Michael G Cassaro, M.D., P.S.C.
200 Missouri Avenue, Suite B
Jeffersonville, IN 47130
Phone 812-207-2092
Fax 812-284-5083

Dear Patient,

Please bring previous x-rays, CT scans, MRIs, nerve tests, and laboratory test results with you on your initial evaluation. This is very important. If you do not bring them, you may have to reschedule your appointment. Also, please bring any medical records that might be pertinent to your problem.

Bringing these items with you will help make your initial examination more productive. Time for review of previous results is allotted during the initial evaluation, not on subsequent evaluations.

Please complete the enclosed forms prior to your appointment. If the forms are not complete, you may have to reschedule your appointment.

Appointment date _____

Please arrive by _____

If you have any questions, or need further information, please do not hesitate to phone the office.

Thank you,

Michael G. Cassaro, MD

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200 Missouri Avenue, Suite B
Jeffersonville, IN 47130
Phone 812-207-2092
Fax 812-284-5083

Patient Rights

What you can expect:

- You will receive a thorough initial evaluation including review of previous test results and x-rays. New patient visits are scheduled for 45 minutes in person with the physician.
- Your appointment time will not be "double booked" with another patient.
- A complete report will be prepared and sent to whomever you designate.
- If it is determined that evaluation and treatment of your pain problem falls within the limitations of this practice, you will receive a plan for further evaluation and treatment.
- Subsequent evaluations will be scheduled for 15 minutes in person with the physician.
- Dr. Cassaro will be on time for all evaluations unless another patient has taken some of your time from you. In that case, your time will be extended into the next patient's time.
- Dr. Cassaro will fill out forms, write letters or prepare reports as requested. If additional testing is required, those tests will be ordered or discussed with you.

What is expected of you:

- Please arrive on time.
- Please bring previous x-rays, CT scans, MRIs, nerve test results, and laboratory test results with you on your initial evaluation. Most chronic pain patients have already seen many other physicians. If any of those previous physicians had figured everything out, you would not need another evaluation. Get the most out of this evaluation.
- Please bring any medical records that might be pertinent to your problem.
- Please bring complete, accurate, current information about all prescription medicines, over the counter medicines, vitamins, nutritional supplements and other remedies that you currently take or have taken in the past. It is best to prepare a written list including dose, frequency and dates.
- If you come to your initial evaluation without necessary information, x-rays or other test results, it may be necessary to schedule you for a second "initial" evaluation. Be advised, insurance will not pay for a second initial evaluation. You will be on your own. Please use the time awaiting your initial evaluation to gather up all pertinent information. Have it all with you when you arrive.
- You must have a primary care physician.
- There is a fee for filling out forms, writing letters or preparing reports. Fees are based upon the time actually spent. Insurance does not usually cover any of these fees.
- Be prepared to pay your coinsurance or copayment on the date of service.

Practice limitations:

Dr. Cassaro limits his practice. The scope of practice is limited:

- To patients able to be evaluated in an outpatient, office setting;
- To the diagnosis of chronic pain problems;
- To invasive treatment of chronic pain problems;
- To neuroendocrine modulation.
- Once invasive treatments are completed, or a long-term neuroendocrine regimen is established, you will be sent back to your primary care physician for continuation of care. For patients not falling within the scope of practice, a list of other pain management physicians in the area will be provided along with referral to your primary care physician.

Hours of operation:

- Monday through Friday, except as posted in the office lobby,
  8:15 AM until 4:15 PM
- We are closed for lunch from 12 Noon until 1:15 PM daily

HIPAA Notice of Privacy Practices

Michael G. Cassaro, M.D., P.S.C.
200 Missouri Avenue, Suite B
Jeffersonville, IN 47130
812-207-2092

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures **Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.**

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **January 1, 2004.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

PATIENT INFORMATION Date

Patient_____
Last Name First Name Middle initial
Responsible party (if minor)_____
Street Address_____
City_____State_____Zip_____
Telephone number where you can be reached _____
Sex __M __F Age____ Birthdate _____ __Single __Married Other_____

Patient employed by_____
__Retired __Unemployed __Student __Disabled
Business Address_____Business phone_____
Occupation_____Social Security #_____

Spouse(responsible party) Name_____Birthdate____Relationship_____
Employer name_____Occupation_____
Employer address_____Business phone_____
City, State, Zip _____Spouse Social Security #_____

INSURANCE INFORMATION

List accident insurance as primary insurer.
Name of Primary Insurer_____
Identification #_____Group #_____

Name of Secondary Insurer_____
Identification #_____Group #_____

Name of Other Insurer_____
Identification #_____Group #_____

ACCIDENT INFORMATION

If you have ever had any injury claim, even if the claim is closed or settled, you must provide the following information:

Auto Accident__ Work injury__ Other_____
Place of accident_____Accident date_____Claim #_____
Contact person_____Telephone #_____

If work or auto, please provide this as your primary insurance.

IN CASE OF EMERENCY

Please list a person or persons that live outside of your household.
Name _____Relationship_____Phone #_____
Name _____Relationship_____Phone #_____

INSURANCE AUTHORIZATION

Request for treatment, assignment of benefits and release of information:

I Hereby request treatment from Michael G. Cassaro, M.D., P.S.C. I authorize Michael G. Cassaro, M.D., P.S.C. to have any and all medical records, including but not limited to: x-rays, other physicians' reports, government medical records from the military, workers compensation, social security, Veterans Administration, insurance companies, laboratories, hospitals, Medicaid, and billing records from any medical provider. I specifically release any rights under any PRIVACY ACT or other respective or protective legislation.

I authorize Michael G. Cassaro, M.D., P.S.C. to file claims with my insurance companies as a courtesy to me. I request that payment of benefits be made directly to Michael G. Cassaro, M.D., P.S.C. for any services or supplies furnished to me. I assign directly to Michael G Cassaro, M.D., P.S.C. all medical benefits, if any, other wise payable to me for services rendered. I authorize Michael G. Cassaro, M.D., P.S.C. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. A copy hereof is as valid as the original.

I agree that I am responsible for the entire bill, including amounts not paid by my insurance company for any reason. I further agree to pay reasonable collection costs incurred by Michael G. Cassaro, M.D., P.S.C., including bank charges, collection agency fees, court costs, statement fees, attorney fees and reasonable interest of one and one half per cent per month from the date of service. I agree to be called by an Auto/Predictive Dialer at my home or cell phone. I agree to pay all charges.

_____ _____

Beneficiary Signature Date

Privacy Practices Acknowledgement:

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature _____ Date_____

Referring And Primary Care Physician

Referring Physician:

Name_____

Address_____

_____

Phone Number_____

Primary Care Physician:

Name_____

Address_____

_____

Phone Number_____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby request a complete copy of my medical records. A copy of this authorization is as valid as the original.
Please send the records to:

Michael G. Cassaro, M.D., P.S.C.
200 Missouri Avenue, Suite B
Jeffersonville, IN 47130

Patient Name (Printed) _____ Date Of Birth _____

Address _____ Social Security Number _____

City, State Zip _____

Patient Signature _____ Date _____

Witness _____

Michael G. Cassaro, M.D., P.S.C.
Health History Questionnaire

Patient Identification

Patient Name _____ Date of Birth _____ SSN _____

Primary Care Physician _____ Referring Physician _____

Family History

	Age	Alive Y N	Serious medical problems (and cause of death, if applicable)
Mother			
Father			
Sister(s)			
Brother(s)			

Use an additional sheet if necessary

Do you have children? __Y __N List sex and ages _____

Social History

Marital status: ____ Married ____ Single
____ Widowed ____ Divorced

How many children do you have? _____

Are you sexually active? __Y __N

What is your sexual orientation? _____

Do you have a history of risky sexual activity? __Y __N

Do you smoke? __Y __N How much? _____
Did you quit? __Y __N When? _____
How old were you when you started? _____

Do you use smokeless tobacco? __Y __N
Did you quit? __Y __N When? _____
How old were you when you started? _____

Do you drink Alcohol? __Y __N How much? _____
Did you quit? __Y __N When? _____

Do you have a history of alcohol or drug abuse? __Y __N
Did you quit? __Y __N When? _____
How long have you been in recovery? _____
What substances were involved? _____

Highest level of education you have completed? _____

Are you currently employed? __Y __N

What is your current profession/job? _____

Are you currently working? ____ No ____ On leave
____ Full duty ____ Limited duty ____ Part time

If no, who took you off work? _____

Do you have any work restrictions? __Y __N

List restrictions _____

Who gave you the restrictions? _____

Are you on disability? __Y __N

Are you applying for disability? __Y __N

If you are disabled, what was your last job/occupation? _____

Work hours per week, current _____

Work hours per week, before onset of pain _____

Do you have a legal claim? __Y __N

____ Auto accident ____ Workers compensation
____ Personal injury ____ Other (specify) _____

Lawyer's name and address _____

Have you ever been arrested for prescription drug problems? __Y __N

Have you ever been in trouble for doctor shopping? __Y __N

Are you, or have you ever been, an officer or agent for the police, DEA, licensure board or other government agency? __Y __N

Agency _____ Current? __Y __N

Current Prescription Medications

Medication	Strength	Times Daily	Medication	Strength	Times Daily

Current Over the Counter Medications

Medication	Strength	Times Daily	Medication	Strength	Times Daily

Vitamins and Nutritional Supplements

Supplement	Strength	Times Daily	Supplement	Strength	Times Daily

Discontinued Medications

Medication	Date Discontinued	Medication	Date Discontinued

Drug Allergies

Medication	Reaction	Medication	Reaction

Michael G. Cassaro, M.D., P.S.C.
Health History Questionnaire

Medical History

____ High blood pressure	____ Scleroderma	____ Kidney Stones	____ Stomach Ulcers
____ Angina	____ Rheumatic fever	____ Bladder infections	____ Irritable bowel
____ Coronary Artery Disease	____ Lupus	____ Prostate problems	____ Crohn's disease
____ Heart Attack	____ Multiple Sclerosis	____ Depression	____ Hepatitis-type_____
____ Vascular disease	____ Rheumatoid arthritis	____ Other Mental illness	____ Chronic active hepatitis
____ Stroke	____ Osteoarthitis	____ Seizure disorder	____ Pancreatitis
____ High cholesterol	____ HIV or AIDS	____ Cancer -where_____	____ Hiatal hernia
____ High triglycerides	____ Glaucoma	____ Fibromyalgia	____ Acid reflux - G.E.R.D.
____ Emphysema	____ Cataracts	____ Nervous disorders	____ Colon polyps
____ Asthma	____ Diabetes	____ Paralysis	____ Venereal Disease
____ Pneumonia	____ Hypothyroidism	____ Shingles	____ Bleeding problems
____ Chronic Bronchitis	____ Hyperthyroidism	____ Gout	____ Migraine headaches

Physician Notes: _____

Surgical History

____ I have never had any surgeries.

Surgery	Date	Complication	Surgery	Date	Complication

If you had a hysterectomy, were your ovaries removed? __Y __N

Review of Systems

How many doctors have you already seen for your current pain problem? _____
Hours of uninterrupted sleep per night _____
Total hours of sleep per night _____
Do you feel rested upon awakening __Y __N

Constitutional

Unexplained fever __Y __N Comments:
Weight loss __Y __N
How many lbs?
Over what time?
Weight gain __Y __N
How many lbs?
Over what time?
Wide spread pain __Y __N
Chronic stress __Y __N
Sources _____

Environmental/occupational

Toxic chemical exposures __Y __N
Specify _____

Eyes, ears, nose, mouth, throat

Wear glasses or contacts	__Y __N
Uncorrected blurred vision	__Y __N
Uncorrected double vision	__Y __N
Eye pain	__Y __N
Wear hearing aids	__Y __N
Difficulty hearing	__Y __N
Ringing in the ears	__Y __N
Ear pain	__Y __N
Sensitive to loud noise	__Y __N
Recurrent bloody nose	__Y __N
Chronic nasal congestion	__Y __N
Chronic sinus congestion	__Y __N
Recurrent sinus infections	__Y __N
Loose teeth, gum disease	__Y __N
Painful teeth	__Y __N
Sensitive teeth	__Y __N
Difficulty opening mouth	__Y __N
TMJ problems	__Y __N
Recurrent sore throat	__Y __N
Difficulty swallowing	__Y __N
Painful swallowing	__Y __N

Heart and vascular

Shortness of breath when lying flat	__Y __N
Shortness of breath with minimal exertion	__Y __N
Heart murmur	__Y __N
Chest Pains	__Y __N
Heart valve problems	__Y __N
Irregular heart beat	__Y __N
Swelling of the legs and feet	__Y __N
Calf pain with walking	__Y __N
Poor circulation	__Y __N
Phlebitis	__Y __N
Pulmonary embolism	__Y __N

Pulmonary

Night Sweats	__Y __N
Productive cough	__Y __N
Ever suddenly awaken short of breath	__Y __N
Snore when sleeping	__Y __N
Stop breathing when sleeping	__Y __N
Wheezing	__Y __N
Bloody sputum	__Y __N
Shortness of breath with simple activities	__Y __N
Tuberculosis	__Y __N

Genitourinary

Frequent urination __Y __N
Bloody urine __Y __N
Awaken more than twice at night to urinate __Y __N
Painful urination __Y __N
Menstrual problems __Y __N
Explain _____
_____
LNMP _____
Impotence or problem with sexual activity __Y __N
Loss of libido __Y __N
Erectile dysfunction __Y __N

Gastrointestinal

Acid reflux __Y __N
Interrupting sleep __Y __N
Recurrent heartburn __Y __N
Ulcers __Y __N
Vomiting blood __Y __N
Vomiting coffee grounds __Y __N
Black or tarry stools __Y __N
Bright red blood per rectum __Y __N
Chronic constipation __Y __N
Chronic diarrhea __Y __N
Intermittent constipation and diarrhea __Y __N
Chronic indigestion __Y __N
Abdominal pain after eating __Y __N
Colitis __Y __N
Special diet __Y __N
Describe _____
_____
Jaundice __Y __N
Recent weight change __Y __N

Musculoskeletal

Do you have or have you been treated for:
Arthritis __Y __N
Where? _____
Broken bones __Y __N
Specify _____
_____
Limited joint motion __Y __N
Specify _____
_____
Joint pain __Y __N
Specify _____
_____
Back pain __Y __N
Neck pain __Y __N
Leg pain __Y __N
Arm pain __Y __N

Endocrine

Chech all that apply

____ Hot flashes
____ Vaginal dryness
____ Urinary incontinence
____ Foggy thinking
____ Depressed
____ Memory lapses
____ Night Sweats

____ Tearful
____ Sleep disturbance
____ Heart palpitations
____ Bone loss
____ Dry skin and hair
____ Headaches

____ Mood swings
____ Tender breasts
____ Fibrocystic breasts
____ Bleeding changes
____ Uterine fibroids
____ Breast cancer
____ Cold body temperature
____ Elevated triglycerides

____ Low libido
____ Nervous
____ Weight gain in hips
____ Irritable
____ Headaches
____ Sleep disturbance
____ Weight gain in waist
____ Water retention

____ Yeast infections
____ Fibrocystic breasts
____ Endometriosis
____ Anxiety
____ Headaches

____ Fluid retention
____ Arthritis
____ Hair loss
____ Stressed easily

____ PMS
____ Irregular periods
____ Heavy periods
____ Uterine cramps
____ Break thru bleeding

____ Uterine fibroids
____ Sleep disturbance
____ Weight gain
____ Irritable
____ Hypothyroid

____ Urinary incontinence
____ Vaginal dryness
____ Fatigue
____ Aches and pains
____ Arthritis
____ Memory lapses
____ Sleep disturbance
____ Heart palpitations

____ Depressed
____ Low libido
____ Thinning pubic hair
____ Bone loss
____ Loss of muscle mass
____ Thinning skin
____ Fibromyalgia

____ Ovarian cysts
____ Breast cancer
____ Excessive facial hair
____ Excessive body hair

____ Oily skin
____ Elevated triglycerides
____ Hair loss on scalp
____ Nervous
____ Irritable
____ Increased acne

____ Fatigue
____ Sugar cravings
____ Allergies
____ Chemical sensitivities
____ Stress

____ Cold body temperature
____ Irritable
____ Arthritis
____ Heart palpitations
____ Aches and pains

____ Breast cancer
____ Increased facial hair
____ Increased body hair
____ Weight gain or loss
____ Loss of muscle mass
____ Thinning skin
____ Elevated triglycerides
____ Cold body temperature
____ Irritable
____ Anxious
____ Memory lapses

____ Heart palpitations
____ Headaches
____ Stress
____ Sleep disturbance
____ Sugar cravings
____ Low libido
____ Hair loss
____ Bone loss
____ Fatigue
____ Acne
____ Nervous

____ Tired all the time
____ Cold hands and feet
____ Depressed
____ Cold body temperature
____ Exhaustion
____ Weight gain
____ Can't lose weight
____ Memory lapse
____ Forgetful

____ Difficulty concentrating
____ Mood changes
____ Swelling
____ Puffy eyes/face
____ Low blood pressure
____ Slow pulse rate
____ Decreased sweating
____ Hair dry/brittle
____ Hair loss

____ Nails breaking/brittle
____ Aches and pains
____ Low libido
____ Heart palpitations
____ Sleep disturbance
____ Bone loss
____ Loss of muscle mass
____ Thinning skin

____ Infertility problems
____ Slowed reflexes
____ Constipation
____ Thick tongue
____ Hoarseness

If you suffer from fatigue, please give more information

Date of onset_____

Sudden onset __Y __N

Onset with injury or stress __Y __N

Specify _____

_____

Neurologic

Do you have or have you been treated for:

Focal weakness in one side or part of your body	__Y __N
Inability to walk	__Y __N
Loss of coordination	__Y __N
Head injury	__Y __N
Fainting	__Y __N
Headaches	__Y __N
Numbness/tingling in extremities	__Y __N
Temporary loss of vision in one eye	__Y __N
Polio	__Y __N
Have you ever been physically, emotionally or sexually abused	__Y __N

Psychiatric

Do you have or have you been treated for:

Depression	__Y __N
Bipolar disorder	__Y __N
Post traumatic stress	__Y __N
Other mental illness or behavior disorder	__Y __N

Specify _____

_____

Hematologic/Lymphatic

Do you have:

Problems clotting	__Y __N
Easy bruising	__Y __N
Enlarged lymph nodes	__Y __N
Lymphedema	__Y __N

Allergic/Immunologic

Have your allergies changed suddenly	__Y __N
Are your immunizations up to date	__Y __N
Did you have any serious childhood illnesses	__Y __N
Do you get sick easily	__Y __N
Do you take allergy shots	__Y __N

Integumentary

Do you (have):

Any skin rashes or changes	__Y __N
Any unusual moles or birthmarks	__Y __N
Any changes to your breasts	__Y __N
Do regular breast self-exams	__Y __N

All of the information provided is correct as of the date signed.

_____ _____

Patient signature Date signed

Michael G. Cassaro, M.D., P.S.C.
200 Missouri Avenue, Suite B
Jeffersonville, IN 47130
812-207-2092

Pain Distribution Diagram

Name_____ Date_____

On the drawing below, please indicate where your pain is located. Feel free to label any area and describe how your pain feels, (i.e. burning, aching, stinging, etc.). Don't worry about staying in any of the lines unless that is exactly how your pain is distributed. You may also use different colors to indicate different types of pain.