

Physician's Choice, Inc.

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www.prolotherapyheals.com

New Patient Information

Thank you for choosing Physician's Choice Prolotherapy for your medical needs. We specialize in providing chronic pain relief with prolotherapy, a simple, drug free, nonsurgical technique that stimulates the body's natural healing response to repair and grow new ligament and tendon tissue. Our goal is to provide you with the best possible medical care, personalize a treatment plan to meet your individual needs, and to provide the best value for your investment in your own health. **Thank you for entrusting your care to us. We look forward to getting to know you.**

New Patient Questionnaire

Please fill out the enclosed medical questionnaire in full, and **remember to bring it to your first visit.** The answer to each of these questions is important to provide the best care for you. Allow yourself plenty of time to answer thoughtfully and completely. No patient will be seen for an initial visit unless these questions are first completed.

How to Find Us

PHYSICIAN'S CHOICE is conveniently located in the Wellstar Kennestone Hospital area. We're just north of the downtown Marietta Square and easily reached from I-75:

- ✓ From I-75 (North or South) take Exit # 267- B
- ✓ This will put you on the Hwy 5 Connector which will merge with Church Street.
- ✓ You will travel a short distance on Church Street (through 2 traffic lights). Kennestone - Wellstar Hospital will be on the right.
- ✓ Turn LEFT at the 3rd traffic onto Cherry Street.
- ✓ Turn LEFT at traffic light at the end of Cherry Street, onto Cherokee Street
- ✓ **Our office building, 754 CHEROKEE ST., is the 4th building on the RIGHT, just past Lewis Drive and Store. BEFORE the Right Aid Drug**
Our building is gray stucco, Kennestone Professional Building. You'll see our "GOT FAT" sign on the side of the building.
- ✓ **Turn into the second entrance and drive around to the back of the building.** The glass door on the **back of the building** is the entrance to our office in Suite B.
- ✓ Call us at 770-427-1454 if you need further directions.

Nearby Hotel Accommodations

The most convenient hotels are located off I-75 on Barrett Parkway (exit #269) and Chastain Road (exit #271)

Previous Medical Records

If you have medical records, test results, and/or x-rays pertinent to your condition, please bring them with you to your first visit.

Preparing for Your First Visit

Please plan to arrive 15 minutes prior to your scheduled time for your first visit. We will do our best to be prompt and on time.

Please wear loose, comfortable clothing. Your examination and treatment may require putting on a paper gown. We recommend that you take 1000 mg of Tylenol (*not* Advil, Aleve, Aspirin or other anti-inflammatory medication) around the time you arrive in our office if you are planning to receive a treatment. We strongly recommend that you discontinue taking steroid medication at least one month prior and anti-inflammatory medication at least one week prior to receiving Prolotherapy. To ensure optimal results from Prolotherapy, discontinuing these medications for the duration of your Prolotherapy treatment is recommended.

In the rare situations where sedation is requested, you must bring someone to drive for you and you must not drive until the next day.

Charges and Payment Policy

Please review our payment policy before you come and the information regarding the relationship between Physician's Choice, Inc. and insurance companies, Medicare and Medicaid. You will need to sign the enclosed agreement prior to receiving evaluation and treatment.

Appointment Cancellation

Please notify us if you are unable to attend your appointment at least 24 hours in advance. Your appointment time has been reserved especially for you and we work very hard to make sure that your appointment time is convenient for you. We are glad to reschedule a time that is more convenient. If you miss an appointment and do not allow us to make that time available to someone else, then perhaps someone else is suffering needlessly. Your consideration for your fellow-man is appreciated. We reserved the right to charge a \$50 fee for missed appointments without proper notification.

***Thank you for entrusting your care to us.
We look forward to meeting you !!***

Everyday holds the possibility of a miracle.

Physician's Choice, Inc. – Robert C. Shuman, M.D.

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Date: ____/____/____
Last First Middle Initial

Age: _____ Date of Birth: ____/____/____ Social Security No: _____-_____-____

Address: _____
Street

City State Zip Code

Home Phone: _____-_____-____ Cell Phone: _____-_____-____

Daytime Phone: _____-_____-____

Email: _____

Employer: _____

Work Phone: _____-_____-____

Spouse: _____

Emergency Contact: _____
Name Telephone

Text Message reminders for office visits? ___N___Y Cell _____

_____ Please do not send mail or contact me at home.

_____ Please do not send mail or contact me at home – however, send mail to:

Payment is due at the time of service
We Accept Cash, Check, Visa, MasterCard, Discover, American Express & Care Credit

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CONFIDENTIAL MEDICAL HISTORY

Name _____ Date ____/____/____
Last First Middle Initial

Date of Birth ____/____/____ Age ____ Single__ Married__ Widowed__ Divorced__

Occupation: _____

How did you hear about Physicians Choice/Dr. Shuman? Referral Doctor _____

Friend _____ Patient _____ Internet _____

Number of Children _____ Religion (Optional) _____

HEIGHT: _____ WEIGHT: _____

ALLERGIES: *Foods?* No ____ Yes ____ *Please specify which foods and type of reaction:*

ARE YOU ALLERGIC TO FISH, IODINE OR SHELLFISH ? No ____ Yes ____

If Yes, Describe Reaction: _____

ARE YOU ALLERGIC OR HAVE YOU EVER HAD AN ADVERSE REACTION TO ANY LOCAL ANESTHETIC SUCH AS NOVACAINE OR LIDOCAINE ? No ____ Yes ____

If Yes, Describe Reaction: _____

Allergic or adverse reaction to any *Other* MEDICATION, ANESTHETIC OR CHEMICAL?

No ____ Yes ____

Please specify which medications and type of reaction: _____

Do you require multiple injections of local anesthetic when you go to the dentist or have you had problems getting “numb enough” during other local anesthetic procedures?

No ____ Yes ____

CHIEF COMPLAINT / REASON FOR APPOINTMENT: _____

Severity of pain (1 – 10) Average _____ Worst _____

Previous Diagnosis & Test Results: _____

Previous Treatments & Results: _____

Has Surgery Been Recommended? If So, What Kind? _____

How and When Did the Problem Begin? _____

What Motions or Activities Make the Pain Better or Worse?

B _____

W _____

Are You Currently Under the Care of Other Practitioners?

Name	Specialty	Treating what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have You Taken Steroidal or Non-Steroidal Anti- Inflammatory Medication For This Problem? No _____ Yes _____

Drug	For how long?	Most Recent Dose?
_____	_____	_____
_____	_____	_____
_____	_____	_____

List Joints / Areas of Your Body Where You Experience Recurring or Chronic Symptoms

Location & Type of Symptom	R or C	Severity (1 – 10)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If You Have Any of the Following Symptoms Associated With Your Condition Please Describe:

Pain, Numbness, Tingling, Aching, etc. going to other areas: _____

Muscle Tightness, Spasm, Trigger Points, Weakness, Limitation of Range of Motion: _____

Headache, Ringing in Ears, Sinus Problems, Visual Problems, Hearing Problems, other head & neck symptoms: _____

Loose joints, unstable joints, cracking and popping, loss of cartilage, unusual flexibility, history of torn meniscus or labrum; _____

SLEEPING HABITS:

Do you have trouble sleeping? _____ Average Hours of Sleep / Night _____

Do you take a sleep aid? _____

Hours of Uninterrupted Sleep during an average night? _____

Reasons for awakening _____

EATING HABITS:

Would you describe your Nutrition / Eating Habits as:

EXCELLENT _____ AVERAGE _____ POOR _____

Do You a Nutritional Supplement? Yes _____ No _____

Have you seen a nutrition professional? Yes _____ No _____

LIFESTYLE:

Do you currently smoke? _____ How often / How much ? _____

Use other tobacco products? _____

How long have you used tobacco products? _____

Would you like to stop smoking? _____

Have you ever smoked or used tobacco? _____

Alcohol use? _____

Average drinks per week? _____

Recreational Drug Use? Current? _____ Past? _____

EXERCISE AND ACTIVITY:

How many times / week? _____ Consistent or Inconsistent? _____

Activity and duration _____

Are You Currently or Formerly Involved In: *Martial Arts* _____ *Kickboxing* _____

Yoga _____ *Gymnastics* _____ *Boxing* _____ *Cheerleading* _____ *Triathelons* _____

Marathons _____ *Professional Sports* _____ *Olympic Level Amateur Sports* _____

Club Level Amateur Sports _____ *Other* _____

PAST MEDICAL HISTORY:

Have you ever had any of the following diseases or medical problems:

	Yes	No	When Diagnosed
Diabetes	_____	_____	_____
Angina	_____	_____	_____
Heart Attack	_____	_____	_____
High Blood Pressure	_____	_____	_____
Stroke	_____	_____	_____
Elevated Cholesterol	_____	_____	_____
Seizure Disorder	_____	_____	_____
Migraines Headaches	_____	_____	_____
Blurred Vision	_____	_____	_____
Ringing in Ears	_____	_____	_____
Chronic Sinusitis	_____	_____	_____
Asthma/Bronchitis	_____	_____	_____
Shortness of Breath	_____	_____	_____
Thyroid Disorder	_____	_____	_____
Liver Disease	_____	_____	_____
Gall Bladder Disease	_____	_____	_____
Gastro Intestinal Disorders	_____	_____	_____
Degenerative or Ruptured Disc Arthritis	_____	_____	_____
Bleeding Problems	_____	_____	_____
Kidney or Bladder Disorders	_____	_____	_____
Hysterectomy	_____	_____	_____
Prostate Problems	_____	_____	_____
Cancer	_____	_____	_____
Chronic Fatigue / Fibromyalgia	_____	_____	_____
Depression or Psychiatric Illness	_____	_____	_____
HIV / AIDS	_____	_____	_____
Other	_____	_____	_____

List any accident or injury with symptoms lasting longer than one month: _____

KNOWLEDGE OF PROLOTHERAPY:

I have:

- Read the www.Prolotherapyheals.com website in some detail _____
- Received Prolotherapy treatment by another physician _____
- Read one or more books on Prolotherapy _____
- Reviewed other websites in some detail _____
- Heard about this treatment in detail from a friend _____
- Heard about this treatment from medical professional _____

What kind of practitioner? _____

- Heard about this treatment from a media source _____
- How knowledgeable are you about this treatment:
Very _____ Fairly _____ Barely _____
- What resources, books, websites, etc., did you find most helpful?

- What questions do you have about this treatment? _____

Signature _____ Date ____/____/____

Medical History Reviewed by _____ Date ____/____/____

Physician's Choice, Inc. - Payment Policy

Charges for Initial Consultations range between	\$ 50.00 and \$ 95.00
Charges for Follow-up Visits between Prolotherapy treatments	\$ 45.00 and \$ 75.00
Charges for Prolotherapy Treatments range between	\$ 75.00 and \$ 500.00

At your initial visit, you will receive separate charges for the office visit and for the Prolotherapy treatment, if administered.

There is no charge for Follow-up visit if Prolotherapy treatment is also received.

Charges are based on the number of Prolotherapy injections required and the Proliferant medications used. All charges will be explained prior to treatment and all of your questions will be answered.

Prices for office visits, treatments and supplies are subject to change without notice.

PAYMENT IS DUE AT THE TIME OF SERVICE – NO EXCEPTIONS

Our payment policy allows us to keep our prices as low as possible because we do not staff for billing and collections. Our staff is available exclusively to provide you the best value for your investment in your health. All payments for services (office visits, Prolotherapy treatments or medical procedures) are final. No refunds will be given, no exceptions.

Physician's Choice, Inc. / Dr. Shuman does not participate in Medicare or Medicaid. If you have Medicare or Medicaid, you must sign a waiver acknowledging that these services will not be covered by Medicare or Medicaid, nor will they be covered by a Medigap or co-insurance policy, and agreeing to pay the fees charged by Physician's Choice, Inc.

Insurance is not accepted. We do not participate in any insurance plans and will not accept payment from your insurance company. If your insurance plan pays for weight loss care (most plans do NOT), **you may file for reimbursement from your company.** We will give you the form with the correct codes to file. Unfortunately, our staff will not be able to contact your insurance company for the purpose of "problem solving". If your company requires treatment records, you may provide us with a self-addressed, stamped envelope and we will mail a copy of these records to you.

We accept Flexible spending and Medical Savings account charge cards (Visa / MasterCard).

Discounted reimbursement by your insurance company (their arbitrary assignment of 'reasonable and customary charges', 'medically necessary,' etc.) reflects an agreement between the policyholder and company. This in no way influences the charges or payment due to Physician's Choice, Inc. for services rendered.

I understand the fees and payment policies of Physician's Choice, Inc., and I agree to be bound by these policies.

I also understand that in the event I have any unpaid account balance that is forwarded to a collection agency for collection, I am responsible for all collection costs, including but not limited to, collection agency costs, attorney's fees and filing costs.

Name _____ Date ____/____/____

Print Name: _____