Piedmont Comprehensive Pain Management Group, LLC

Eric P. Loudermilk, MD
Medical Director
Board Certified Anesthesiology
Board Certified Pain Management

Michael T. Grier, MD
Board Certified Anesthesiology
Board Certified Pain Management

Sung J. Han, MD
Board Certified Pain Management
Board Certified Physical Medicine
and Rehabilitation

Brian M. Jakubowicz, MD
Board Certified Pain Management
Board Certified Anesthesiology

Sarah A. Hensley, MD
Board Certified Pain Management
Board Certified Anesthesiology

Susan L. Cramer, MD
Board Certified Pain Medicine
Board Certified Physical Medicine
and Rehabilitation

Interested in learning more about Piedmont Comprehensive Pain Management Group, LLC?

Check out our new website at **www.PiedmontPain.com** to find up-to-date information about the practice including: maps/directions, contact information, physician biographies, hours of operation, and information about the services our physicians provide.

Your Appointment:

Patient Name:____

Anderson Office: ____/____/____ at ___________ with:
- ☐ **Eric P. Loudermilk, MD**
- ☐ **Michael T. Grier, MD**
- ☐ **Sung J. Han, MD**
- ☐ **Sarah A. Hensley, MD**
- ☐ **Brian M. Jakubowicz, MD**
- ☐ **Susan L. Cramer, MD**

Greenville Office: ____/____/____ at ___________ with:
- ☐ **Eric P. Loudermilk, MD**
- ☐ **Michael T. Grier, MD**
- ☐ **Sung J. Han, MD**
- ☐ **Sarah A. Hensley, MD**
- ☐ **Brian M. Jakubowicz, MD**
- ☐ **Susan L. Cramer, MD**

Anderson Office
100 Healthy Way, Suite 1260, Anderson, SC 29621 (864)225-3551

Greenville Office
3 St. Francis Drive, Suite 480, Greenville, SC 29601 (864)269-4416

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Dear PCPMG Patient,

You have been referred to our pain clinic by your primary care or specialty physician for treatment of your condition. We will require you to maintain your relationship with your primary physician as a stipulation of being seen in our clinic.

We will expect your primary care physician to continue to care for your general health needs including providing you with the appropriate medications and treatments you are receiving now. Unless you have been specifically told BY YOUR PAIN CLINIC PHYSICIAN, be advised that we will NOT be assuming responsibility for any and all medications currently prescribed by your primary care physician. We are not primary care providers and do not treat conditions outside the narrow scope of our pain practice. Often, pain medications prescribed by your primary care physicians are not the optimal medications to treat your condition and may not be continued through this office.

Should you be dismissed from the care of your primary care physician, you will be expected to establish care with another primary care provider in order to continue chronic pain management through our practice.

Sincerely,

______________________________ Eric P. Loudermilk, MD

______________________________ Michael T. Grier, MD

______________________________ Sung J. Han, MD

______________________________ Brian M. Jakubowicz, MD

______________________________ Sarah A. Hensley, MD

______________________________ Susan L. Cramer, MD

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Dear Sir or Madam:

You have been referred for evaluation and treatment at Piedmont Comprehensive Pain Management Group, LLC. The clinic utilizes many modalities in the treatment of chronic pain including medications, physical therapy, psychotherapy (stress management, coping skills, relaxation therapy, and biofeedback), a variety of nerve block procedures, as well as more advanced techniques such as implantable devices. We also have the means for referral to neurosurgeons, orthopedic surgeons, neurologists, psychologists, and physical therapists.

On your visit, we will perform a thorough medical history and physical examination so that we may formulate an appropriate treatment plan for your pain problem. **Due to scheduling demands of our physicians, patients will be required to see a Nurse Practitioner or a Physician Assistant.** This allows more flexibility in scheduling your appointments. **Patients will not get a nerve block procedure on their initial visit**. Some treatment plans need approval from insurance companies and approval cannot always be obtained in a timely manner.

We utilize a variety of medications for the management of chronic pain including anti-inflammatory agents, muscle relaxants, antidepressants, anticonvulsants, and anti-arrhythmic agents. **Narcotic pain medications are usually reserved for cancer patients** or patients who have failed multiple non-narcotic medications and nerve block procedures. When appropriate, narcotics are prescribed under stringent guidelines, which are outlined in a "narcotic contract" that will be signed by the prescribing physician and the patient. **If the guidelines are not followed, therapy will be discontinued**.

The goal of our clinic is to help reduce or resolve your pain so that you may comfortably perform routine daily activities and live a more normal life. An effective pain management strategy often requires several treatment modalities (nerve blocks, medications, physical therapy, etc.), but your help and motivation are essential in order to be successful. Please allow a reasonable amount of time for your prescribed treatment plan to take effect by keeping your scheduled appointment. **We are not a walk-in clinic.**

If you need to cancel or reschedule an appointment, please call our office within 24 hours of your appointment. Failure to do so will result in a no-show fee up to or equal to the fee of the scheduled visit. **This may be from $40.00 to $200.00.** Our time is valuable and other patients can be seen in your time slot if we have proper notice. If you are more than 10 minutes late for your appointment you may have to be rescheduled. This is at the discretion of the healthcare provider with which your appoint is scheduled. You may be dismissed and no further appointments given if you fail to show for a scheduled appointment more than two times.

We ask that you bring all the medications or a list of the medications that you are currently taking with you to your appointment. We also ask that you obtain a copy of your drug formulary from your insurance company to bring with you. This will avoid delaying medical treatment because of potential drug interactions. **We will not routinely call in any prescriptions to your pharmacy between appointments.** Please obtain all prescriptions during your appointment. There will be a **$30.00** charge for any prescriptions requested between appointments. If your insurance requires a prior authorization for your medication, you will be responsible for calling your insurance company, obtaining the prior authorization form and personally delivering the form to our office. **All prior authorizations are sent in online and can take up to 72 hours to be processed**. There is a **$10.00** fee for providing this service.

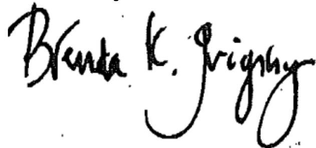
Your pharmacy's name, address, and telephone number is required at your initial consultation. No prescription will be given until this information is provided. **<u>If you change pharmacies, doctors, or insurance, it is your responsibility to notify our office staff at an office visit.</u>**

At times, you may be required to leave a message for the nurse. Messages will be returned in 24-48 hours unless stated as an emergency. Due to HIPPA regulations voicemails will not be left on unidentified machines. A **$25.00** consult fee may be charged if a call from the physician is required.

Enclosed you will find a Pain Assessment Booklet. In order to evaluate and assist you, please complete the assessment booklet and bring with you on your initial appointment. You will also find an Authorization for Release of Medical Information form. Please sign and bring this sheet with you on your initial visit.

We are looking forward to meeting you and, hopefully, providing you with effective treatment for your pain. If you have any further questions, please do not hesitate to contact us. The phone number for Piedmont Comprehensive Pain Management Group, LLC is 864-225-3551 in Anderson and 864-269-4416 in Greenville.

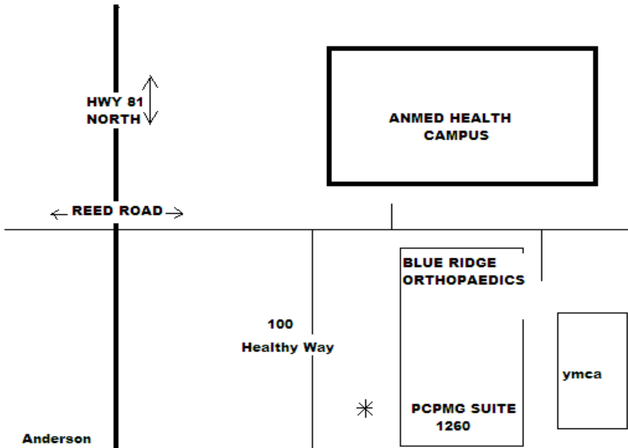
Sincerely,



Brenda K. Grigsby
Administrator
Piedmont Comprehensive Pain Management Group, LLC

Enclosures

Anderson Office:
100 Healthy Way, Suite 1260
Anderson, SC 29621
Phone: (864)225-3551



From Greenville:

-Take exit 27 off I-85
-Turn left on Hwy 81 (Williamsburg Rd) for 6.5 miles
-Turn left on Reed Rd. at the intersection of Anmed Health Campus and Shell
-Turn right on Healthy Way
-Parking lot N
-PCPMG is the last office, Suite 1260
-Same Entrance as Carolina Cardiology

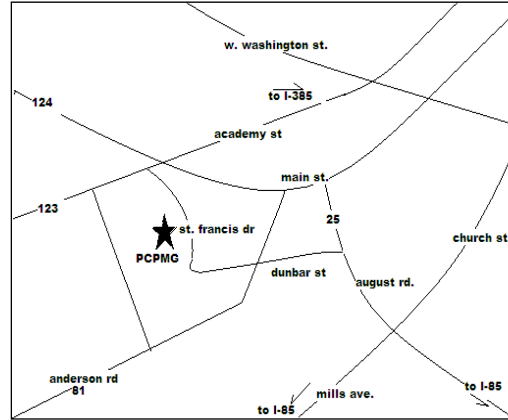
From Downtown Anderson:

-Take E. Greenville St. from Main St.
-Pass the Anmed Medical Center (old hospital)
-Continue for 2.6 miles
-Turn right on Reed Rd. at the intersection of Anmed Health Campus and Shell
-PCPMG is the last office, Suite 1260
-Same Entrance as Carolina Cardiology
-Parking lot N

From Clemson Blvd in Anderson:

-From the Anderson Mall go southeast toward downtown Anderson
-Turn left on Concord Rd. at CVS and Walgreens
-Turn right at first light onto Reed Rd.
-Go through the intersection of E. Greenville St.
-Turn right onto Healthy Way (first street after the Shell station)
-PCPMG is the last office, Suite 1260
-Same Entrance as Carolina Cardiology
- Parking lot N

Greenville Office:
3 St. Francis Dr., Suite 480
Greenville, SC 29601
Phone: (864)269-4416



From I-85 North

-Exit Hwy 185/29 to Greenville.
-At 3rd traffic light, turn **LEFT** onto **Augusta Rd.**
-At 1st traffic light, turn **LEFT** onto **Dunbar St.**
-At St. Francis Hospital, turn **RIGHT** onto **St. Francis Drive.**
-Continue past hospital on **LEFT**.
-Continue past Bernadine Building on **LEFT**
-Entrance for parking for 3 St. Francis Drive (Outpatient Building) is on **LEFT**.

From I-85 South

-Exit 46-C onto **Mauldin Rd**. towards Greenville.
-At 2nd light, turn **RIGHT** onto **Augusta Rd.**
-Continue approximately 11 lights to intersection of Mills Ave and Church St. (See KFC/Taco Bell)
-Continue **STRAIGHT** to next light and turn **LEFT** onto **Dunbar St.**
-At St. Francis Hospital, turn **RIGHT** onto **St. Francis Drive.**
-Continue past the hospital on **LEFT**.
-Continue past Bernadine Building on **LEFT**
-Entrance for parking for 3 St. Francis Drive (Outpatient Building) is on **LEFT**.

From I-385 North

-Continue into Downtown Greenville to light at **Academy St and Hwy.123**
-Continue **STRAIGHT** through intersection of **Pendleton St. and Academy St.**
-Just past intersection turn **LEFT** onto S**t. Francis Dr**. (See blue sign with St. Francis Emergency Room Arrow)

- -Entrance to parking for 3 St. Francis Drive (Outpatient Building) is on **RIGHT**

Piedmont Comprehensive Pain Management Group, LLC

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THIS FORM MUST BE COMPELTED

Name:____ Date of Birth:____________ Age:______
Last First M. Initial MM/DD/YYYY

Social Security Number:___________________ Sex: _____ Race:________ Marital Status:____________
XXX-XX-XXXX M/F

Patient's Street Address:____
Street City State Zip Code

Contact Phone Numbers: ____________________ ____________________ ____________________
Home Cell Work

Primary Email Address: ____

Emergency Contact Information: ________________________ / _________________ / _________________
Full Name Telephone Number Relationship

Employer: ____ Job Title: ________________________

Parent/Spouse's Information: ______________________________ / _________ / _____________________
Full Name DOB Social Security Number

Primary Care Physician: ____ ________________________
Name of Doctor/ Practice Office Telephone Number

Who referred you to our office? _____________________________________ ______________________
Name of Doctor/ Practice Office Telephone Number

Reason for Referral: ____

Any relatives treated by PCPMG? ____
Please list full names/relationship

Insurance Information (Include Medicare/Medicaid):

Primary Insurance Company:_________________________________ / _______________ / ______________
Company Name ID Number Group Number

Insured:_____________________________________ ___________________________
Name of Insured (if self, please write "Self") Relationship to insured (N/A if "self")

Secondary Insurance Company:_______________________________ / _______________ / ______________
Company Name ID Number Group Number

Insured:_____________________________________ ___________________________
Name of Insured (if self, please write "Self") Relationship to insured (N/A if "self")

Prescription Drug Coverage: __________________________________ /_____________________________
Company Name ID number

________________ / ________________ / ________________
Rx BIN Rx PCN Rx GRP

Is this a Workers' Compensation Claim?______ Is this an Auto Liability Claim?______ Date of Accident:_______
Y/N Y/N mm/dd/yyyy

Is an attorney involved?________ If yes, _________________________________ _____________________
Y/N Attorney Name Attorney Telephone Number

All professional services rendered are charged to the patient. Insurance forms will be completed upon request. PLEASE READ AND SIGN: I hereby authorize my insurance companies to pay any benefits due directly to Piedmont Comprehensive Pain Management Group, LLC and also authorize Piedmont Comprehensive Pain Management Group, LLC to release any medical information necessary to process my medical insurance. I understand that I will be responsible for any balance not paid by my insurance.

Patient Signature: ____ Date: _____________

THIS FORM MUST BE COMPLETED

Name: ______________________________ **Date of Birth:**______________

Are you currently on any anticoagulants (blood thinners)? ☐**Yes** ☐**No**

Past Medical History: Past or present medical conditions (circle all that apply):

Angina
Arthritis
Bleeding Disorders
Cancer
Cardiac Abnormalities
Diabetes
Hepatitis
Hypertension
Kidney Problems
Lung Disease
Psychiatric Problems
Stroke
Ulcers
Herpes Zoster / Shingles
Seizures

Previous Surgeries:

Date: ____________ Hospital: ________________________ Procedure: ____

____________ ________________________ ____

____________ ________________________ ____

____________ ________________________ ____

Diagnostic Studies Performed:

	Date:	Location:
X-Rays	___________	______________________________
MRI	___________	______________________________
CT Scan	___________	______________________________
EMG/NCV	___________	______________________________

Previous Pain Treatments:

****This is required for Procedure Authorization****

Type of Treatment	Yes	No	If yes, approximate dates received and location
Physical Therapy			
Massage			
Heat/Cold			
TENS/E-stim Unit			
Nerve Blocks/Steroid Injections			
Spinal Cord Stimulator Implant			
Infusion Pump			
ER/Hospitalization for pain control			

1. Have you ever been to another pain clinic? Y / N If yes, where and when?(list all)______________________
____

2. Since your condition began, which individuals have you consulted for treatment and pain relief? Please Circle:

Acupuncturist Cardiologist Chiropractor Dermatologist Neurologist Neurosurgeon

Ophthalmologist Orthopedic Surgeon ENT Endocrinologist Primary Care Physician Gastroenterology

General Surgeon Gynecologist Psychiatrist/Psychologist Radiologist Rheumatology

THIS FORM MUST BE COMPLETED

Universal Medication Form

Today's Date:	**Address:**
Name:	
Phone Number:	
Birth Date:	
Emergency Contact & Phone number:	

Pharmacy Name:	**Pharmacy Phone Number:**

Allergic To / Describe Reaction:	**Allergic To / Describe Reaction:**

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

DATE STARTED	NAME OF MEDICATION / DOSE	DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.)	DATE STOPPED	Notes: Reason for Taking / Doctor Name

Name: ______________________________ **Date of Birth:**______________

Medication History: Please indicate current or past use of the following medications:
Please circle variation if applicable.

NSAIDS:

Aspirin/ Excedrin/Goody Powder	☐Current ☐Past	Celecoxib/Celebrex	☐Current ☐Past
Naproxen/Aleve/Vimovo/Naprelan	☐Current ☐Past	Meloxicam/Mobic/Vivlodex	☐Current ☐Past
Ibuprofen/Advil/Motrin/Duexis	☐Current ☐Past	Nabumetone/Relafen	☐Current ☐Past

Diclofenac/Arhrotec/Voltaren/Zipsor/Zorvolex/Cambia ☐Current ☐Past Use

Other: ____ ☐Current ☐Past

Opioids:

Oxycodone/Percocet/OxyContin/Xtampza	☐Current ☐Past	Codeine/Tylenol#3	☐Current ☐Past
Hydrocodone/Vicodin/Lortab/Hysingla/Zohydro	☐Current ☐Past	Tramadol/Ultracet	☐Current ☐Past
Tapentadol/Nucynta	☐Current ☐Past	Methadone	☐Current ☐Past
Morphine/Kadian/MS Contin/Morphabond	☐Current ☐Past	Fentanyl	☐Current ☐Past
Hydromorphone/Dilaudid/Exalgo	☐Current ☐Past	Belbuca/Butrans	☐Current ☐Past
Suboxone/Subutex/Zubsolv/Buprenorphine	☐Current ☐Past	Levorphanol	☐Current ☐Past

Other: ____ ☐Current ☐Past

Muscle Relaxers:

Cyclobenzaprine/Flexeril	☐Current ☐Past	Methocarbamol/Robaxin	☐Current ☐Past
Tizanidine/Zanaflex	☐Current ☐Past	Baclofen/Lioresal	☐Current ☐Past
Metaxalone/Skelaxin	☐Current ☐Past	Chlorzoxazone/Lorzone	☐Current ☐Past

Other: ____ ☐Current ☐Past

Neuropathic Pain:

Gabapentin/Neurontin/Horizant/Gralise	☐Current ☐Past	Pregabalin/Lyrica	☐Current ☐Past
Amitriptyline/Elavil	☐Current ☐Past	Nortriptyline/Pamelor	☐Current ☐Past
Duloxetine/Cymbalta	☐Current ☐Past	Doxepin/Silenor	☐Current ☐Past
Topiramate/Topamax	☐Current ☐Past	Levetiracetam/Keppra	☐Current ☐Past

Other: ____ ☐Current ☐Past

Opioid Induced Constipation

Naloxegol/Movantik	☐Current ☐Past	Naldemedine/Symproic	☐Current ☐Past	Fiber/BeneFiber	☐Current ☐Past
Lupiprostone/Amatiza	☐Current ☐Past	Polyethylene Glycol/Miralax	☐Current ☐Past	Docusate/Senna	☐Current ☐Past
Methylnaltrexone/Relistor	☐Current ☐Past	Linaclotide/Linzess	☐Current ☐Past	Bisacodyl/Dulcolax	☐Current ☐Past

Other: ____ ☐Current ☐Past

Patient Name: ___________________________ **Date:** ________________

Review of Systems: Please check any of the following which you have experienced:

Constitutional:	☐Fatigue	☐Weight Gain	☐Weight Loss
Cardiac:	☐Chest Pain	☐Leg Swelling	☐Bleeding Problems
Pulmonary:	☐Shortness of Breath		☐Recent Upper Respiratory Infection
Gastrointestinal:	☐Nausea	☐Vomiting	☐Constipation
Neurological:	☐Numbness	☐Weakness	☐Headaches
Musculoskeletal:	☐Joint Pain	☐Joint swelling	☐Muscle Spasms
Psychiatric:	☐Sleeping difficulties		☐Anxiety/Depression
Genitourinary:	☐Difficulty with urination		☐Burning or painful urination
	☐Sexual Difficulties		☐Urinary/Bowel Incontinence
HEENT	☐Changes in vision		☐Changes in hearing

Social History:

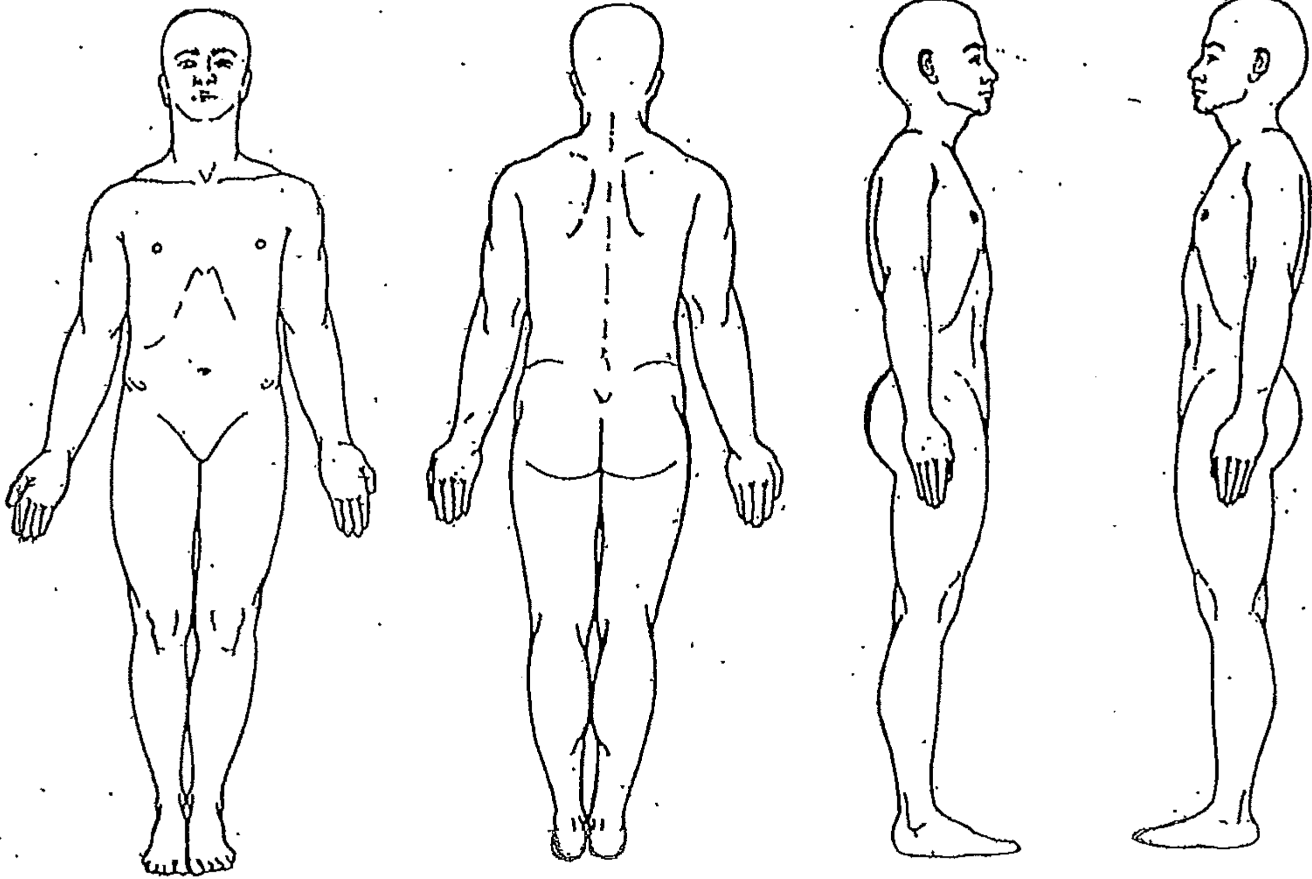
1. Job Description (heavy lifting or physical exertion involved?):___________________________________
2. Are you receiving workers' compensation? ☐Yes ☐No
3. Do you smoke? ☐Yes ☐No If yes, how much per day? _______________
4. Do you drink alcohol? ☐Yes ☐No If yes, how much per day? _______________
5. Do you use marijuana? ☐Yes ☐No If yes, how much per day? _______________

Pain Questionnaire:

1. Where is your pain? ____
2. When did your pain begin? ____
3. Is the pain related to an on-the-job injury (if yes, date of injury)? _________________________________
4. Describe the quality of your pain (aching, burning, throbbing, stabbing, sharp, etc.)_________________
5. Is any part of your body numb (if yes, which part)? ____
6. Have you been to physical therapy? ____
   6a. If so, was it helpful? ☐Yes ☐No

Name:________________________ **Date of Birth:________________**

Your Pain: Please indicate where your pain is by shading in the figures below



Your Pain Level:

At your Best: 0 (No Pain) (Moderate Pain) 5 (Worst Possible Pain) 10

Please Circle: 0 1 2 3 4 5 6 7 8 9 10

At your Worst: 0 (No Pain) (Moderate Pain) 5 (Worst Possible Pain) 10

Please Circle: 0 1 2 3 4 5 6 7 8 9 10

Piedmont Comprehensive Pain Management Group, LLC

Payment Policy and Precertification Authorization

You are responsible for all charges associated with your visit here today. As a courtesy to you, we will be glad to file your insurance. If your insurance has not responded within 60 days, **you will need to make regular monthly payments until balance is paid**. If your exam is due to an accident that may or may not involve an attorney, you will be responsible for making monthly payments until this is resolved, at which time payment in full will be expected.

Our office will contact your insurance provider prior to the scheduled date or service. Confirmation that our office has your most current information on file will help to ensure that this process is completed in a smooth and timely fashion.

The responsibility of verifying completion of the pre-certification process ultimately resides with the patient. Please contact your insurance carrier prior to the date scheduled for assurance as well as to verify benefit and/or networking information. Remember, when speaking with your insurance carrier, always record the date, time and name of the individual with whom you spoke for later reference if needed.

I authorize the release of any medical or other information to or from Piedmont Comprehensive Pain Management Group regarding any charges or procedures necessary.

I hereby authorize insurance benefit payments to be made directly to Piedmont Comprehensive Pain Management Group. I understand that I will be billed for any balance due.

I understand that procedures performed by a physician at Piedmont Comprehensive Pain Management Group may not be covered under my Medicare or other insurance coverage. In the event of claim denial from Medicare or other insurance, **I will be held responsible for all bills acquired.**

Please Sign below indicating that you understand these arrangements and that you agree to make regular monthly payments for all dates of service provided to you by our physicians.

Patient Name (Please Print): ________________________________ Date: ___________

Patient or Guarantor Signature: ______________________________ Date: ___________

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• Brian M. Jakubowicz, MD• Sarah A. Hensley, MD • Susan L. Cramer, MD

Authorization for Release of Medical Information

Date:________________

Patient's Full Name	Date of Birth (MM/DD/YYYY)
Street Address	Social Security Number
City, State, Zip Code	Contact Phone Number

Medical Records to be released by (if you are unsure please leave this section blank):

____
Name of Practice

____
Street Address

____
City, State, Zip Code

Phone Number	Fax Number

Records to be sent/released to:

Anderson Office	**Greenville Office**
100 Healthy Way, Suite 1260	**3 St. Francis Drive, Suite 480**
Anderson, SC 29621	**Greenville, SC 29601**
Phone: 864-225-3551	**Phone: 864-269-4416**
Fax: 864-328-0328	**Fax: 864-269-8989**

Patient or Legal Guardian's Signature	**Date**
Witness	**Date**

Piedmont Comprehensive Pain Management Group, LLC

Policies and Procedures

Please familiarize yourself with the policies and procedures of our practice before you come to your appointment.

Appointments: If you are late, your appointment may be rescheduled.

Due to the nature of our practice, you may have an extended wait time.

We require a 24 hour notice if you need to cancel or reschedule your appointment. The charges are **$200.00** for procedures and EMGs**, $165.00** for consults, and **$40.00** for all other appointments. You will be responsible for payment of any fees.

You are responsible for updating your information: address, phone # and insurance changes. **Please advise the receptionist of any changes prior to each appointment.**

Please allow a reasonable amount of time for your prescribed treatment plan to take effect by keeping your scheduled appointment. **We are not a walk-in clinic.**

Prescriptions: **We will not call in prescriptions** to your pharmacy routinely between appointments. Please obtain all prescriptions during your appointment.

There will be a **$30.00** charge for any prescriptions requested between appointments.

If your insurance requires a prior authorization for your medication, you are responsible for contacting your insurance company, obtaining the prior authorization form, and **personally delivering** the form to our office. There is a **$10.00** fee for providing this service. **All prior authorizations are sent in online and can take up to 72 hours to be processed.**

Phone Calls: You may be charged **$25.00** for any problem that cannot be addressed by the nurse and requires a return call by the physician.

Please sign and date below to acknowledge that you have been informed and are aware of the policies and procedures of our practice. A copy is available upon request.

Name: ____ Date: ____/____/____

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General Consent for Care and Treatment/Assignment of Benefits

To the Patient: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. This consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designee as deemed necessary, to perform reasonable and necessary medical examinations, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent form(s) prior to the test(s) or procedure(s).

I authorize PCPMG to request on my behalf and collect directly all public and private insurance coverage benefits due or services/treatments supplied by PCPMG. In the event payments for insurance benefits are made directly to my representative or me, I/We agree to endorse to PCPMG all checks for such payments. This payment will not exceed my indebtedness to PCPMG.

By signing below, I understand that claims filed under Piedmont Comprehensive Pain Management Group, LLC may not be covered under my Medicare or other health coverage. In the event of a claim dealt from Medicare or other insurance, I will be held responsible and will pay for all balances acquired. I certify that I have read and fully understand the above statements and consent in full and voluntarily to its content.

Patient Name Patient Signature DOB Date

Patient’s Email

Piedmont Comprehensive Pain Management Group, LLC

Eric P. Loudermilk, MD
Medical Director
Board Certified Anesthesiology
Board Certified Pain Management

Michael T. Grier, MD
Board Certified Anesthesiology
Board Certified Pain Management

Sung J. Han, MD
Board Certified Pain Management
Board Certified Physical Medicine and Rehabilitation

Brian M. Jakubowicz, MD
Board Certified Pain Management
Board Certified Anesthesiology

Sarah A. Hensley, MD
Board Certified Pain Management
Board Certified Anesthesiology

Susan L. Cramer, MD
Board Certified Pain Medicine
Board Certified Physical Medicine and Rehabilitation

Protected Health Information (PHI)

Prior to using or disclosing your protected health information to carry out treatment, payment, or health care operations, PCPMG, LLC is required under federal law to obtain your consent. Please review this consent. If you understand and agree with its terms, please sign and date consent below.

I consent to the use or disclosure of my protected health information by PCPMG, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of PCPMG, LLC. I understand that diagnosis and treatment by PCPMG may be refused if I do not provide my consent as evidence by my signature on this document.

I understand I have a right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. PCPMG is not required to agree to the restrictions that you request but any restrictions agreed to are binding.

I have the right to revoke this consent in writing, at any time, except to the extent that PCPMG, LLC has already taken action in reliance to this consent.

My “protected health information” means health information, including my demographic information collected from and created or received by my physician which is the possession of PCPMG. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review PCPMG’s Notice of Privacy Practices prior to signing this document, and a copy of this document is available upon request. The Notice of Privacy Practices more fully describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of PCPMG, LLC.

PCPMG, LLC reserves the right to change the privacy practices that are printed in the Notice of Privacy Practices. I may obtain a revised notice by calling the office and ask that one be sent in the mail or ask for one at my next appointment time.

I, ____________________________________, hereby certify that I have read the provisions set forth in this consent form and agree to the terms.

____________________________________ ____________________________________
Signature of Patient Printed Name of Patient

Today’s Date: _______________________

List the people that you authorize us to speak with on your behalf regarding appointments & medical care

Name	Phone	Relationship