

The Johns Hopkins Voice Center located at GBMC
The Milton J Dance Jr Head & Neck Center
Greater Baltimore Medical Center
6569 N. Charles Street , PPW Suite 402
Baltimore, Maryland 21204
phone: 443-849-2087
fax: 443-849-8534
www.gbmc.org/mjdancehome
www.gbmc.org/voice

GBMC



To whom it may concern:

**Welcome to the Johns Hopkins Voice Center *LOCATED* at GBMC.
Thank you for accessing our new patient voice forms online.**

The attached packet has all the forms needed for your initial appointment with us. Please bring these completed forms with you to your appointment along with the following:

1. Insurance cards and driver's license (or MD state identification card).
2. Exact co-pay amount, which may require you to call your insurance company before your appointment. Co-pay amounts may vary according to the type of service given. When calling your insurance company please specify the appointment as, the type of evaluation, treatment, therapy or procedure (as highlighted above).
3. Referrals, if required by your insurance carrier. Please obtain this from your primary care physician and/or insurance company. Primary care physicians are not required to provide us with referrals on or after the day of your appointment. You will be asked to sign a liability form accepting responsibility for any charges incurred if no referral is obtained.

***Note: The Johns Hopkins Voice Center at GBMC is located in Physicians Pavilion West SUITE 402.**

Please complete the attached forms and bring them to your scheduled appointment. To schedule an appointment or, regarding questions concerning your upcoming appointment, please call 443-849-2087.

We hope to make this a 'Very Good' experience for you and strive to meet the needs of our patients. If you have any questions or concerns please feel free to call me at 443-849-8451.

Sincerely,

Barbara P. Messing, M.A., CCC-SLP, BCS-S
Administrative-Clinical Director

PERSONAL INFORMATION

Patient Name _____ Age _____ Date of Birth _____ / _____ / _____

PHYSICIANS

Referring Physician _____

Primary Physician _____

Address _____

Address _____

City _____ State ___ ZIP Code _____

City _____ State ___ ZIP Code _____

Phone Number _____

Phone Number _____

HEALTH PROBLEM PROMPTING TODAY'S VISIT**PERSONAL MEDICAL HISTORY – Please list PAST and CURRENT medical problems.**

SURGICAL HISTORY – Please list surgeries you have had and the approximate year.

Type of Surgery	Year	Type of Surgery	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY MEDICAL HISTORY – Please list significant medical conditions affecting family members.

REVIEW OF SYSTEMS – Please check any symptoms you currently experience.

Constitutional <input type="checkbox"/> fever <input type="checkbox"/> chills <input type="checkbox"/> weight loss <input type="checkbox"/> fatigue	Nose/Sinuses <input type="checkbox"/> drainage <input type="checkbox"/> congestion <input type="checkbox"/> post-nasal drip <input type="checkbox"/> smell	Gastrointestinal <input type="checkbox"/> heartburn <input type="checkbox"/> constipation <input type="checkbox"/> vomiting <input type="checkbox"/> nausea	Integumentary (skin) <input type="checkbox"/> rashes <input type="checkbox"/> dry skin <input type="checkbox"/> change in hair <input type="checkbox"/> itching	Endocrine <input type="checkbox"/> excessive sweating <input type="checkbox"/> excessive thirst <input type="checkbox"/> feel too hot or too cold
Eyes <input type="checkbox"/> blurred vision <input type="checkbox"/> double vision <input type="checkbox"/> contacts/glasses <input type="checkbox"/> pain	Respiratory <input type="checkbox"/> cough <input type="checkbox"/> wheezing <input type="checkbox"/> shortness of breath	Genitourinary <input type="checkbox"/> frequent urination <input type="checkbox"/> painful urination <input type="checkbox"/> incontinence	Neurological <input type="checkbox"/> dizziness <input type="checkbox"/> fainting <input type="checkbox"/> weakness <input type="checkbox"/> tremor	Hematologic <input type="checkbox"/> easy bruising <input type="checkbox"/> easy bleeding <input type="checkbox"/> history of transfusion
Ears <input type="checkbox"/> hearing loss <input type="checkbox"/> ear pain <input type="checkbox"/> drainage <input type="checkbox"/> ringing	Cardiovascular <input type="checkbox"/> chest pain <input type="checkbox"/> palpitations <input type="checkbox"/> leg swelling	Musculoskeletal <input type="checkbox"/> muscle/joint pain <input type="checkbox"/> stiffness <input type="checkbox"/> back pain	Psychiatric <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> memory loss <input type="checkbox"/> stress	Allergic/Immunologic <input type="checkbox"/> sneezing <input type="checkbox"/> clear, runny nose <input type="checkbox"/> frequent colds/flu

OFFICE USE ONLY

Vital signs: BP _____ / _____ Pulse _____ Resp _____ Temp _____ Wt _____ Ht _____

Physician review _____ Date _____ / _____ / _____

New Voice Patient Intake Form

PROFESSIONAL INFORMATION

Occupation _____
Do you use your voice as part of your professional duties? No Yes
If yes, how? _____
Do you use your voice as a performer? No Yes
If yes, how? _____

If you are a singer, please fill out the following section. If you are not a singer, skip to the next section:
What is your voice type? _____ What is your style? Classical Pop/Rock
What is your level of training (years of lessons, etc.)? Musical Theater Church/Gospel
_____ Other _____
What are your aspirations as a singer? _____ How many hours each day/week do you spend:
_____ in rehearsal? _____ in performance? _____

PROBLEM

Please briefly summarize the problem for which you are seeking evaluation: _____
If you are having voice problems: *what about your voice has changed? What doesn't it do that it should, or what does it do that it shouldn't?* _____
How long have you had the problem? _____ Problem began gradually suddenly?
Was anything else going on in your life at the time of onset? (like cold/flu, yelling, stress, etc?) _____
What makes it better? _____ Worse? _____
Characteristics of your voice problem—Check those that apply to you:
 Voice is raspy Voice requires more effort Voice feels strained Cannot get loud Uncomfortable to use voice
 Worse in AM Worse in PM Loss of high range Loss of low range Decreased vocal endurance
How talkative are you, on a scale of 1 to 7? Check your answer based on your personality, not what your job requires of you:
 1 2 3 4 5 6 7
Quiet Listener Average Very talkative
Previous voice diagnosis and treatments? _____
Other symptoms: Trouble/Pain with swallowing Throat clearing Coughing Heartburn Feeling something stuck in throat

SOCIAL HISTORY

Marital Status: Single Married Divorced Separated Widow/er Other

Do you smoke tobacco? Yes No Do you drink alcohol? Yes No
If yes: Packs per day: _____ Number of years: _____ If yes: Drinks per week: _____
Would you like to quit? Yes No If no: Did you used to drink? Yes No
If no: Did you used to smoke? Yes No If yes, when did you stop? _____
If yes: How many packs per day _____ Do you use recreational drugs? Yes No
For how long? (number of years) _____ If yes: What? _____
When did you quit? _____ How often? _____

Caffeine Intake: How many servings per day of the following: coffee _____ tea _____ soda _____

Water Intake: How many servings of water per day? _____ Do you feel this is enough? Yes No

Have you ever been told that you have acid reflux? Yes No Or a hiatal hernia? Yes No
Do you take an antacid medication? Yes No If yes, drug and dose: _____
How often do you eat/drink tomato and citrus foods? Rarely Sometimes Frequently

Patient Quality-of-Life Surveys

For the surveys below, there are no “right” or “wrong” answers. When answering, please consider both how severe the problem is when you get it, and how frequently it happens.

How much of a problem has this been over the last two weeks? Check the appropriate response.

Because of my voice

	NOT A PROBLEM	A SMALL AMOUNT	A MEDIUM AMOUNT	A LOT	AS BAD AS IT CAN BE
1. I have trouble speaking loudly or being heard in noisy situation.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. I run out of air and need to take frequent breaths when talking	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3. I sometimes do not know what will come out when I begin speaking.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
4. I am sometimes anxious or frustrated (because of my voice).	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5. I sometimes get depressed (because of my voice).	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
6. I have trouble using the telephone (because of my voice).	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
7. I have trouble doing my job or practicing my profession (because of my voice).	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
8. I avoid going out socially (because of my voice).	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
9. I have to repeat myself to be understood.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
10. I have become less outgoing (because of my voice).	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
V-RQOL TOTAL					

Within the last MONTH, how did the following problems affect you?

	(0=NO PROBLEM					5=SEVERE PROBLEM)
1. Hoarseness or a problem with your voice.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. Clearing your throat.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3. Excess throat mucous or postnasal drip.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
4. Difficulty swallowing food, liquids, or pills.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5. Coughing after you ate or after lying down.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
6. Breathing difficulties or choking episodes.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
7. Troublesome or annoying cough.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
8. Sensations of something sticking in your throat/lump in your throat.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
9. Heartburn, chest pain, indigestion, or stomach acid coming up.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
RSI TOTAL						

How much of a problem has this been over the last two weeks? Check the appropriate response.

	(0=NO PROBLEM				4=SEVERE PROBLEM)
1. My swallowing problem has caused me to lose weight.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2. My swallowing problem interferes with my ability to go out for meals.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3. Swallowing liquids takes extra effort.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4. Swallowing solids takes extra effort	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5. Swallowing pills takes extra effort.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6. Swallowing is painful.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7. The pleasure of eating is affected by my swallowing.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8. When I swallow food sticks in my throat.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9. I cough when I eat	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
10. Swallowing is stressful.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
EAT-10 TOTAL					

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MEDICATIONS SHEET

MEDICATION LIST

It is important that you fill this out **COMPLETELY**. If need be, find out from your doctors, the exact dose of any medicines you are taking. This list should include prescription medicines, over-the-counter medicines, vitamins, and supplements from any source. For example, the list should include aspirin, the contraceptive birth control pill, vitamins, minerals, herbal remedies, sports supplements, and any supplements (powders, tablets, drinks, etc.) from an alternative medicine source or health shop.

Name of Local Pharmacy _____ Name of Mail Order Pharmacy _____
 City _____ City _____
 Phone _____ Fax _____ Phone _____ Fax _____

Medication Name	Dose (how much)	Frequency (how often)

DRUG ALLERGIES (please list any medications you have had a reaction to)			
Name of Medication	Reaction	Name of Medication	Reaction

PERMISSIONS / ACKNOWLEDGEMENTS – Page 1 of 4

USE AND DISCLOSURE OF HEALTH INFORMATION – I authorize GBMC Healthcare and independent physicians or other practitioners providing services by or in the Health System to disclose any health information (including information related to psychiatry, drug abuse, alcoholism, or HIV testing) for my treatment as well as use of routine Health System operations and payment for services and associate care. I further authorize release of health information pertaining to this hospitalization to other health care providers for continuing care and treatment.

PRE-CERTIFICATION REQUIREMENTS – If my insurance company or third-party requires pre-certification, then I understand that it is my responsibility to contact them to obtain such certification.
EXCEPTION: Medicare

ASSIGNMENTS OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS – I hereby authorize payment directly to GBMC Healthcare of hospital benefits otherwise payable to me, including major medical insurance benefits, PIP benefits, sick benefits, or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third party payable by any person, employer, or insurance company to or for the patient unless the account is paid in full upon discharge. I also authorize payment of surgical or medical, including major medical benefits, directly to attending physicians, but not to exceed charges for these services. I understand that I am financially responsible to the hospital and physicians for charges, whether or not covered by this assignment. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts may bear interest at the legal rate. I further authorize refund of overpaid insurance benefits in accordance with my policy conditions where my coverages are subject to coordination of benefits clause. I understand that I am responsible for any deductibles, coinsurance, or co-payments associated with my policy to include Point of Service (POS), Preferred Provider Organization (PPO), "opt-out" plan, "out-of-network" preferred, and indemnity benefits and for payment of services not covered under my policy or those services I elect to receive if denied for coverage by my insurer. I will contact my insurer or Health Advocacy Unit of the Attorney General's Office to learn how to appeal adverse decisions made by my insurer.

MEDICARE/MEDICAID PATIENT CERTIFICATION(for Medicare/Medicaid patients only) – I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf.



PERMISSIONS / ACKNOWLEDGEMENTS – Page 2 of 4

I understand that I have been instructed to leave all valuables at home, give such valuables to a friend or family member, or if that is not possible, to deposit such valuables with the GBMC Security Office. I understand that I am responsible for safekeeping such items as eyeglasses, dentures, or hearing aids, or any of my property while it is in my possession or under my control. I release the hospital from any responsibility for loss of any item not deposited with the Security Office.

Has the patient received the Notice of Privacy Practices?

Yes
 No

Reason no NOPP given:

Newborn
 Patient Unable to Accept

PATIENT FINANCIAL POLICY

We are committed to providing you with quality and affordable health care. You are receiving this information because under Maryland law, GBMC must have a financial assistance policy and must inform you that you may be entitled to receive financial assistance for the cost of medically necessary hospital services if you have a low income, do not have insurance or your insurance does not cover your medically necessary hospital care and you have a low income.

Hospital Financial Assistance Policy:

- GBMC provides emergency and urgent care to all patients regardless of ability to pay.
- GBMC offers several programs to assist patients who are experiencing difficulty paying their hospital bills.
- GBMC complies with Maryland's legal requirement to provide financial assistance based on income level and family size.
- GBMC Patient Representatives are available to assist you with the application process (**see contact information on page 6**), or you may access an application by going to <http://www.gbmc.org/> (go to the Patient & Visitor Tab and then click Financial Support).

Patient Rights:

- Those patients that meet the financial assistance policy criteria described above may receive assistance from the hospital in paying their bill.

PERMISSIONS / ACKNOWLEDGEMENTS – Page 3 of 4

- If you believe you have wrongly been referred to a collection agency, you have the right to contact the hospital to request assistance (**see contact information on page 6**).
- You may be eligible for Maryland Medical Assistance a program funded jointly by the state and federal governments (**see contact information on page 6**).

Patients' Obligations:

- For those patients with the ability to pay their hospital bill, it is the obligation of the patient to pay the hospital in a timely manner.
- GBMC makes every effort to see that patient accounts are properly billed. It is your responsibility to provide correct insurance information.
- If you do not have health coverage, we expect you to pay the bill in a timely manner. If you believe that you may be eligible under GBMC's financial assistance policy, or if you cannot afford to pay the bill in full you should contact the Patient Financial Services department promptly to discuss this matter (**see contact information on page 6**).
- If you fail to meet your financial obligations for services received, you may be referred to a collection agency. In determining whether a patient is eligible for free, reduced cost care, or a payment plan, it is the obligation of the patient to provide accurate and complete financial information. If your financial position changes, you have an obligation to promptly contact Patient Financial Services to provide update/corrected information (**see contact information on page 6**).

Physician Services:

Physician services provided during your stay will be billed separately and are not included on your hospital billing statement. Depending upon your treatment plan, you may receive separate bills for all services rendered including but not limited to, GBMC, the physician treating you, Charles Emergency Physicians, Advanced Radiology, Physicians Anesthesia Associates, Radiation Oncology Healthcare, Greater Baltimore Pathology Associates, Pediatric Physicians, etc.

Insurance: We participate in most insurance plans, including Medicare. Please remember to always bring your insurance card with you when you come for a visit.

- **Co-payments and deductibles** – All co-payments and deductibles must be paid at the time of services. This arrangement may be part of your contractual agreement with your insurance company. Please assist us by being prepared to submit your co-payment for each visit.
- **Referrals/Authorizations/Pre-certifications** – You may be responsible for obtaining precertification, submitting a referral and/or authorization prior to being seen, if required by your insurance carrier (except Medicare). Please obtain your pre-certification, referral and/or authorization from your primary care physician and submit at the time of service.
- You may also be responsible for tracking your referrals (number of remaining visits and expiration date). Please obtain additional or new referrals as necessary.

PERMISSIONS / ACKNOWLEDGEMENTS – Page 4 of 4

- **Non-covered services** – Some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. Please contact your insurance company with any questions you may have regarding coverage. If your insurance does not cover the services it does not necessarily mean that you do not need the services. Your physician will explain why he or she thinks that you can benefit from a service or procedure. If you elect to receive the non-covered services, you will be financially responsible.
- **Medicare patients** – If we believe you are receiving a service that Medicare considers not reasonable or necessary for your condition, you will be notified in writing on a form called an Advance Beneficiary Notice of Non-coverage (ABN). This will provide you with the opportunity to decide if you will proceed with the service ordered. This process is required by Medicare and preserves your right to appeal Medicare’s decision.
- **Claims submission** – We will submit your claim(s) and assist in any way we reasonably can to ensure claim payment. Your insurance company may require you to supply certain information directly. The balance of your claim is your responsibility regardless of your insurance company payment and GBMC is not party to that contract.
- **Coverage changes** – Please notify us before your next visit of any coverage changes so that we may assist you in maximizing your benefits.
- **Acceptable forms of payment** – We accept cash, personal checks, money orders, Visa, MasterCard, Discovery, American Express and we offer payment plans.

Contact Information

- **GBMC Patient Representatives are available Monday through Friday, from 8:00 am to – 6:00 pm at (443) 849-2450, option 1, or at 1-800-626-7766, option 1.**
- Our representatives can assist you with applying for Maryland Medical Assistance or you may also obtain information about or apply for Maryland Medical Assistance by contacting your local Department of Social Services by phone at 1-800-332-6347; TTY: 1-800-925-4434; or on the Internet at www.dhr.state.md.us .

I have read and understand in its entirety the information provided in this document and agree to follow its guidelines.

Signature of Patient or Responsible Party

Date

**Relationship to Patient
(if signed by person other than the patient)**

GBMC Managed Care Liability Form

I am (or the minor or other individual for whom I am responsible is) enrolled in _____
(HMO/PPO/POS) managed care health plan.

I understand that, if appropriate, GBMC will bill my health plan for services to be rendered. However, I also understand that there are instances where GBMC is authorized to bill me directly:

- **When I receive services that are not covered under my health plan.**

If my health plan decides that the services I receive are not covered under my benefit policy, I understand that I will be responsible for payment of these services rendered.

- **When I receive services at GBMC which are covered by my health plan only when performed by a specific provider.**

My health plan may require me to obtain certain services from a specific provider or facility. I understand that I have been informed that GBMC is not one of those providers for which payment will be made, yet I choose to go ahead and request the service from GBMC anyway due to convenience, preference or any other reason, I will be responsible for payment of these services rendered.

I understand that I am responsible for any deductibles, coinsurance or co-payments associated with my policy to include Point of Service (POS), Preferred Provider Organization (PPO), and “out-of-network” preferred and indemnity benefits and for payment of services not covered under my policy. I understand that I can receive treatment regardless of my ability to pay. If I choose NOT to obtain these services at GBMC, I understand I am accepting responsibility for this decision. My signature below indicates that I understand the above, and if any of the above apply, I agree to pay all fees that result from receiving these services.

Patient/Responsible Party Signature

Date

Patient/Responsible Party Name - Printed

REVIEW WITH PATIENT DURING EACH VISIT

Authorization for Release of Protected Health Information to a Spokesperson

As stated in the Greater Baltimore Medical Center's (GBMC) Notice of Privacy Practices, "we may release health information about you to a family member, other relative, or any other person identified by you who is involved in your care with your permission"

By signing this authorization, I allow GBMC to tell the spokesperson(s) named below the following information: My x-ray, laboratory, test findings, diagnosis, prognosis, and treatment plan either in person or by telephone.

By signing this authorization, I understand the following:

- This applies to services being rendered to me by the GBMC physician practice named below _____.
- This authorization is voluntary.
- Once this information is released to the spokesperson(s), the released information may no longer be protected by the federal privacy regulations.
- The spokesperson(s), medical power of attorney, health care agent or other individual allowed by law will be the only person(s) who may obtain specific information about me.
- My spokesperson(s) does not have decision-making abilities unless he/she is able to do that as set forth in the law.
- This authorization will expire one year from the date signed below unless a specific expiration event or condition is named here: _____.
- I may withdraw this authorization at any time by notifying the GBMC Privacy Officer in writing. If I do withdraw the authorization, it will not have any effect on actions taken by GBMC prior to receiving the written request.
- My treatment will not be affected by me choosing to sign or not to sign this document.
- I may refuse to sign this authorization.

YOU WILL RECEIVE A COPY OF THIS FORM ONCE IT IS COMPLETED

Patient Name: _____ DOB: _____

Spokesperson Information: PRINT CLEARLY

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

Signature of Patient or Patient's Representative

Date

Printed name of Patient's Representative

Relationship to Patient

**GBMC HEALTHCARE
CLINICAL POLICY AND PROCEDURE**

**APPENDIX C
OUTPATIENT PAIN ASSESSMENT TOOL**

GBMC HEALTHCARE
6701 North Charles Street
Baltimore, Maryland 21204

OUTPATIENT PAIN ASSESSMENT TOOL

DATE: _____

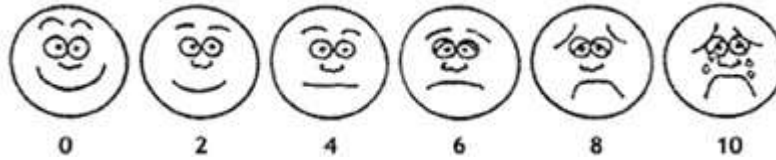
1. Are you having pain? (circle) NO YES (if yes, complete questions 2-11)

2. Where is your pain? _____

3. Circle all the words that can be associated with your pain:

constant	aching sharp	penetrating	tearful	gnawing
intermittent	throbbing	tender	nagging	moaning
dull	shooting	burning	numb	grimace
even at rest	exhausting	stabbing	miserable	unbearable

4. Rate your pain by circling on one of the scales below:



Faces Scale

Numbers Scale

0 1 2 3 4 5 6 7 8 9 10

No Pain

Worst Pain

5. What makes your pain better? _____

6. What makes your pain worse? _____

7. Does your pain interfere with daily activities? (circle) YES NO

8. What treatments or medicine do you use to relieve your pain?
(include prescriptions and over the counter drugs)

9. How effective has your treatment/medication been?

- Always effective Often effective Often not effective
 Never effective

10. Have you experienced any side effects (sleepiness, nausea, constipation) from medicines?

- No Yes, explain _____

11. What level of pain is tolerable and acceptable to you? _____

12. Please check the following:

_____ I have been educated about pain and its treatment

_____ I have received the GBMC brochure regarding my rights for effective pain management.

_____ I refuse education and treatment at this time.

_____ I refuse to fill out this form

Patient Signature _____

(Physician/Nurse to complete)

13. Treatment Plan:

_____ Referred to Physician _____ M.D.

_____ RX given _____

Physician/Nurse Signature _____

Follow up assessment:

Telephone Contact:

Date: _____

- See post-operative/procedure phone call form.

Comments: _____

Visit Contact: Date: _____

Physician/Nurse _____