HAL S. BLATMAN, M.D.
10653 TECHWOODS CIRCLE, SUITE 101
CINCINNATI, OHIO 45242
513-956-3200

Directions to our office:

75 Southbound:

75 South to 275 East
Exit onto Reed Hartman Highway (3 exits) turn right
At the 5th or 6th light turn left onto Creek Road.
Right on Techwoods Circle (first street)
Turn into the 4th driveway on the right
Take an immediate left and park in designated area

75 Northbound:

75 North to Ronald Reagan/Cross County Highway East
Exit onto Plainfield Rd./Reed Hartman Highway, turn left and follow about a mile
Turn right onto Creek Road
Turn right at Techwood Circle
Turn into the 4th driveway on the right
Take an immediate left and park in designated area

71 Southbound:

Exit Pfeiffer Road
Right at the light onto Pfeiffer Road
Turn right onto Kenwood Road (Sunoco Station on corner)
At light make a left onto Creek Road
Left onto Techwoods Circle
Turn left into 3rd driveway, which is after Candlewood Hotel
Take an immediate left and park in designated area

71 Northbound:

Exit Pfeiffer Road
Left at the light onto Pfeiffer Road
Right onto Kenwood Road (Sunoco Station on corner)
At light make a left onto Creek Road
Left onto Techwoods Circle
Turn left into 3rd driveway, which is after Candlewood Hotel
Take and immediate left and park in designated area

CHECK LIST OF ITEMS TO **MAIL** BACK **PRIOR** TO YOUR VISIT

☐ FINANCIAL POLICY	SIGN AND DATE ON BACK
☐ PATIENT INFORMATION RECORD	COMPLETED BOTH SIDES
☐ CURRENT MEDICAL HISTORY	COMPLETED
☐ INITIAL PAIN ASSESSMENT TOOL	COMPLETED
☐ ZUNG SELF-RATED DEPRESSION SCALE	COMPLETED
☐ TIPS ON TALKING ABOUT PAIN	COMPLETED
☐ PATIENT CONSENT FORM	COMPLETED
☐ ARBITRATION AGREEMENT	COMPLETED
☐ PRIVACY POLICY	SIGN AND DATE

PATIENT INFORMATION RECORD
PLEASE PRINT LEGIBLY

DATE OF INJURY OR DATE SYMPTOMS STARTED: _____ DATE TODAY: _____

PATIENT FIRST NAME MIDDLE INITIAL	LAST NAME	SINGLE	WIDOWED
		MARRIED	DIVORCED
STREET ADDRESS	CITY, STATE, ZIP CODE	TELEPHONE NUMBER ( ) dfdd	
BIRTHDATE AGE	PATIENT'S SOCIAL SECURITY NUMBER	PATIENT'S CELL NUMBER ( )	
LIST ANY OTHER NAME YOU HAVE USED	OCCUPATION	PHARMACY NUMBER ( )	
EMPLOYER	ADDRESS, CITY, STATE, ZIP CODE	EMAIL ADDRESS	
NAME OF INSURANCE SUBSCRIBER	BIRTHDATE	OCCUPATION	
EMPLOYER	ADDRESS, CITY, STATE, ZIP CODE	EMPLOYER TELEPHONE **EXT** ( )	

IF PATIENT IS A MINOR OR STUDENT:

FATHER'S NAME BIRTHDATE	ADDRESS, CITY, STATE, ZIP CODE	TELEPHONE NUMBER ( )
EMPLOYER	ADDRESS, CITY, STATE, ZIP CODE	TELEPHONE NUMBER ( )
MOTHER'S NAME BIRTHDATE	ADDRESS, CITY, STATE, ZIP CODE	TELEPHONE NUMBER ( )
EMPLOYER	ADDRESS, CITY, STATE, ZIP CODE	TELEPHONE NUMBER ( )

INSURANCE INFORMATION
MUST BE FILLED OUT COMPLETELY

PRIMARY INSURANCE _____ PHONE NUMBER _(_____)_____

SUBSCRIBER NAME _____ EFFECTIVE DATE: _____

MEMBER NUMBER _____ GROUP NUMBER _____

WORKERS COMPENSATION CL# _____ MCO NAME _____

CLAIMS REPRESENTATIVE _____ MCO PHONE NUMBER _____

EMPLOYER AT DATE OF INJURY _____ DATE OF INJURY _____

PLEASE INTITIAL TO VERIFY ALL THE INFORMATION ABOVE IS CORRECT _____

OVER PLEASE

ADDITIONAL INFORMATION

FAMILY PHYSICIAN _____ REFERRING PHYSICIAN _____

STREET ADDRESS _____ STREET ADDRESS _____

CITY, STATE, ZIP _____ CITY, STATE, ZIP _____

TELEPHONE __(_____)_____ TELEPHONE __(_____)_____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP TO YOU: _____

STREET ADDRESS: _____ TELEPHONE: _(_____)_____

CITY, STATE, ZIP CODE: _____

OK TO RELEASE MEDICAL OR FINANCIAL INFORMATION TO THIS PERSON? YES

THE OFFICE OF HAL S. BLATMAN, M.D., INC WILL PROCESS YOUR PRIMARY INSURANCE CLAIM AS A COURTESY TO YOU, HOWEVER, THE GUARANTOR IS FULLY RESPONSIBLE FOR ALL CHARGES REGUARDLESS OF INSURANCE COVERAGE.

ASSIGNMENT OF INSURANCE BENEFITS:

I HEREBY AUTHORIZE ALL PAYMENTS MADE BY THE INSURANCE COMPANY TO BE PAID DIRECTLY TO HAL S. BLATMAN, M.D., INC.

PATIENT SIGNATURE: _____ DATE: _____

PARENT SIGNATURE: (IF MINOR) _____ DATE: _____.

WHO IS RESPONSIBLE FOR PATIENT'S MEDICAL EXPENSES

☐ PARENT ☐ SELF

dfdfd

NAME GUARANTOR_____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

GUARANTOR SIGNATURE: _____ DATE: _____

BLATMAN HEALTH AND WELLNESS CENTER

10653 Techwoods Circle
Suite 101
Cincinnati, OH 45242
513-956-3200 fax 513-956-3202
www.blatmanhealthandwellness.com

Office Hours are 8:00AM to 5:00PM, Monday through Thursday
Our office is closed Friday, Saturday and Sunday

FINANCIAL POLICY

We welcome you to our office, and we are pleased to have this opportunity to help you as a patient. We are providing this information to help you understand how our business office operates, and to acquaint you with the policies of our practice.

We are committed to providing you with the best possible care, and we are always willing to discuss our professional fees with you. Your clear understanding of our financial policy is important to our professional relationship. If you have any questions about our fees, financial policies, or your financial responsibility, please call our financial coordinator.

PAYMENT METHODS

We accept cash, money orders, Visa, MasterCard, Discover, and American Express.

INSURANCE

We are not a participant in any insurance plans. Most insurance company networks do not cover our treatment completely. It is your responsibility to contact your insurance company prior to your office visit. Payment for services in full is due at the time services are rendered. If you would like, we will file a claim with your insurance company. You must realize however, that your insurance company is a contract between you, your employer and the insurance company. We are not a party to that contract. Again, we urge you to check with your company before your first visit.

We must emphasize that, as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

OVER PLEASE

APPOINTMENTS

We schedule 2 hours for a new patient visit. If you cancel your new patient office visit, you must let us know at least 48 hours in advance of your appointment, or you will be charged $100.00. As an established patient, if you are unable to keep your scheduled appointment, please contact our office at least 24 hours in advance. This courtesy allows us to be of service to other patients. You will be charged a $65.00 no show fee if you cancel less than 24 hours prior to your scheduled time and this charge must be paid prior to your next office visit.

Furthermore, if your account does fall behind and we are forced to send it to a collection agency, you will be further charged a $20.00 fee as well as any other fees associated with the collecting of the money owed. These rates are all subject to change without notice.

CURRENT BALANCES ON PATIENT ACCOUNTS

In an effort to help you manage your account balance, any balance that reaches 30-60 days past due will be expected in full prior to rescheduling.

MEDICARE/MEDICAID

We have had to "opt-out" of Medicare/Medicaid. We **CANNOT** bill Medicare, and patients **CANNOT** bill Medicare for reimbursement of our services. Please contact our patient care coordinator to review your situation.

ATTORNEY/ACCIDENT CASES/INSURANCE REPORTS/DISABILTIY FORMS

Request for information to be sent to your attorney or insurance carrier must come as a written request for information with your signed authorization to release this information. Disability forms require a $75.00 payment for the first form, $35.00 for additional forms. There will be fees for all narrative reports and letters, including BWC, the cost will depend on what is needed. In general, these will be completed within 7 to 10 business days of receipt.

CONFIDENTIALITY

Your medical records are strictly private and confidential. No information from your chart will be given to family members, your employer, your attorney or other doctors without your written permission. Worker's Compensation patients have already signed a release for medical records in order to be seen by the Ohio BWC. Please see our Privacy Policy for additional information.

I have read the financial policy of the Blatman Pain Clinic and agree.

_____

Patient Date

Zung Self-Rating Depression Scale (SDS)

Reply to questions using one of the four replies below (A – D)
A – Little or none of the time
B – Some of the time
C – A large part of the time
D – Most or all of the time

	A Little or none of the time	B some of the time	C A large part of the time	D Most of the time	
1. I feel downhearted and blue	1	2	3	4	☐
2. Morning is when I feel the best	4	3	2	1	☐
3. I have crying spells or feel like it	1	2	3	4	☐
4. I have trouble sleeping at night	1	2	3	4	☐
5. I eat as much as I used to	4	3	2	1	☐
6. I still enjoy sex	4	3	2	1	☐
7. I notice that I am losing weight	1	2	3	4	☐
8. I have trouble with constipation	1	2	3	4	☐
9. My heart beats faster than usual	1	2	3	4	☐
10. I get tired for no reason	1	2	3	4	☐
11. My mind is as clear as it used to be	4	3	2	1	☐
12. I find it easy to do the things I used to do	4	3	2	1	☐
13. I am restless and can't keep still	1	2	3	4	☐
14. I feel hopeful about the future	4	3	2	1	☐
15. I am more irritable than usual	1	2	3	4	☐
16. I find it easy to make decisions	4	3	2	1	☐
17. I feel that I am useful and needed	4	3	2	1	☐
18. My life is pretty full	4	3	2	1	☐
19. I feel others would be better off if I was dead	1	2	3	4	☐
20. I still enjoy the things that I used to	4	3	2	1	☐

Some questions ask the information positively and others negatively but in all cases the **symptom severity is Scored from 1 to 4. The total score is often converted to a 100 point scale (SDS index)**
SDS Index = (score / 80 total points) x 100 or SDS Index = score x 1.25

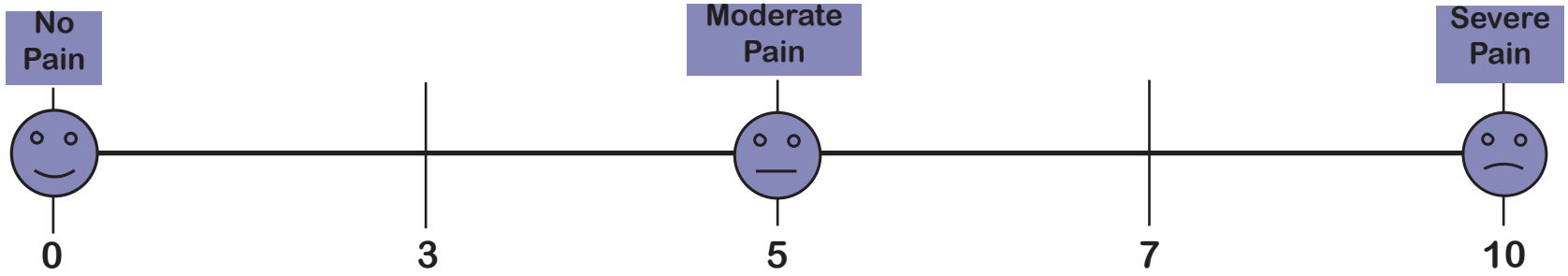
Total SDS raw score	

SDS Index (score x 1.25)	

PAIN SCALE

BLATMAN
HEALTH AND WELLNESS CENTER

0 = No Pain
1 = You are slightly uncomfortable. Occasional minor twinges. No medicine needed.
2 = Pain is a minor bother. No medicine needed.
3 = Pain is annoying enough to be distracting. Mild painkillers like Aspirin or Tylenol help.
4 = Pain can be ignored if you are really involved; it is still distracting. Mild painkillers help for 3-4 hours.
5 = Pain can't be ignored for more than 30 minutes. Mild painkillers help for 3-4 hours.
6 = Pain can't be ignored, but you can still work. Stronger narcotic painkillers help for 3-4 hours.
7 = It is hard to concentrate. Pain bothers sleep. You can still function. Pain-killers only help some.
8 = Your activity is limited a lot. You can read and talk with effort. Nausea and dizziness are part of the pain.
9 = You are unable to speak. You are crying out or moaning.
10 = You are unconscious. Pain makes you pass out.



Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for health care patients take effect. H.I.P.P.A., the Health Insurance Portability and Protection Act requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is safe.

We request that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Signature of Patient or Representative: _____ **Date** _____

Name of Patient or Representative: _____**Date of Birth** _____

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results released to family members you must sign this form. Signing this form will only give consent to release laboratory and radiology results to the family members indicated below. This consent form will not allow us to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Blatman Pain Clinic to release my laboratory/radiology results and reports to the following individuals.

1. _____ Relation to Patient: _____ Date:_____

2. _____ Relation to Patient: _____

PATIENT NAME: _____**PATIENT SIGNATURE :** _____

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for us to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask a patient to call regarding an issue or concern. At no time will a representative discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name:_____

Patient Signature:_____ **Date:**_____