPTOMS

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

NUMERICAL PAIN SCALE

0 1 2 3 4 5 6 7 8 9 10

No pain Moderate pain Worst pain

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PATIENT QUESTIONNAIRE - MEDICAL HISTORY

Medications / Dosage

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergies

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Primary Care Physician / Imaging

Name: _____

Address: _____

_____

Phone: _____

Imaging HX: _____

What? _____

When? _____

Where? _____

Who read? _____

Medical & Surgical History

- ☐ Diabetes
- ☐ Hypertension
- ☐ Thyroid
- ☐ Heart Disease
- ☐ Stroke
- ☐ GI Disorder
- ☐ Hepatitis
- ☐ Kidney Disorder
- ☐ Ulcer

Family History

- ☐ Heart Disease
- ☐ High BP
- ☐ Stroke
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Bleeding Tendency
- ☐ Diabetes
- ☐ Arthritis
- ☐ Other: _____

Social History

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Tobacco:

- ☐ Never
- ☐ Quit
- ☐ Current

Packs/day: _____

Years: _____

Illegal drugs? Y / N

Occupation: _____

Additional Medical History

- ☐ Mental Illness
- ☐ Infections
- ☐ Anemia
- ☐ Pregnancy

Surgical History

- ☐ Appendectomy
- ☐ Tonsillectomy
- ☐ Inguinal Hernia
- ☐ Ventral Hernia
- ☐ Umbilical Hernia
- ☐ Cholecystectomy
- ☐ Hysterectomy
- ☐ Cesarean Section
- ☐ CABG
- ☐ Coronary Stent
- ☐ Carotid Endarterectomy
- ☐ Angioplasty
- ☐ Vascular Bypass
- ☐ Craniotomy
- ☐ Total Hip
- ☐ Total Knee
- ☐ Rotator Cuff
- ☐ Carpal Tunnel Release
- ☐ Cervical Fusion
- ☐ Lumbar Laminectomy
- ☐ Arthroscopy
- ☐ Ganglion
- ☐ Mastectomy
- ☐ Prostatectomy

OTHER DOCTORS SEEN FOR THIS CONDITION: ☐ MD ☐ DC ☐ DO ☐ DDS

_____

_____

_____

_____

_____

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INFORMED CONSENT FOR TREATMENT

CAREMEDICALCENTER.COM

I hereby 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 with, 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 treatment, 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, based upon the facts then known, is in my best interests.

I have read or have had read to me the above consent. 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 _____

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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. 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 does not apply to companies that 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 CareCredit. 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 ACKNOWLEDGMENT

Patient Name: _____ Date: _____

Signature: _____ Date: _____

Finance Counselor: _____ Date: _____

Front Desk: _____ Date: _____

OPTIONAL CREDIT CARD ON FILE

For your convenience, you may keep your credit card on file with us.

Card # _____ Exp. Date _____

Name on Card _____ CVC _____

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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 disclosure of information for other purposes compatible with the purpose for which the information was collected by identifying the disclosure as a "routine use" and publishing notice of it in the Federal Register, the Act applies to federal agencies and certain federal contractors who operate Privacy Act systems of records on behalf of federal agencies. Some federal agencies and contractors are subject to federal statutes and regulations. If a 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 discretion to make a routine-use disclosure but the privacy regulation prohibits the disclosure, the federal agency must follow the applicable privacy restriction.

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

Waycross Office
1411 Alice Street
Waycross, GA 31501
912-282-2989

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HIPAA 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 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" includes demographic information that may identify you and information relating 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 our office who are 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 related services, including coordination or management with a third party. For example, protected health information may be provided to a physician to whom you have been referred so that the physician has the information necessary 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 relevant protected health information be disclosed to the health plan.

We may use or disclose protected health information without your authorization in situations including those Required by Law, Public Health Issues, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Defense of professional liability claims, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, and other Required Uses and Disclosures. Under the law, we must make disclosures to you and, when required, to the Secretary of the Department of Health and Human Services to investigate or determine compliance with applicable requirements.

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 or disclosure indicated in the authorization.

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HIPAA NOTICE OF PRIVACY PRACTICES

2. Your Rights & Complaints

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

You have the right to request restrictions on your protected health information. This means you may ask us not to use or disclose any part of your protected health information for treatment, payment, or healthcare operations. You may also ask that information not be shared with family members or friends involved in your care or for notification purposes. 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 and provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made 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. We will not retaliate against you for filing a complaint.

Signature _____ Date _____

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WESTERN ONTARIO AND MCMASTER OSTEOARTHRITIS INDEX (WOMAC)

PLEASE CIRCLE THE APPROPRIATE RATING FOR EACH ITEM.

RATE YOUR PAIN WHEN...	None (0)	Slight (1)	Moderate (2)	Severe (3)	Extreme (4)
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 (0)	Slight (1)	Moderate (2)	Severe (3)	Extreme (4)
Morning	0	1	2	3	4
Evening	0	1	2	3	4

RATE YOUR DIFFICULTY WHEN...	None (0)	Slight (1)	Moderate (2)	Severe (3)	Extreme (4)
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 flat	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
Heavy domestic duties	0	1	2	3	4
Light domestic duties	0	1	2	3	4

Patient Signature: _____ Date: _____

Reviewed by Physical Therapist: _____ WOMAC Total Score: _____

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

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 or 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 concerning drug/alcohol treatment or use, psychiatric treatment, AIDS/HIV, and other communicable diseases, where applicable and legally permitted.

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 bills, or gaining enrollment or eligibility in a health insurance plan, except as permitted by applicable law. I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on it. 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. If signing on behalf of a patient as legal guardian or personal representative, supporting documentation may be required.

Signature of Patient / Legal Guardian / Personal Representative: _____ Date: _____

Relationship to Patient (if applicable): _____ Witness: _____

Patient Address (if different from above): _____

☐ Initial here if patient will pick up copies at Care Medical Center.