Physical Medicine & Pain Management Associates P.C.

William Tham, MD
Susan Zimmerman, MD
Thomas, Lee, MD

Sophia Leonard-Burns, PA-C
Michael T. Weeks, PA-C
Lori Rodey, PA-C
Amy Raquepau, PA-C

NEW PATIENT REGISRATION PACKET

Dear Patient: APPT DATE_____ TIME_____

Enclosed is our office and financial policy sheet. Please complete all of these forms, sign and bring them with you at the time of your appointment. You may retain the policy information for your records. If you are covered by insurance, please bring your card and a referral if required. If we participate with your insurance, your co-payment will be due at the time of service.

DOCTOR: (circle one) William Tham, MD Susan Zimmerman, MD Thomas Lee, MD
OFFICE LOCATION: (circle one) Annapolis Office Glen Burnie

Please arrive at least 30 minutes before your scheduled appointment and bring the following items with you:

- **Insurance ID card** and **Referral** if required
- **Valid Photo ID**
- X-ray films/MRI/CT films and reports
- Referring Physicians reports
- Laboratory reports
- List of medications and supplements

Directions to ANNAPOLIS Office:

From Route 50 Heading East: Take Exit 23 (Parole), stay in the right lane and continue on to the stop light (staying in the right hand lane as you drive). Turn right on to Jennifer Road. Go to the fourth (4th) traffic light and turn left on to Medical Parkway. The Sajak Pavilion will be the building on your left (the Anne Arundel Medical Center will be on your right). Sajak Pavilion Management requires patients to park in the parking garage. There is no fee.

From Route 50 Heading West: Take Exit 23A, Jennifer Road. Make a left at the light onto Jennifer Road. Continue on Jennifer Road thru 1 light passing (Medical Parkway). Make the next right into Sajak Parking area and continue to parking garage.

Directions to GLEN BURNIE Office:

Traveling From Annapolis: Take Rt. 97 North to exit 12 toward MD Rt. 3 Business/New Cut Road. Merge onto Veteran's Highway. At light, bear right onto MD-3 Crain Highway. Proceed several miles and turn right onto Oak Manor Drive.

Traveling From Baltimore: Using MD-100: East on I-695 East/Baltimore Beltway outer loop toward Key Bridge/Glen Burnie. Take Rt. 97 South (Annapolis/Bay Bridge) to exit 12 toward MD Rt. 3 Business/New Cut Road. Make a left onto MD-3 Crain Highway. Proceed several miles and turn right onto Oak Manor Drive.

Using Rt-97: Take Rt. 97 South to exit 12, MD-3 Business/New Cut Road. Turn left at light onto MD-3 Business/New Cut Road. Proceed several miles and turn right onto Oak Manor Drive.

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OFFICE & FINANCIAL POLICY

We welcome you as a new patient to Physical Medicine & Pain Management Associates.
The following information will help to familiarize you with some of the basic office and financial policies.

APPOINTMENTS: The doctors are available to see patients on an appointment only basis Monday thru Friday. You will be seen by a Physician Assistant on follow up visits, unless otherwise determined by the Physician. Please notify us 24 hours in advance if you will be unable to keep your appointment. Our office reserves the right to charge $25 for missed appointments. The doctors do their best to see patients without having them wait too long; however in a practice such as this, emergencies do arise and such patients will be seen immediately, ahead of those waiting. Please bring a photo ID and your insurance card to every appointment. If you arrive more than fifteen (15) minutes late for your appointment, you may be asked to reschedule your appointment. The Sajak Pavilion Management requires that patient's park in the garage. There is no fee.

INSURANCE: We participate in most insurance plans. ***If you are not insured by a plan we accept, payment in full is expected at each visit. We require a copy of your insurance card to verify eligibility, mailing information, identification number and co-pay/deductible information.*** If we accept your plan, but you do not have a current insurance card, then payment is required in full for each visit until we are able to verify coverage. If we participate with your insurance plan, it is our contractual obligation to collect all co-payments and deductibles for services rendered at the time of service. ***Knowing your insurance benefit plan is your responsibility***. Please contact your insurance company with any questions you may have regarding your coverage. If your insurance requires you to have a referral from your primary care physician, it is your responsibility to obtain the referral prior to your appointment. Failure to have the proper referral will result in your appointment being rescheduled or you may pain full for the service prior to your appointment.

PAYMENT/FEES: **Payment for services is expected prior to being seen by the provider.** We accept payment by cash, check, VISA, MasterCard or Discover. All previous balances must be paid at time of service, unless prior arrangements have been made with the billing department. Charges for initial office visits range from $100-$250. Charges for office follow-up visits range from $40-$120. Any questions regarding your bill should be directed to our Business Office at 410-266-2701.

RETURN CHECK: If a check is returned for insufficient funds or payment has been stopped, you will be charged a $25 fee in addition to the amount of the check. If you have a second check returned, you will be asked to pay by cash, money order, cashier's check or credit card for future visits.

MOTOR VEHICLE ACCIDENT: This office does not bill a third party, therefore the patient is required to use their individual PIP coverage. All available PIP benefits will be utilized first. When PIP becomes exhausted we will bill your health insurance. For this reason you must provide us with your health insurance information. If your health insurance requires a referral, you will need to bring referrals to all appointments while using PIP, as referrals cannot be backdated. This office does not wait for settlement of any services rendered and you will be asked to sign a financial agreement making you aware of your financial responsibility.

(Office & Financial Policy Continued on Next Page)

PMPMA

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WORKERS COMPENSATION POLICY: Your Workers' Compensation Adjuster must authorize each visit before you see a provider. Workers' Compensation patients' must also provide our office with their health insurance prior to the first visit. The health insurance carrier will be billed only in the event that the W/C carrier contest or denies your claim. The patient will be responsible for any remaining balance after the health insurance carrier has paid.

PHONE CALLS: The doctors will be happy to return your calls regarding simple medical questions. If the doctor you normally see is not available, your message may be given to one of the other providers.

PATIENT PORTAL: The practice maintains a patient portal which is accessible online for all patients. Ask our front desk for a brochure and PIN letter if you wish to create an account and link it to your patient chart.

MEDICATION / NARCOTICS POLICY: Pain medications are to be prescribed only by a single physician. You will be asked to sign an agreement stating that you will not attempt to get pain medication from any other health care provider while you are under the care of this practice. No lost or stolen prescription medications will be replaced. You may be subject to periodic lab testing at your healthcare provider's discretion including urine drug screening.

PRESCRIPTION: Requests for prescription refills should be called directly to your pharmacy. The pharmacy will then fax the request to our office. Prescription requests require 24-48 hours and are not considered an emergency. Due to HIPAA, only the patient can pick up narcotic prescriptions unless a designated personal representative has been assigned. An ID and signature will be required. Narcotic prescriptions cannot be called in or mailed, they must be picked up in-office.

FORMS / MEDICAL RECORDS: Please be advised that there is a fee for filling out forms and/or copying of medical records.

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PATIENT NAME:_____ACCT#_____DATE OF VISIT_____

Who referred you to us?_____ Primary Care Physician_____

Where is your pain? **Age**_____

_____

_____

_____

_____

_____

When did your problem start?_____

Is this related a **CAR ACCIDENT**? ☐ YES ☐ NO If yes, Date of Accident ____/____/____
Is this related a **WORK INJURY**? ☐ YES ☐ NO If yes, Date of Accident ____/____/____

How bad is your pain **right now**? No Pain 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Severe Pain
How about when it **flares up**? No Pain 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Severe Pain

How often do you get **flare ups**?_____

How would you **describe your pain**?

☐ Burning ☐ Aching ☐ Constant
☐ Stabbing ☐ Pins & Needles ☐ Intermittent
☐ Throbbing ☐ Cramping ☐ Other:_____

What **makes it worse**?

☐ Sitting ☐ Bending ☐ Coughing & Sneezing
☐ Standing ☐ Lifting-_____lbs. ☐ Driving
☐ Walking ☐ Push/Pulling ☐ Squatting
☐ Climbing ☐ Laying Down ☐ Other:_____

What **makes it better?**

_____

_____

Do you have any **weakness**? ☐ YES ☐ NO If yes, where?_____
Do you have any **numbness**? ☐ YES ☐ NO If yes, where?_____

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PATIENT NAME:_____ACCT#_____DATE OF VISIT_____

Leave this box blank

What **kind of doctors have you seen** for this problem?

☐ Orthopedics ☐ Family Doctor ☐ Physiatry
☐ Neurosurgery ☐ Chiropractor ☐ Other:_____
☐ Neurology ☐ Pain Management ☐ Other:_____

What **treatments** have you had?

What **diagnostic testing** have you had?

	When was it done?		*When was it done?*
☐ Discogram		☐ MRI	
☐ EMG		☐ CT Scan	
☐ Blood Tests		☐ Myelogram	
☐ X-Rays		☐ Bone Scan	
☐ Other			

Leave Blank (test results)

Annapolis Office
2002 Medical Parkway, Ste 430
Annapolis, MD 21401
(o) 410-266-2700
(f) 410-268-1862

Glen Burnie Office
331 Oak Manor Drive, Ste 102
Glen Burnie, MD 21061
(o) 410-761-0030
(f) 410-761-4895

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PATIENT NAME:_____ACCT#_____DATE OF VISIT_____

What **medications are you taking now**, including medications for this pain?

_____

_____

_____

_____

_____

_____

Are you **allergic** to any medications? ☐ YES ☐ NO If yes, what are they?_____

_____

Do not write in this box, your physician will fill this out

Diagnosis	**Rational for Cox2 inhibitors (circle one)**	**Other pertinent patient history**
☐ Osteoarthritis		
☐ Bursitis/Tendonitis	*GI Bleeds / Peptic Ulcer / GERD	
☐ Acute Pain	*On PPIs / Antacids / H2 Blockers/Coumadin	
☐ Chronic Pain	Steroids / Aspirin / Methotrexate / Plavix	
☐ Dysmenorrhea	Ticlid / Platelet Inhibitors	
☐ Rheumatoid Arthritis	*Age over 60 / Chronic Smoker	
☐ Other_____	*Demonstrate response to Cox2 Inhibitors	
	*Failed with 2 other NSAIDS:	
	1. _____	
	2. _____	
	3. _____	

Have you had any of the following **symptoms since the pain started**?

☐ Fevers, Chills or Night Sweats	☐ Headaches	☐ Fatigue
☐ Severe Night Time Pain	☐ Dizziness	☐ Cold Feet or Hands
☐ Weight Loss	☐ Blurred Vision	☐ Difficulty Swallowing
☐ Chest Pain	☐ Blood in Urine	☐ Shortness of Breath
☐ Abdominal Pain	☐ Feet or Hand Swelling	☐ Nausea, Vomiting or Diarrhea
☐ Coughing Up blood	☐ Tremors	☐ Incontinence of Bowel or Bladder
☐ Excessive Thirst	☐ Rashes	
☐ Bruise Easily	☐ Difficulty Walking	☐ Ringing in Ears

Family History (Have any members of your family had any of the following?)

☐ Hypertension	☐ Diabetes	☐ Back or Neck Pain
☐ Kidney Disease	☐ Stomach Ulcers	☐ Cancer
☐ Arthritis	☐ Heart Disease	☐ Stroke

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☐ Thyroid Disease ☐ Lung Disease

PATIENT NAME:_____ACCT#_____DATE OF VISIT_____

What **medical problems** do you have?

☐ Kidney Disease	☐ High Blood Pressure	☐ Irritable Bowel Disease
☐ Liver Disease	☐ Heart Disease	☐ Diabetes
☐ Thyroid Disease	☐ Lung Disease	☐ Ulcers / Reflux Disease
☐ Asthma	☐ Arthritis	☐ Depression
☐ Lyme Disease	☐ Cancer	

☐ Other:_____

Prior Surgeries (include dates)

_____

_____

_____

_____

_____

Previous injuries including auto and work related accidents (include dates)

_____

_____

For <u>Women</u>

Are you pregnant? ☐ YES ☐ NO

Do you have any problems with your menstrual cycle? ☐ YES ☐ NO

Social History

☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Married

Working Status

Are you working now? ☐ YES ☐ NO If no, when did you stop?_____(Year)

If yes: what is your occupation?_____

If yes: how long have you been at this job?_____(Years)

Job/Activity Requirements

☐ Heavy (lifting over 60lbs frequently)

☐ Medium (lifting 30lbs-50lbs)

☐ Light (lifting 10lbs-20lbs

☐ Sedentary (sit most of the time, very little heavy lifting)

Do you **smoke**? ☐ YES ☐ NO If yes, how many packs per day?_____

Have you had any past history of **alcoholism**? ☐ YES ☐ NO

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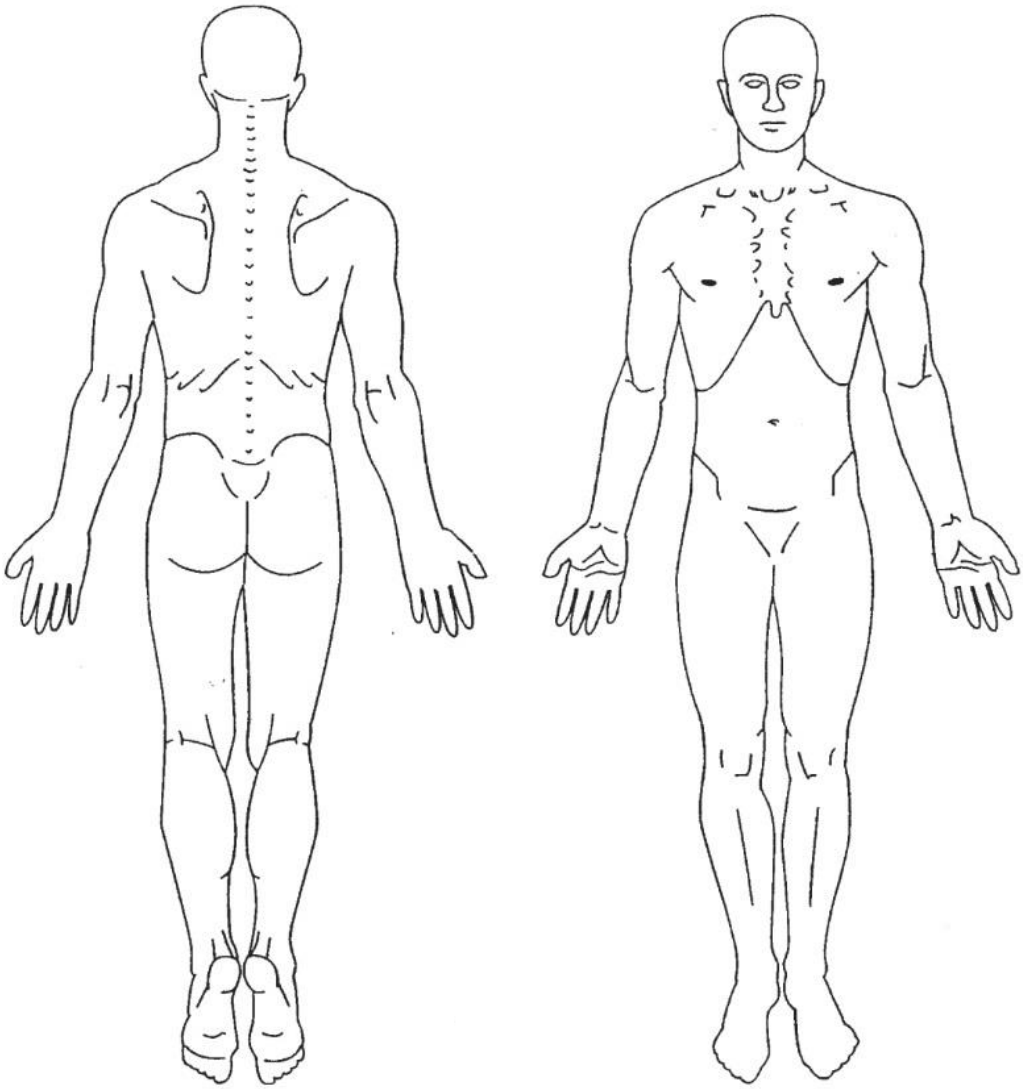
Have you had any past history of **drug abuse**? ☐ YES ☐ NO
Do you currently or have you recently had any major life stress? ☐ YES ☐ NO

PATIENT NAME:_____ACCT#_____DATE OF VISIT_____

Mark the location of your pain

xxxxxx for sharp stabbing pain
ooooo for dull aching pain
////// for burning pain and numbness



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