





# SPINE CARE & PAIN MANAGEMENT

*Because life doesn't have to hurt.*

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Our physicians are specialists in pain management. Our goal is to improve your quality of life while decreasing dependence on narcotic medication, if you are currently using such, through other treatments. We understand that you may have been prescribed certain medications in the past. We may NOT write narcotic medications on your first visit, unless our physician feels that is appropriate.

Please understand that our doctors will write prescriptions for medications they feel are safe for you. Your first visit with our office will be a consult with one of our doctors to determine the appropriate plan of treatment, which may include procedures, physical therapy, massage therapy, psychological evaluation and/or a referral to another specialist. In order for you to receive treatment in our clinic we strongly recommend that you follow the plan of treatment recommended by our doctor. Please be advised your payment is for the care and treatment plan received from the doctor, not to receive prescriptions.

Please note that by signing below you are acknowledging that you understand and will comply with the information above.

\_\_\_\_\_  
Patient Name (Please print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

### ***List of Past Medical Providers***

So that we may better evaluate your medical condition, we would like to have a complete record of your past medical history. Please list all of the medical providers you have seen for your pain so that we may request your records. We ask that this list be as complete as possible so that we may provide a proper treatment plan.

<b>Medical Provider's Name:</b>	<b>Provider's Telephone #:</b>
1.	
2.	
3.	
4.	
5.	
6.	
7.	

# Spine Care & Pain Management

## MEDICAL INFORMATION RELEASE FORM

1. I AUTHORIZE:

2. TO RELEASE TO:

\_\_\_\_\_  
Name of sending person/organization

**Spine Care and Pain Management**  
Name of receiving person/organization

\_\_\_\_\_  
Street Address

Street: \_\_\_\_\_

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
City State Zip Code

Ph. \_\_\_\_\_ Fax. \_\_\_\_\_

3. INFORMATION TO BE RELEASED:

- Last three Office Notes**  
 **Current Medication list**  
 **X-ray & MRI Reports in paper format only, actual films not to be included.**

4.  RECORDS FROM THE TIME PERIOD: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ through \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

5. PURPOSE OF DISCLOSURE: (Check applicable purpose)  **Continued Medical Care**

Payment of Insurance  Personal  Workers' Compensation Claim  Other: \_\_\_\_\_

6. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

7. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

8. The requestor may be provided with a copy of this authorization.

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**\*Please Note\***

**Fill out below and sign ONLY if it applies to you.**

**SPECIAL AUTHORIZATION: Check applicable box(es) and sign immediately below:**

By signing below, I am authorizing the office to release any and all information regarding:

Alcohol  Drugs  Mental Health  Sexually Transmitted Diseases  HIV  AIDS

**Note:** If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For office use only: \_\_\_\_\_  
MR# Date Initials of Staff Member Sending