**PIEDMONT** ~Complex, Chronic Pain
**PHYSICAL MEDICINE** ~Physical Medicine and Rehabilitation
**& REHABILITATION, P.A.** ~Regenerative & Vascular Medicine
317 ST. Francis Drive, #350, Greenville, SC. 29601 P (864)235-1834 Fax: (864)235-2486 piedmontpmr.com
***Matthew Terzella, M.D***. ***Robert G. Schwartz, M.D.***

**CONSENT/AUTHORIZATION TO RELEASE PROTECTED MEDICAL INFORMATION FROM 3RD PARTIES**

PATIENT NAME: _____
LAST FIRST INITIAL

SOCIAL SECURITY NUMBER: _____---_____---_____ DOB: ____/____/_____

ADDRESS: _____
STREET CITY STATE ZIP

I consent to and authorize Piedmont Physical Medicine and rehabilitation, PA to receive all records/reports from my medical chart (or other protected health information). Please send them via postal or facsimile (PLEASE MAIL IF MORE THEN 10 PAGES) to:

Piedmont Physical Medicine & Rehabilitation, 317 St. Francis Dr. Suite 350 Greenville, SC 29601

I do not give permission to release any information regarding: Substance Abuse _____, HIV_____, or Psychiatric/Mental Health_____.

Time Limit & Right to Revoke Consent/Authorization: Except to the extent that action has already been taken in reliance on this authorization, I understand that at any time I can revoke this authorization by submitting a notice on writing to Piedmont Physical Medicine & Rehabilitation, P.A. Unless revoked, this authorization shall be in force (without a time limit).

Re-disclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability Act of 1996. Piedmont Physical Medicine & Rehabilitation, P.A., its employees, officers, and physicians are hereby released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

**Patient Signature: _____Date: _____**

**Witness Signature: _____ Date: _____**

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**CONSENT/AUTHORIZATION TO RELEASE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS/PRACTICE PRIVACY POLICY ACKNOWLEDGEMENT/MEDICAL SERVICES WAIVER/PATIENT RESPONSIBILITY FOR CHARGES/LETTER OF PROTECTION**

1. **Consent/Authorization to Release Information:** I hereby authorize Piedmont Physical Medicine & Rehabilitation (PPM&R) to release any information regarding my treatment to all payers to facilitate payment on pending claims and I consent to PPM&R's use and disclosure to protected health information about me, for treatment, payment, and health care operations in accordance with the HIPAA Law. I hereby consent/authorize and direct all payers to release to PPM&R any information regarding coverage or benefits that I may have, including, but not limited to, the amount of the coverage, the amount(s) paid thus far, and the amount of any outstanding claims.
2. **Acknowledgement of Practice Privacy Policy:** I acknowledge notice of PPMR's Practice Privacy Policy as required by the HIPAA law.
3. **Medical Services Coverage Waiver:** I hereby authorize PPM&R to perform any medical services that they may offer. While PPM&R will try to inform me in advance of any possible non-covered insurance issues, in the event that my carrier determines that it will either not pay, or grossly under pay for services rendered, then this document will act as a private contract for the delivery of medical services rendered. I further agree and consent to pay PPM&R any dollar amount that my third-party payer withholds or offsets from PPM&R, or denies payment to PPM&R, because of my failure to adhere to the terms of my third-party contract.
4. **Patient Responsibility for Charges:** I am fully aware that I am personally responsible for all charges incurred by me at PPM&R. If PPM&R must take action to collect any outstanding balance on my account, I will be responsible for the payment of those charges and will reimburse PPM&R for all costs of collection, including, but not limited to, normal business expenses, attorney's fees and court costs. I authorize PPM&R to apply my credit balance on charges incurred by me to any other outstanding charges still owed by me, spouse, and my dependents or otherwise. This instrument shall not be modified or revoked without the mutual consent of PPM&R any myself.
5. **I consent/authorize my Spouse, Legal Guardian and/or (print name) _____ to have full access to my protected health information.**

***PATIENT NAME_____MEDICAL RECORD #_____***
***PATIENT SIGNATURE_____DATE_____***

**********

**I am not a Medicare beneficiary, or I have notified PPM&R that I am one so that I may sign a Medicare Opt-out Contract.**

**Letter Of Direction/Letter of Protection:** **Doctor:**

To: Attorney's Name_____ PPM&R, Matthew Terzella, MD Robert G. Schwartz, MD

Attorney's Address_____317 St. Francis Dr. Ste. 350 Greenville, SC 29601

This document authorizes Piedmont Physical Medicine & Rehabilitation (PPM&R) to furnish you, my attorney, with a full report of my case history, examination, diagnosis, etc. regarding the accident, which occurred on_____ This advises you that I am undergoing treatment at PPM&R for injuries sustained in the accident. You may be calling on them for reports and/or testimony. I authorize and direct you to pay PPM&R out of the proceeds of any settlement or collection made by you for my injuries. I direct you to use this letter as a Letter of Protection for PPM&R. I agree that such LOP cannot be revoked or modified without PPM&R's written consent. DATE: _____

WITNESS: _____PATIENT SIGNATURE: _____ATTORNEY SIGNATURE: _____

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## Consent to Patient Financial Responsibilities

Thank you for choosing Piedmont Physical Medicine & Rehabilitation, PA. We are honored and committed to providing you with the highest quality of healthcare. We ask that you sign this form to acknowledge your understanding of our patient financial policies.

Each patient is required to provide us with the most correct and updated information about their insurance. As a courtesy we will assist you by billing your insurance if we are contracted with them, including workers compensation claims.

*Each patient, however, is still responsible for all charges incurred, even if due to no fault of their own the insurance information provided to us is incorrect or not updated. Each patient (patient's guardian, if a minor) is ultimately responsible for the payment of their treatment and care.*

***Patients are always responsible for ALL copays, coinsurance, and deductible payments*** along with any other procedures or treatments not covered by their insurance plans. ***Payment is due at the time of service.*** As a convenience to you we accept cash, check, and most major credit and debit cards.

Patients may incur and will be responsible for additional non-insurance related charges. These charges are at the discretion of Piedmont Physical Medicine & Rehabilitation and include (but are not limited to): Charges for returned checks, charges for form completion, costs associated with the collection of patient balances.

By signing this form, you are acknowledging that you have been notified of your financial responsibilities and that you both consent and agree to them.

**Patient Signature: _____ Date: _____**

**Witness Signature: _____ Date: _____**

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## Agreement to Self-Pay for Services

By signing this agreement, I agree to self-pay Piedmont Physical Medicine & Rehabilitation, PA for services offered or rendered. I understand that payment for any services, including any portions of them, or the supplies associated with them are my personal responsibility, regardless of any third-party insurance that I may have. I understand and agree that these services, or a portion of them, will not be filed with my insurance.

I further understand that Piedmont Physical Medicine & Rehabilitation, PA has expenses associated with offering and providing services. Since I want to have services made available to me, upon request I agree to prepay for any services offered or provided by Piedmont Physical Medicine & Rehabilitation PA. I further understand that any payment for these services is non-refundable, even if I fail to keep my appointments for them.

I also understand that if I later change my mind and request that services rendered be filed under a third-party payment arrangement (such as private health insurance) then Piedmont Physical Medicine & Rehabilitation, PA is under no obligation to do and in fact may not be able to do so.

If however Piedmont Physical Medicine & Rehabilitation, PA does agree to later file either a portion or all of the services rendered to my third party insurance then I understand that I will be responsible to pay an administrative fee to compensate Piedmont Physical Medicine & Rehabilitation, PA for doing so. I also understand that I may have to make additional payments to Piedmont Physical & Rehabilitation, PA to cover all charges that are either not allowed by my insurance company or are paid at a rate less than Piedmont Physical Medicine & Rehabilitation, PA's charges.

In addition, I understand that any additional payment due Piedmont Physical Medicine & Rehabilitation, PA under the terms of this agreement will have to be made to Piedmont Physical Medicine & Rehabilitation, PA prior to filing my charges with my third-party arrangement.

**Patient Signature: _____Date: _____**

**Witness Signature: _____ Date: _____**

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We here at Piedmont Physical Medicine and Rehabilitation strive for excellence regarding all aspects of care for our patients. Your health and wellness are and will always be our priority.

As you know, the specialty services we offer here are not found at many other offices. We want to continue to be able to provide the care that you have come to expect while you receive treatment with us.

We want to make you aware that many, if not all the insurances we take are now paying less and less for the treatment we offer. We will continue to submit claims to your insurance. However, if they deny your treatment for any reason, you will be responsible for the unpaid amount. This could be anything from denying due to "lack of medical necessity", no authorization on file, service not covered, service is experimental, etc.

As always, we check your benefits beforehand. However, the insurance companies can make their own rules and may pick and choose what they want to pay, not pay, or even take payment back from years past.

We take this very seriously and want to inform you that the quality of care you receive from Piedmont PMR will NOT change regardless of how insurance companies choose to act.

Please, if you have any questions, we will be happy to discuss that with you!

***Please sign below to agree that you have read this notice and will be responsible for any claims denied through no fault of Piedmont Physical Medicine and Rehabilitation.***

_____ _____

***Patient Name*** ***Patient Signature***

_____ _____

***Witness*** ***Date***

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***Matthew Terzella, M.D.***

I _____ am acknowledging that Piedmont Physical Medicine has informed me of the Follow My Health website. I have been made aware of the fact that I can go on this site and access my medical records from Piedmont Physical Medicine.

**Signature : _____Date :_____**

***www.followmyhealth.com***

Piedmont Physical Medicine and Rehabilitation's goal is to provide excellent care for each patient. If it is necessary to cancel an appointment, patients are required to call or leave a message at least 24 hours before their appointment time. Notification allows the practice to better utilize appointments for other patients. **If notification is not received, or you "no show" you will accrue a charge of $50.00**.

"**No Show"** shall mean any patient who fails to arrive for a scheduled appointment.

**"Same Day Cancellation"** shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment.

**"Late Arrival"** shall mean any patient who arrives at the clinic 15 minutes after the expected arrival time for the scheduled appointment. You may or may not be worked back into the schedule.

**Patient Signature: _____Date: _____**

**Witness Signature: _____ Date: _____**

# PIEDMONT PHYSICAL MEDICINE & REHABILITATION, P.A.

Specializing in:
- Complex, Chronic Pain
- Non-Surgical Specialty Care
- Vascular Medicine

317 St. Francis Drive • Suite 350 • Greenville, SC 29601-3988 • Tel: (864) 235-1834 • Fax: (864) 235-2486

**Robert G. Schwartz, M.D.** **Matthew Terzella, MD**


**NAME:** _____ **AGE:** _____

**HISTORY OF PRESENT ILLNESS:**

1. WHERE DO YOU HURT? _____

   _____

2. HOW WOULD YOU DESCRIBE THE PAIN (SHARP, SHOOTING, DULL, ACHY, CRAMPING, ETC.?) _____

   _____

3. WHAT DATE DID IT START? (COMPLETE EVEN IF PAIN IS NOT YOUR PRIMARY COMPLAINT)

   _____

4. WHAT CAUSED IT TO START (CAR WRECK, WORK INJURY, SPORTS INJURY, DON'T KNOW, ETC.?) _____

   _____

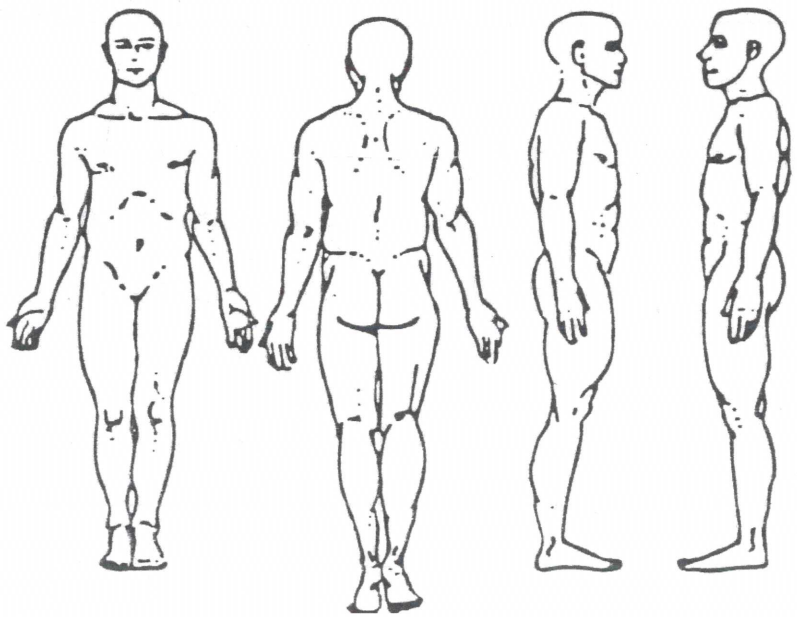
5. IF YOU WERE IN A CAR WRECK: (A) WERE YOU THE DRIVER OR PASSENGER? _____

   (B) DID YOU HAVE ON A SEATBELT? _____ ( C) HOW FAST WERE BOTH CARS TRAVELING? _____

   (D) HOW MUCH VISIBLE DAMAGE WAS THERE TO YOUR CAR? _____

   (E) WHAT DID IT COST TO FIX THE CAR? _____

6. PLEASE MARK ON THE DRAWINGS BELOW THE AREAS WHERE YOU FEEL PAIN.



**B.** 1. DO YOU HAVE ANY WEAKNESS IN PARTS OF YOUR BODY?_____ WHERE?_____

_____

2. DO YOU HAVE ANY NUMBNESS (pins & needles or cold feelings) IN PARTS OF YOUR BODY? _____
WHERE? _____

3. PLEASE CHECK WHICH OF THESE SYMPTOMS, IF ANY, YOU HAVE NOTICED ASSOCIATED WITH YOUR PAIN:

| | | | |
|---|---|---|---|
| _____ | EARS RINGING | _____ | HOT/COLD SENSATIONS |
| _____ | BLURRED VISION | _____ | OVERLY SENSITIVE SKIN |
| _____ | TROUBLE SWALLOWING | _____ | CONGESTION |
| _____ | CHRONIC FATIGUE | _____ | TROUBLE SLEEPING |
| _____ | TIGHTNESS | _____ | LIMB SWELLING |
| _____ | BALANCE PROBLEMS | _____ | OTHER _____ |

4. DO YOU HAVE ANY PROBLEM WITH LOSS OF BOWEL OR BLADDER CONTROL? _____

_____

5. HAVE YOU EVER HAD A PAIN IN THE PAST IN THE SAME PART OF YOUR BODY?_____

_____

6. DOES YOUR PAIN INCREASE IF YOU COUGH OR SNEEZE?_____

7. DOES THE WEATHER OR TEMPERATURE AFFECT YOUR PAIN?_____

8. DO YOU ALWAYS HAVE COLD HANDS OR FEET?_____

**C.** 1. WHAT MAKES THE PAIN BETTER? _____

_____

2. WHAT MAKES IT WORSE? _____

_____

3. HOW MANY MINUTES CAN YOU SIT UNTIL YOU MUST STAND? _____

4. HOW MANY MINUTES CAN YOU STAND UNTIL YOU MUST SIT? _____

**D.** MARK ON THE LINE BELOW YOUR ESTIMATE OF YOUR AVERAGE PAIN:

**0** _____ **10**

**E.** 1. PLEASE NAME ANY DOCTORS YOU HAVE SEEN FOR YOUR PAIN SO FAR. _____

_____

2. WHAT TEST HAVE THEY DONE (BLOOD TEST, X-RAYS, CT SCANS, BONESCAN, MYELOGRAM, EMG, MRI)?

_____

3. WHERE WERE THESE TEST DONE? _____

_____

4. WERE ANY OF THEM ABNORMAL? _____ IN WHAT WAY? _____

_____

5. HAVE YOU EVER HAD FREQUENT OR SEVERE INFECTIONS? _____

6. DO YOU HAVE A PERSONAL OR FAMILY HISTORY OF ANY BLEEDING, BRUISING OR CLOTTING DISORDERS?

_____

7. HAVE YOU HAD ANY UNUSUAL ENVIRONMENTAL EXPOSURES? _____

8. HAVE YOU EVER TAKEN AN MMPI? _____

**F.** 1. WHAT MEDICINE HAVE YOU TAKEN FOR THE PAIN IN THE PAST? _____

_____

2. WHAT PAIN MEDICINES ARE YOU TAKING NOW?

| NAME | DOSAGE | FREQUENCY | DATE STARTED |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

3. HAVE YOU EVER HAD ANY SURGERY FOR YOUR PAIN? _____ WHAT KIND? _____

_____

4. WHAT OTHER KIND OF TREATMENT (PHYSICAL THERAPY, CHIROPRACTIC, HYPNOSIS, INJECTIONS, ETC. ) HAVE YOU TRIED FOR YOUR PAIN? _____

_____

## G. PAST MEDICAL HISTORY:

1. DO YOU HAVE DIABETES, HIGH BLOOD PRESSURE, CARDIOVASCULAR DISEASE, STOMACH ULCERS OR OTHER MEDICAL PROBLEMS? _____

2. ARE YOU TAKING ANY MEDICINES? _____ WHICH ONES? _____

_____

3. WHAT SUPPLEMENTS IF ANY, DO YOU TAKE? _____

4. WHO IS YOUR PRIMARY CARE PROVIDER? _____

5. ARE YOU ALLERGIC TO ANY MEDICINES? YES / NO WHICH ONES AND WHAT HAPPENS? _____

_____

6. HAVE YOU EVER HAD SURGERY OF ANY KIND? _____ FOR WHAT? _____

_____

7. HAVE YOU EVER HAD A FRACTURED BONE? _____ WHERE? _____

_____

8. ARE YOU RIGHT OR LEFT HANDED? _____

## H. REVIEW OF SYSTEMS:

1. CONSTITUTIONAL: ANY RECENT OR UNUSUAL WEIGHT LOSS? _____

2. HEENT: ANY DIFFICULTY WITH VISION OR HEARING? _____

3. CARDIOVASCULAR: ANY CHEST PAIN OR PALPITATIONS? _____

4. RESPIRATORY: ANY CURRENT OR RECENT INFECTION? _____

5. HEMATOLOGIC: IS THERE ANY UNUSUAL BLEEDING OR ANEMIA? _____

6. GI: ANY UNUSUAL CONSTIPATION OR DIARRHEA? _____

7. GU: ANY FREQUENCY OR URGENCY OR URINATION? _____

8. SKIN: ANY OPEN SORES? _____

9. NEUROLOGICAL: ANY DOUBLE VISION OR TROUBLE SWALLOWING? _____

10. PSYCHIATRIC: ANY CONFUSION ON THE DATE, YOUR NAME OR WHERE YOU ARE? _____

## I. FUNCTIONAL HISTORY:

1. CAN YOU FEED, BATHE AND DRESS YOURSELF? _____

2. DO YOU NEED ADAPTIVE AIDS (BRACES, ETC.) TO WALK? _____

3. RATE YOUR FUNCTIONAL INDEPENDENCE. 0 _____ 5 _____ 10

Totally Dependent — Wheelchair Independent — Complete Indepedence

## J. FAMILY HISTORY (IF ANY LINE IS AFFIRMATIVE PLEASE INDICATE WHICH FAMILY MEMBER):

1. HAVE ANY OF YOUR BLOOD RELATIVES HAD ARTHRITIS? _____

2. HAVE ANY OF YOUR BLOOD RELATIVES HAD CANCER? _____

3. HAVE ANY OF YOUR BLOOD RELATIVES HAD HEART OR VASCULAR DISEASE? _____

## K. SOCIAL HISTORY

1. ARE YOU MARRIED? _____
2. HOW MANY CHILDREN DO YOU HAVE? _____
3. WHAT ARE THEIR AGES? _____
4. DO YOU DRINK ALCOHOL? _____ HOW MUCH? _____
5. DO YOU SMOKE CIGARETTES? _____ HOW MANY? _____
6. ARE YOU PRESENTLY WORKING? _____ FOR WHOM? _____
7. IF YOU WERE INJURED AT WORK, WHERE DID YOU WORK AT THE TIME? _____
8. HOW LONG HAVE YOU BEEN EMPLOYED BY THE PLACE OF EMPLOYMENT WHERE YOU WERE INJURED?

   _____
9. WHAT IS YOUR JOB? _____
10. WHEN DID YOU LAST WORK? _____
11. WHAT LEVEL OF EDUCATION HAVE YOU COMPLETED? _____
12. WHAT IS THE OCCUPATION OF YOUR SPOUSE? _____
13. ARE YOU INVOLVED IN A LAW SUIT BECAUSE OF YOUR PAIN? _____
14. WHAT IS YOUR ATTORNEY'S NAME AND ADDRESS? _____

    _____

1. DO YOU REQUIRE A FEMALE STAFF MEMBER AS A CHAPERONE WITH YOU IN THE EXAM ROOM DURING EACH VISIT? ☐NO ☐YES
2. ON OCCASION THERE MAY BE A VISITING PHYSICIAN PRESENT WITH THE DOCTOR DURING VISITS. DO YOU HAVE ANY OBJECTION TO THIS? ☐ NO ☐ YES

_____ _____

PATIENT'S SIGNATURE
(GUARDIAN SIGNATURE IF PATIENT IS A MINOR)

DATE

_____

RELATIONSHIP IF OTHER THAN PATIENT

## PATIENT INFORMATION FORM

Patient Name: _____
First Middle Initial Last

Social Security Number: _____ - _____ - _____ Phone: (Home) _____
(Cell) _____

Can we leave you a detailed message on your voice mail? Yes ❑ No ❑ Initials_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

E-Mail Address: _____

Date of Birth: _____ Age: _____ Sex: M ❑ or F ❑ Student: Full ❑ Part time ❑

Marital Status: M S W D Employment Status: Full ❑ Part ❑ Unemployed Self Retired ❑

Patient's Employer: _____ Work Number: _____

Employer' s Address: _____

City: _____ State: _____ Zip Code: _____

Spouse/Guardian's Name: _____ Date of Birth: _____

Spouse/Guardian's Social Security Number: _____- _____ - _____

Spouse/Guardian's Employer: _____ Work Number:_____

### EMERGENCY CONTACT NOT LIVING WITH YOU

Name: _____ Phone Number: _____

WHO MAY WE THANK FOR THIS REFERRAL: _____

---

### INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company: _____

If you have Medicare or Government Sponsored Insurance then please make advance arrangements as we do not accept Government Sponsored Insurance.

I hereby assign all financial benefits available to me under my insurance for medical and related services to PPM & R. In connection with this assignment, I authorize and direct all insurance carriers, attorneys, individuals and legal entities ("payers") which may be obligated to pay or distribute benefits to me for any medical conditions, injuries or illnesses, to pay directly in the name of PPM & R such sums as may be owed for services rendered and for PPM & R to endorse/sign my name on any checks listing me as a payee which are presented.

Patient's Signature: _____ Date: _____

---

**IF YOUR INJURY WAS A RESULT OF AN ACCIDENT THEN PLEASE COMPLETE PAGE TWO**

## ACCIDENT INFORMATION FORM

**Please complete this section if your injury is JOB RELATED:**

Date of Injury: _____

Employer's Address: _____ City: _____ State: _____

Name of Contact Person: _____ Phone Number: _____

Name of Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Claim Number: _____

Please give a brief description of how you were injured: _____

_____

---

**Please complete this section if your injury is related to an AUTOMOBILE ACCIDENT:**

Name of Person Who Hit You: _____

Name of Policy Holder: _____

Name of Insurance Company: _____

Name of Adjuster: _____ Phone Number: _____

Policy Number: _____ Claim Number: _____

Does your Insurance Company have Medpay/PIP Benefits? Yes or No

If yes, what is the limit of coverage: _____

Name of Policy Holder for Your Insurance: _____

Name of Insurance Company: _____

Name of Adjuster: _____ Phone Number: _____

Policy Number: _____ Claim Number: _____

---

## ATTORNEY INFORMATION

Name of Attorney: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

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