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

Carol W. Burnette, MD
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** ☐ **Carol W. Burnette, MD**

Greenville Office: ____/____/____ at _____ with: ☐ **Eric P. Loudermilk, MD** ☐ **Michael T. Grier, MD** ☐ **Sung J. Han, MD** ☐ **Carol W. Burnette, 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

Carol W. Burnette, MD

Sung J. Han, 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, orthopaedic 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. **Not all patients undergo 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 even antiarrhythmic 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 $35.00 to $200.00.** Our time is valuable and other patients can be seen in your time slot if we have proper notice. 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 call in any prescriptions to your pharmacy.** Please obtain all written prescriptions during your appointment. There will be a **$10.00** charge for any prescriptions requested between appointments. You will be required to pick up the prescription at the front desk. 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. 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 written until this information is provided. If you change pharmacies, doctors, or insurance, it is your responsibility to notify our office staff.

Mail order pharmacy patients: Please be advised that we will write your prescriptions for you, however, we cannot call, write, or fax to these companies, as we do not have the office staff sufficient to accommodate the time and effort involved.

At times, you may be required to leave a message for the nurse. Any messages left after 4:00 PM will be returned the following day. 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 864-225-3551in Anderson and 864-269-4416 in Greenville.

Sincerely,

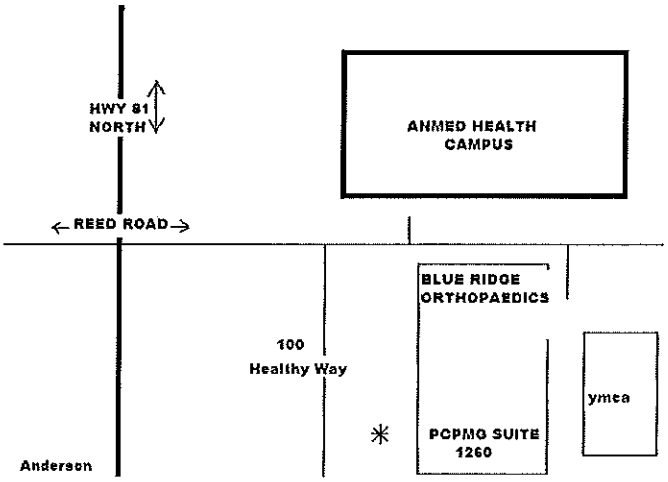
Brenda K. Grigsby

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
-PCPMG is the last office, Suite 1260
-Same Entrance as Carolina Cardiology

From Downtown Anderson:

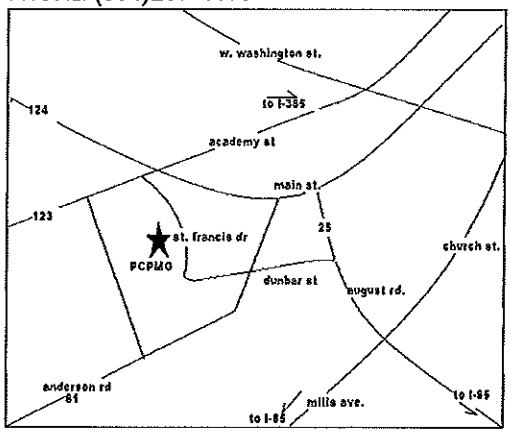
-Take E. Greenville St. from Main St.
-Pass the Anmed Medical Center (old hospital)
-Continue for 2.6 miles
-Turn right on Reed Rd. at the intersection of Anmed Health Campus and Shell
-PCPMG is the last office, Suite 1260
-Same Entrance as Carolina Cardiology

From Clemson Blvd in Anderson:

-From the Anderson Mall go southeast toward down town 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

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 (Out Patient 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 (Out Patient 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 **St. Francis Dr.** (See blue sign with St. Francis Emergency Room Arrow)
-Entrance to parking for 3 St. Francis Drive (Out Patient Building) is on **RIGHT.**

Initial Pain Assessment

Name: _____ Date: _____

Address: _____

_____

SSN: _____

Date of Birth: _____ Age: _____ Sex: _____

Home Phone Number: _____

Work Phone Number: _____

Cell Phone Number: _____

Marital Status:( )Single ( )Married ( )Divorced ( )Separated ( )Widowed

Emergency Contact: Name: _____

Phone Number: _____

Education: _____ Occupation: _____

Referring Physician: _____

Primary Care Physician: _____

Diagnosis: _____

Relatives treated by PCPMG: _____

_____

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

Angina	Diabetes	Psychiatric Problems
Arthritis	Hepatitis	Stroke
Bleeding Disorders	Hypertension	Ulcers
Cancer	Kidney Problems	Other:_____
Cardiac Abnormalities	Lung Disease	

Previous Surgeries:

Date:	Hospital:	Procedure:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Diagnostic Studies Performed:

	Date:	Location:
X-Rays-	_____	_____
MRI-	_____	_____
Myelogram-	_____	_____
CT Scan-	_____	_____
EMG/NCV-	_____	_____

Previous Pain Treatments: Please indicate below any previous treatments

Type of Treatment	Yes	No	If yes, approximate dates received
Physical Therapy			
Massage			
Heat/Cold			
TENS Unit			
Nerve Blocks/Steroid Injections			
Spinal Cord Stimulator Implant			
Infusion Pump			
Hospitalization for pain control			
Emergency room visits 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 Anesthesiologist Cardiologist Chiropractor Dentist Dermatologist Neurologist

Neurosurgeon Ophthalmologist Orthopedic Surgeon ENT Endocrinologist Primary Care Physician

General Surgeon Gynecologist Hypnotist Psychiatrist/Psychologist Radiologist

UNIVERSAL MEDICATION FORM

Fold this form and keep it in your wallet Date form started:

Name:	Address:
Phone Number:	
Birth Date:	
Emergency Contact/Phone numbers:	

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

Medication History: Please indicate if you are currently taking or have EVER taken any of the following medications (circle). *Please ask the nurse if you have any questions.*

Anacin
Ascriptin
Buferrin
Empirin
Exedrin
Norgesic
Parafon Forte
Phenaphen
Tylenol (acetaminophen)

Codeine
Darvocet
Darvon
Equagesic
Fiorinal
Fioricet
Methadone
Percodan
Talwin
Lortab (hydrocodone)
Vicodin
Demerol
Dilaudid
Heroin
Mepergan
Morphine
Duragesic (Fentanyl)
Oxycodone
Oxycontin
Percocet
Benadryl
Periactin
Placidyl
Quaalude

Benzadrine
Dexedrine
Ritalin
Adderall

Ergotrate
Metergine

Sansert
Caffergot
Imitrex

Atarax
Flexeril (cyclobenzaprine)
Librium
Miltown
Robaxin
Serax
Tranxene
Valium
Vistaril
Klonipin
Soma
Baclofen
Dalmane
Restoril
Ambien
Amytal
Xanax
Nembutal
Phenobarbital
Seconal

Elavil (amitriptyline)
Nardil
Parnate
Sinequan
Tofranil
Triavil
Vivactyl
Paxil
Zoloft
Effexor
Trazadone
Doxepin
Hashish
LSD
Marijuana
Compazine
Marinol

Haldol
Mellaril
Phenergan (promethazine)
Prolixin
Stellazine
Thorazine
Trilafon

Dilantin
Tegretal
Valproic Acid
Gabapentin (Neurontin)
Cortisone
Dexamethasone
Hydrocortisone
Indocin
Butazolidin
Prednisone
Medrol Dose Pak
Relafen
Daypro
Orudis
Oruvail
Lodine
Naproxyn
Naprosyn
Aleve
Anaprox
Advil
Ibuprofen
Clinoril
Mobic (meloxicam)
Arthrotec
Celebrex (celecoxib)
Vioxx (rofecoxib)
Feldene
Ultram (tramadol)
Ultracet
Zipsor
Zanaflex
Mexitil
Zostrix

Personal History Questionnaire:

Please review the following list and check any symptoms which you have experienced:

- ☐Fatigue
- ☐Insomnia
- ☐Numbness
- ☐Nausea
- ☐Vomiting
- ☐Difficulty falling or staying asleep
- ☐Sexual difficulties
- ☐Thoughts of suicide
- ☐Changes in appetite
- ☐Weight loss
- ☐Weight gain
- ☐Swelling in armpits or groin
- ☐Seizures or convulsions
- ☐Headaches more than 1/week
- ☐Heartburn
- ☐Discomfort in the pit of your stomach
- ☐Frequent urination
- ☐Burning or painful urination
- ☐Difficulty starting urine flow
- ☐Bowel problems
- ☐Stiff or painful muscles or joints
- ☐Swollen joints
- ☐Pain in the back
- ☐Pain in the shoulders
- ☐Pain when twisting your neck quickly
- ☐Changes in your level of concentration

Social History:

1. Job Description (heavy lifting or physical exertion involved?):_____
   _____
2. Are you currently working? Y / N , Number of years worked? _____
3. Have you been off work previously for a similar problem? Y / N

   If yes above, did you return to work following your injury? Y / N
4. Are you receiving workers' compensation? Y / N , Disability income? Y / N
5. Do you smoke? Y / N If yes, how much do you smoke a day? _____
6. Do you drink alcohol? Y / N If yes, how many drinks do you drink per week? _____
7. Do you use marijuana? Y / N
8. Do you regularly use sleeping pills, tranquilizers, or painkillers? Y / N
   If yes above, what type? _____
9. Have you ever sought psychiatric help (if so, who and when)? _____

Pain Questionnaire:

1. Where is your pain? _____

2. When did your pain begin? _____

3. Have you had similar problems in the past (if yes, when)? _____

_____

4. What do you think is the cause of your pain? _____

5. Is the pain related to an on-the-job injury (if yes, date of injury)? _____

_____

6. Describe the quality of your pain (aching, burning, throbbing, stabbing, sharp, etc.)_____

7. Does your pain occur in separate attacks or episodes and how long does each episode tend to last?_____

8. Is the pain worse in the morning or evening? _____

9. What relieves your pain? _____

10. What causes or increases your pain? _____

11. Is any part of your body numb (if yes, which part)? _____

12. Do you exercise more than 3 times per week? _____

13. What effect has your pain had on your activity level? _____

14. Has your pain affected your relationship with friends or family? _____

15. How has your pain affected your emotions? _____

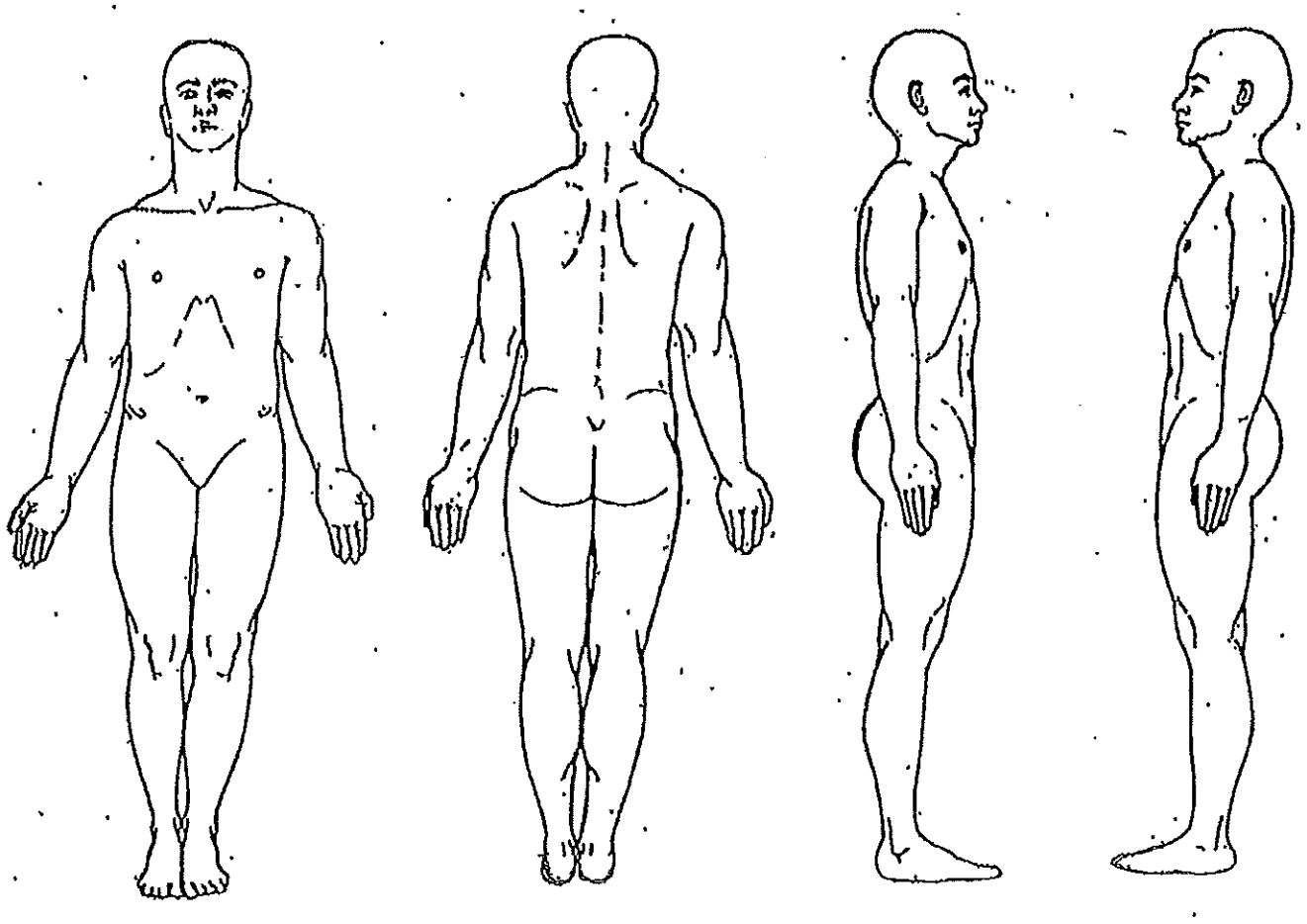
16. What do you want from your pain treatment? Be Specific:_____

_____

17. What do you expect from your pain treatment? Be Specific:_____

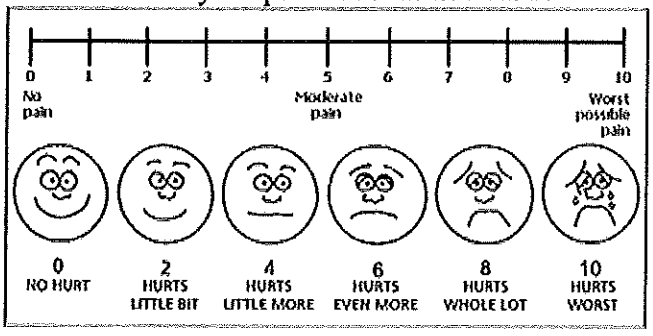
_____

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

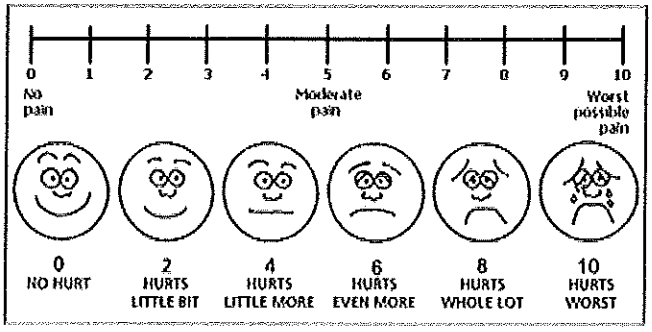


Your Pain Level:

Please rate your pain level at its BEST:



And at its WORST:



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 insure 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: _____

Piedmont Comprehensive Pain Management Group, LLC

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Ph (864) 225-3551 • Fax (864) 328-0328
Greenville Office: 3 St. Francis Drive, Suite 480, Greenville, SC 29601
Ph (864) 269-4416 • Fax (864) 269-8989

Eric P. Loudermilk, MD • Michael T. Grier, MD • Carol W. Burnette, MD • Sung J. Han, 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:

_____
Name of Practice

_____
Street Address

_____
City, State, Zip Code

_____ _____
Phone Number Fax Number

Records to be sent/released to:

Anderson Office
100 Healthy Way, Suite 1260
Anderson, SC 29621
Phone: 864-225-3551
Fax: 864-328-0328

Greenville Office
3 St. Francis Drive, Suite 480
Greenville, SC 29601
Phone: 864-269-4416
Fax: 864-269-8989

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

_____ _____
Witness **Date**

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 per your Doctor's discretion.

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 **$35.00** 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. Please obtain all written prescriptions during your appointment.

There will be a **$10.00** charge for any prescriptions requested between appointments. You will be required to pick up the prescription at the front desk.

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.

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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Consent for Purpose of Treatment, Payment and Healthcare Operations

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 we can speak to:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

PCPMG
Piedmont Comprehensive
Pain Management Group, LLC

Piedmont Comprehensive Pain Management Group, LLC

100 Healthy Way, Suite 1260, Anderson, SC 29621 • (T) 864-225-3551 • (F) 864-328-0328
3 St. Francis Drive, Suite 480, Greenville, SC 29601 • (T) 864-269-4416 • (F) 864-269-8989

Patient Information:

Date:_____

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

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")

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: _____