Cleveland Medical Institute
David A. Demangone, M.D.

6025 Commerce Circle, #2
Willoughby, OH 44094
(440) 944-1414 Fax: (440) 944-1445

Willoughby Office – 6025 Commerce Circle, #2

Dear Patient:_____

We have set aside an appointment for you on _____ at _____
For your pain management evaluation. In the event that you must cancel or reschedule this appointment, please notify the office **at least 24 hours in advance**. **Please fill out the enclosed pain evaluation forms, front and back, and bring them in with you at the time of your visit, as they will need to be completed before you are seen by the doctor, to help him understand your problem**. If you have undergone MRI evaluations of your spine, please obtain these films and reports, and bring them in for the doctor to evaluate. We look forward to seeing you.

***** **Please Bring In Your Insurance Cards and Photo ID** *****
***** **Co-Pays are to be Paid Upon Arrival** *****

Directions:
From the East: Via Rte. 90: Take Rte. 90 West, passing the Rte 306 exit, and get off at the Rte. 91 exit. On the exit ramp, get into the right lane at the light, and make a right onto Rte. 91 North, and stay in the right lane. Make a right at the next light: turning onto Maple Grove (right after Eat and Park). Go to the bottom paragraph.

Via Rte. 2: Take Rte. 2 west, and get off at Rte. 91 exit. Get into the left lane at the light and make a left onto Rte. 91 South, and stay in the left lane. Go straight through multiple lights, crossing Rte. 20, and then Rte. 84. Make a left at the next light, turning onto Maple Grove (at CVS). Go to bottom paragraph.

From the West: Via Rte. 90 or 2: Take 90 / 2 East and stay on Rte. 90. After passing Rte. 271 exit, get into the right lane. Get off at the next exit Rte. 91. On the exit ramp, get into the right lane at the light and make a right onto Rte. 91 North, and stay in the right lane. Cross over the bridge (Rte. 90) and go straight at the next light. Make a right at the next light, turning onto Maple Grove (right after Eat and Park)- Go to bottom paragraph.

From the South: Via Rte. 271 Business (Do not take Express Lanes): Take Rte- 271 North, and after the Wilson Mills exit, get into the **MIDDLE** lane. Merge onto **Rte. 90 EAST**. After it forms 3 lanes again, immediately get into the right lane, and get off at the Rte. 91 exit. On the exit ramp, get into the right lane at the light, and make a right onto Rte. 91 North, and stay in the right lane. Cross over the bridge (Rte. 90) and go straight at the next light. Make a right at the next light, turning onto Maple Grove (right after Eat and Park). Go to bottom paragraph.

From the North: Via Rte. 91: Take Rte. 91 South. After crossing Rte. 2, get in the left lane. Go straight through multiple lights, crossing Rte. 20, and then Rte. 84. Make a left at the next light, turning onto Maple Grove (at CVS). Go to bottom paragraph.

Bottom Paragraph: Go one block, and make a right onto Commerce Circle, and my office is the first building on the left a pink 2 story brick building, directly behind the Eat and Park restaurant. Go to the 2nd floor.

Cleveland Medical Institute **DEMOGRAPHIC SHEET**

Last Name:_____ First:_____ Date of Birth:_____

Age:_____ Social Sec#: _____ - _____ - _____ Sex: M or F Home Phone: (_____) _____-_____

Home Address: _____ City: _____

State: _____ Zip: _____ Marital Status: Sin Mar Div Wid Cell Phone: (_____) _____-_____

Home Mailing Address (if different): _____

Employer Name:_____ Occupation: _____ Work Phone: (____) _____-_____

Employer Address: _____ Employer Phone: (____)_____-_____

Spouse's Name: _____ Spouse's Social Sec#:_____ - _____ - _____

Emergency Contact Person: _____ Relationship: _____ Phone: (____)_____-_____

Name of Referring Doctor: _____ Phone: (____)_____-_____

Primary Care Physician: _____ Phone: (____)_____-_____

Please provide this office with a copy of your Insurance Cards at time of registration

Is this procedure related to an auto accident, work injury, or condition involving legal assistance? _____Yes _____ No

If so, Type of accident: ____Work Injury _____Auto _____Home _____Other Claim #_____

If so, Date of Injury/Accident: ___/____/_____ Fill in Insurance under Primary Insurance

Attorney's Name: _____ Phone: (____)_____-_____

Medicare Insurance #_____ **Medicaid Insurance #**_____

Primary Insurance Carrier Name: _____

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

Phone: (____)_____-_____ Policy #:_____ Group:_____

Name of Person this policy is under:_____

Secondary Insurance Carrier Name:_____

Primary Insurance Carrier Name: _____

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

Name of Person this policy is under:_____

Medical Authorization / Financial Assignment Agreement (Important)

I authorize my holder of my medical information to release this information to Cleveland Medical Institute (CMI) should they request. I authorize CMI (Dr. Demangone) to provide medical services for my condition, and to release any medical information about me to my insurance company. I authorize any holder for request of payments to make payment directly to CMI for services rendered. I will be responsible for any amounts not covered under my insurance plan, including co-pays, deductibles, or any charges not covered by insurance plan. If my insurance is Medicare, or any others with a contract with CMI, CMI will file all claims directly to the carrier on my behalf and CMI will receive payment from the carrier. If my insurance is not contracted with CMI, as a courtesy, CMI will still file a claim with my insurance carrier. However, if my insurance company denies payment to CMI for services rendered, I will be responsible for the debt in full, and the bills will then be sent to me. If there is any outstanding debt that is eventually turned over to a collection agency, I understand that I still will be responsible for the initial debt plus any fees that the collection agency will collect regarding my account with CMI.

I have read the above statement, and understand the credit policy set forth

Patient Signature: _____ Date:_____

Guardian Name: (print) _____ Signature:_____

Patient Questionnaire **David Demangone, M.D.** **The Pain Specialist**

This questionnaire must be completed prior to your first appointment. Your careful answers will help me understand your pain problem and design the best treatment program for you. It is understandable that you might be concerned about what happens to the information you provide, as much as it is personal. My records are strictly confidential and no outsider is permitted to see your case record without your written permission.

Name:_____ Age:_____

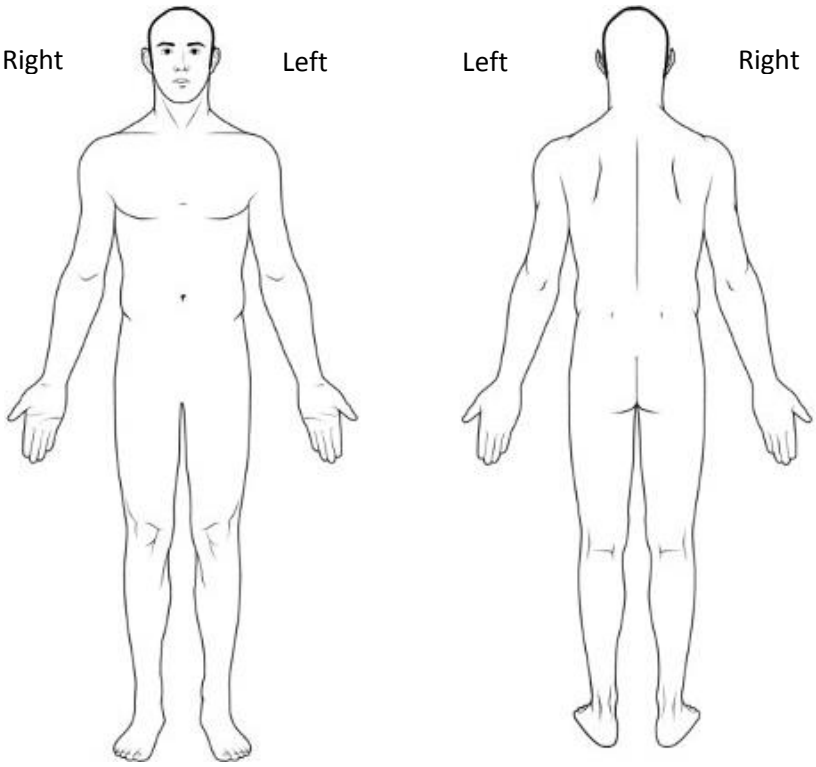
I. **Characteristics of Your Pain**

1. What is your main pain complaint? _____

_____

2. How long have you been experiencing this pain?_____

3. On the diagram below, shade in the areas where you have pain. Place an X on the area that hurts the most.



4. **Where** and **what** initially caused your pain problem?_____

_____

_____

_____

5. Are any of the following symptoms associated with your pain? Yes or No (select all that apply)

Tenderness of affected area	Swelling	Redness
Pain / discomfort with light touch	Numbness	Weakness
Incontinence of Bowel	Urinary Incontinence	Cool / pale skin

6. How often do you have your pain? (select) Constantly (80 – 100% of the time)

Nearly constant (50 – 80% of the time)

Intermittently (25 – 50% of the time)

Occasionally (less than 25% of the time)

7. In general, when is your pain the worst? (select) Morning Afternoon Evening Anytime All times

8. List 3 activities or kinds of things that most exacerbate your pain. 1._____

2._____ 3._____

9. List 3 activities or kinds of things that most relieve your pain. 1._____

2._____ 3._____

10. How has your pain affected your life the most? _____
_____

11. How has your pain affected your occupational work?_____
_____

12. How has your pain affected your housework?_____
_____

13. How has your pain affected your family, personal relationships?_____
_____

14. How many hours a day do you spend lying down because of your pain?_____

15. How many times during the day do you lie down because of your pain?_____

16. How has your weight changed since your pain began? (select) None Gained Lost How much?_____lbs.
What do you attribute this to?_____

17. Does your pain awaken you from sleep during the night? (select) Always Usually Sometimes Never

18. How many hours do you sleep nightly?_____ Is your sleep uninterrupted or interrupted? (select)

19. How has your pain affected your mood?_____
_____

20. Have you had any thoughts of wanting to die? (select) Yes or No If so, describe:_____
_____

21. Does your pain make you feel irritable or angry? (select) Yes or No If so, describe:_____
_____

22. Do you ever act in angry or aggressive ways? (ex. – breaking objects, hitting people) (select) Yes or No
If yes, please describe:_____
_____

23. Do you have thoughts of harming / hurting anyone?(select) Yes or No If yes, please describe these thoughts:_____

24. Have you ever been treated by a mental health professional (psychologist, psychiatrist)? (select) Yes or No
If yes, please describe why, when and type of treatment received: _____
_____

25. Have you ever been hospitalized for psychiatric reasons? (select) Yes or No If yes, please describe why, when, and the treatment you received: _____
_____

Patient Questionnaire -

Your careful completion of this form will help us provide you with our highest quality of care for your procedure.

Name Age Date of Birth / / ft. in. lbs.

Do you have any Allergies to Drugs, Latex, Iodine, Adhesives, Food, or others? Yes No If yes, please list them below.

Allergy to:	Reaction:

Allergy to:	Reaction:

Do you take any medications or herbal supplements? Yes No If yes, please list them below.

Medication Name:	Dose	#/ day

Medication Name:	Dose	#/ day

Your Primary Care Physician:_____ Phone #:_____ Fax #:_____

Dose He/She need to clear you for surgery? Yes No

Have you ever had any surgeries? Yes No If Yes, please list below.

Type of Surgery	Year

Type of Surgery	Year

Other than for surgery, have you been hospitalized for anything else? Yes No If Yes, please list below.

Reason for Hospitalization (Diagnosis)	Year

Reason for Hospitalization (Diagnosis)	Year

CIRCLE the treatments you have tried. Rate the relief effectiveness by writing the appropriate number as described below in the appropriate column and LIST the dates of the treatments. Rating Scale: 1 = No Relief or Worse 2 = Some relief, Temporary 3 = Some relief, Permanent 4 = Complete relief, Temporary

Treatment	Relief	Dates
Acupuncture		
Biofeedback		
Chiropractor		
Exercise		

Treatment	Relief	Dates
Heat/Cold Packs		
Bed Rest		
Hypnosis		
Physical Therapy		

Treatment	Relief	Dates
Psychotherapy		
Surgery		
TENS Therapy		
Ultrasound		

Blocks/ Injections _____ _____ What type of blocks?_____

Other (Describe) _____ _____ _____

Select Answer **General Questions**

Yes No Have you or anyone in your family ever had a serious problem with Anesthesia?
If Yes, please describe:_____

Yes No Recent Cold or Flu? Describe Symptoms:_____

Yes No Do you Smoke? If so, how many packs per day? _____ For how many years?_____

Yes No Do you use any Recreational Drugs? (Cocaine, Marijuana, etc.) Please list them:_____

Yes No Do you drink any Alcohol? How many drinks per day? _____ For how many years?_____

Yes No Any loose Teeth, Caps, Partial Bridges? Describe:_____

Yes No Any Lung / Pulmonary disease? (Select) Asthma, Bronchitis, Emphysema/COPD
Home Oxygen, Sleep Apnea
If Yes, How many days ago did you have a wheezing episode?_____
Are you now the best you can be? Yes No

Yes No Shortness of Breath Upon Climbing Up Stairs? How many flights before you must stop to rest?_____

Yes No Ever have a Heat Attack? If so, when?_____

Yes No Have you been diagnosed with CHF (congestive heart failure)?
If so, how have you been lately?_____

Yes No Ever have a Stress Test or Cardiac Catheterization? If so, select which and write dates and results _____

Yes No Diagnosed with Hypertension? If so, is your doctor pleased with your blood pressure control? Yes No

Yes No Ever had a TIA or Stroke? If so, what deficits do you have now?_____

Yes No Ever had Epilepsy or Seizures? If so, when was your last seizure?_____

Yes No Ever have any Blood Diseases, Anemia, Sickle Cell etc.? Describe:_____

Yes No Excessive Bleeding or Bruising? Describe:_____

Yes No Ever diagnosed with Diabetes? Any Complications? Please Describe:_____

Yes No Any Thyroid Problems? Describe:_____

Yes No Any Liver Problems? Describe:_____

Yes No Chronic Headaches, Neck or Back Pain? Describe:_____

Yes No Weakness / Numbness in a Limb? Describe:_____

Yes No Ever have Reflux or Hiatal Hernia? How has it been lately?_____

Yes No Ever diagnosed with Arthritis or Rheumatological Disease? Describe:_____

Yes No Ever diagnosed with Cancer? Describe:_____

Yes No Any other significant Diseases or Information? Describe:_____

_____

Yes No FEMALE PATIENTS – Could You Be Pregnant? When was your last normal menstrual period?_____

List your Family Medical History: _____

_____

List the medications that you have taken for your pain problem and then please rate the effectiveness
1 = No Relief 2 = Minor Relief 3 = Moderate Relief 4 = Great Relief

Medication Name	Dose (mg)	# / day	Relief		Medication Name	Dose (mg)	# / day	Relief	

Name:_____

Social History

1. Current occupation or last job:_____

2. Present employment status: (select) Full time Part time Leave of absence Retired
Unemployed Homemaker Student Disability

3. If working now, and you stopped working for a period of time, when did you return to work?_____

4. If not working, why?_____

5. If not working, when was your last day of work?_____

6. If not working, have you tried to return to work?_____

7. If not working at your regular job, is your previous job remaining open for you?_____

8. Are you receiving compensation or disability payments now? (select) Yes No

9. Do you have an application for compensation or disability payments pending? (select) Yes No

10. Are you suing because of your pain or injury? (select) Yes No

11. Have you ever brought suit for any reason in the past? (select) Yes No If yes, please describe below:

_____

_____

12. Marital Status (select) Single Married Divorced Separated Widowed Remarried Engaged

13. Number of Children:_____ Their ages:_____

14. Who lives with you?_____

15. What is the highest level of education you have completed?_____

16. Do you use tobacco? Yes No What?(select) Cigarettes Cigars Pipe Chewing Tobacco
How much?_____

17. Do you drink caffeinated beverages (coffee, tea, soda)? Yes No How many cups per day?_____

18. How often do you drink alcoholic beverages? (select) Daily Occasionally (less than 1 drink per week)
Regularly (drink 2 – 3 times/week) Rarely (less than 1 drink per month) Never

19. If you consume alcoholic beverages, have you ever made a conscious effort to decrease your drinking? Yes No

20. Has anyone ever irritated you by suggesting that you decrease your drinking? Yes No

21. Have you ever had symptoms of withdrawal (shakes, sweating) after you have stopped drinking? Yes No

22. Have you ever felt bad about drinking? Yes No

23. Select all of the following drugs you have used: Marijuana Heroine Cocaine Amphetamines Barbiturates
Other illegal substances None of these If so, when was the last time?_____

Thank you for completing this questionnaire. Additional information can be written below

_____

_____

_____

Although Cleveland Medical Institute (CMI) will follow the HIPAA guidelines, as stated earlier, regarding use and disclosure of your health information with other entities, you may further restrict the use and disclosure of you information in any manner you wish, acceptable to CMI, by specifying such restrictions below.

(1) I, _____ request the following restrictions to the use or disclosure of my protected health information in the following manner.

_____

_____

_____

_____

If you wish for certain people, other than yourself, to be able to access your health information, the flowing needs to be completed/described. If you do not complete any further information, then no relatives or friends will be given any information should they request it, other than in an emergency situation.

(2) Cleveland Medical Institute may discuss my medical conditions/information with the following:

(Select) No Yes (If yes, list names)	**NAME**	**Relationship**
Spouse	1)_____	
Parents		
Children	2)_____	
Friends	3)_____	
If more than 4 names, List additional below.	4)_____	

Other:_____

_____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received and read CMI's Notice of Privacy Practices.

(Patient or their representative signature)_____ Date_____

If signed by patient representative, their relationship to the patient is _____

Office Use Only: In the event that the patient doesn't sign the acknowledgment, our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below. **(select one)**

(Patient Name)_____ Refused to sign Physically unable to sign

Specific reasons_____

Employee Signature_____ Date_____

Notice of Privacy Practices for Protected Health Information-Cleveland Medical Institute

This form must be read and signed prior to seeing the doctor, due to new federal guidelines, the Health Insurance Portability and Accountability Act (HIPAA), effective 4-14-03. This Notice of Information describes the terms of how your health information may be used and disclosed by Cleveland Medical Institute, how you can gain access to it and also control who else receives or gains access to this information. At the end of this form, you will be asked to sign an acknowledgement of receipt of this notice, as well as to outline or define specific instances or information that you would like to be restricted from disclosure. to other entities or specified individuals.

1. **Cleveland Medical Institute (CMI)** may use and disclose your protected health information for treatment, payment, healthcare operations, and other certain circumstances. These include public health requirements, current laws and court orders, worker's compensation, entities assisting in disaster relief, or other similar programs.
2. **CMI** will not use or disclose the patient's protected health information without the individual's written authorization. The patient, at any time, can provide a written statement to revise this authorization.
3. **CMI** may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health related benefits and services that may be of interest to the individual patient.
4. **CMI** may release protected health information about you to a friend or family member who is involved in your medical care, provided that you list these specific people below who we may speak to regarding your medical care.
5. **CMI** reserves the right to change the terms of this notice, making new notice provisions effective for all health protected information that it contains. Copies of these changes/revisions will be given to the patient at the next visit, or mailed to the last known address if there is a need to disclose any protected health information.
6. Any person may file a complaint to the Practice and to the Department of Health and Human Services, Office of Civil Rights, if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer, Dr. David Demangone, by phone (440) 944-1414, or mail to Suite 2, 6025 Commerce Circle, Willoughby, OH 44094. It is **CMI** policy that no retaliatory action will be made against an individual who submits or conveys a complaint or a suspected or actual non-compliance of the privacy standards.

Patients have been granted individual rights under the HIPAA Legislation, and these include the following:

1. You have the right to inspect and copy the protected health information that may be used to make decisions about your care. To inspect and copy your protected health information, you must submit your request in writing to the Privacy Officer listed above. There may be a fee charged to cover the cost of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances. If so, you may request that the denial be reviewed. A licensed health care professional, but not the one that denied your request, will be chosen by our organization and will review your request and the denial, and make a determination.
   We will comply with the outcome of the review.
2. If you feel that the protected health information we have about you is incorrect or incomplete, you have the right to request an amendment for as long as the information is maintained in the designated record set. To do so, your request must be made in writing and submitted to the Privacy Officer. You must provide a reason that supports your request. If not, your request for an amendment may be denied. We may deny your request if you ask us to amend information that was not created by us.
3. You have the right to request an "accounting of disclosures", a list of the disclosures we have made of your protected health information in addition to those for treatment, payment, or health care operations. The request must be in writing and submitted to the Privacy Officer. The request must address two points; (l) a time period not longer than 6 years or earlier than 4-14-03, (2) in what form you want the list (paper, fax, etc.). The first list you request within a 12 month period will be free. There may be a charge, as determined by us, for an additional list, at which time you may withdraw or modify your request before any costs are incurred. The list will be provided to you in under 60 days of your request, unless we utilize a 30 day extension period.
4. You have the right to request a restriction or limitation on the protected health information we disclose about you for:
   a) treatment, payment or health care operations, b) to someone who is involved in your care or the payment for your care, like a family member or friend. However, we are not required to agree to your request. To request restrictions, you must make your request in writing to the Privacy Officer, and you must state: 1) what information you may want to limit, 2) whether you want to limit our use, disclosure, or both, 3) to whom the limits apply. Either of us may terminate the restriction after notifying the other.
5. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location, such as at work or by mail. You must make a written request to the Privacy Officer including how or where you wish to be contacted. We will not ask you the reason, and we will try to accommodate your request.