DAVID H. MCCORD, M.D., P.C.

1718 Charlotte Avenue, Suite A
P.O. Box 331109
Nashville, TN 37203-7510
Phone: (615) 329-0333 Fax: (615) 321-0509

Fellowship Trained Orthopaedic Spine Surgeon
A.B.O.S. & A.B.S.S. Board Certified

Please find enclosed an information packet for you to complete and return to our office. In order to expedite the "New Patient Process," please complete the enclosed registration and questionnaire forms. If a question does not pertain to you, please indicate this by marking N/A. A self-addressed envelope has been provided for your convenience. If returning your new patient packet via fax, you must include a copy of the front and back of our insurance card.

You will need to locate all films (MRI, CT, Myelogram), including the related reports. Please make every effort to obtain copies of your films and not originals as this material will become part of your permanent medical record at our office.

NOTE: We will be unable to schedule an appointment for you if all portions of the registration and questionnaire forms are not completed.

DUE TO THE COMPLEXITY OF YOUR EXAM, IT IS ESSENTIAL THAT CHILDREN NOT BE PRESENT DURING YOUR EXAM. PLEASE MAKE PRIOR ARRANGEMENTS

Enclosures:

- Registration form
- Questionnaire
- Medication policy

Dr. McCord's CV is available upon request

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Date: ______________________ E-mail address: ____

Name: ____ Social Security#: ________________________

Date of Birth: __________________________ Marital Status: Married ______ Single______

Address: ____

City: __________________________________ State: _______________________ Zip Code: __________

Phone: Home: ___________________________________ Cell: ____________________________________

SPOUSE: (if applicable) Name: ____

Date of Birth: __________________________ Social Security#: ________________________

PATIENT EMPLOYER INFORMATION: Are you employed: Yes _____ No_____

If yes, Employer Name: ____

Address: ____

City: __________________________________ State: _______________________ Zip Code: __________

REASON FOR VISIT: **IMPORTANT: THIS MUST BE MARKED**

Is this visit related to a motor vehicle accident? Yes / No If yes, is your case still open? Yes / No

Is this visit related to an on the job injury? Yes / No If yes, is your case still open? Yes / No

---

For office use only

Chart #: ____

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PRIMARY INSURANCE:

Carrier name: ____ Phone: ___________________________

Policy#: ____ Group name or #: _________________________

Insured's relation to patient: Self _____ Spouse _____; If spouse, Date of birth: _____________________

SECONDARY INSURANCE:

Carrier name: ____ Phone: ___________________________

Policy#: ____ Group name or #: _________________________

Insured's relation to patient: Self _____ Spouse _____; If spouse, Date of birth: _____________________

WORKERS COMPENSATION **MUST BE MARKED**

Is this visit work related? Yes / No If yes; Is your workers comp case still open? Yes / No

Date of injury: ____________________________ Claim#: ____

Adjustor name: ____ Phone: ____________________________

Name of Workers Comp Insurance: ____

MOTOR VEHICLE ACCIDENT **MUST BE MARKED**

Is this visit auto related? Yes / No If yes; Is your MVA case still open? Yes / No

Date of accident:____________________________Claim#: ____

Adjustor name: ____ Phone: ____________________________

Name of MVA Insurance: ____

ATTORNEY—(If work or auto related)

Do you have an attorney? Yes / No

If yes, Name: ____ Phone: ____________________________

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MEDICAL INFORMATION

Primary Care Physician: ______________________________

Phone: ______________________ City/State: ______________________

Referring Physician: ______________________________

Phone: ______________________ City/State: ______________________

PLEASE MARK

I give my permission to Dr. McCord, M.D., P.C. to release any/all medical records to my primary care physician, my referring physician, and any physician I am referred to if applicable:

☐ **Yes**, I give my permission ☐ **No**, I do not give my permission

DISABILITY

Have you filed for disability? Yes / No If no, are you planning to file? Yes / No

If yes, what was the outcome?
- ☐ I was awarded disability benefits
- ☐ I was denied disability benefits
- ☐ Still in process

Attorney: ______________________ Phone: ______________________

***Disability forms**: We will complete disability forms for a charge of $50 per page. Payment is due prior to completion. Please allow 7-10 days after payment is received.*

MISCELLANEOUS

Name of closest relative not living with you: ______________________________

Phone: ______________________ Relation: ______________________

For office use only

Chart #: ______________________

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Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is the financial policy which we require you to read and sign prior to your treatment.

Regarding Insurance: Insurance is billed as a courtesy to our patients. All balances are your responsibility whether your insurance pays or not. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. All copays and deductibles are due and will be collected at the time services are rendered.

Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Past Due Accounts: In the event that my account becomes past due is placed with a collection agency or any attorney, I have been advised and agree to pay any attorney or collection fees in addition to the account balance.

Missed Appointments: Unless cancelled within 24 hours prior to your scheduled appointment, you will incur a $25 "no show" charge.

I, the undersigned, authorize release of any medical information necessary to process insurance claims on my behalf. I further authorize payments of medical benefits to David H. McCord, M.D., P.C. in the event insurance is filed. I agree to pay for any items that are not covered by my insurance company, if applicable. I understand that these items will be itemized by date of service and I will be billed after insurance, if applicable, is filed. I understand that if my insurance carrier has not paid the charges incurred upon my behalf in a reasonable amount of time, I will be held responsible for payment in full. I understand that if Workers Compensation or another carrier is liable for my bills, my group insurance is not responsible for payment. I understand that all information must be given to David H. McCord, M.D., P.C. prior to my appointment date in order to verify insurance coverage and liability. I am responsible for the amount charged after insurance has paid their portion and will be responsible for any court and collection fees that may be involved in collection of the charged amount.

I have read and understand the above Financial Policy. "'Must be signed before any services will be rendered**

____ ________________________

Signature of Patient or Responsible Party Date

For office use only **Chart #:** ________________________________

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P. O. BOX 331109
NASHVILLE, TN 37203-7510
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new patient questionnaire

Patient Name: ____ **Date**: __________________

How did you learn of Dr. McCord? ____

Who Referred You?____

Current Pain Complaint: ____

Age: ________ I am ☐**right handed** ☐**left handed**. **Sex**:_____ **Height**:_____ **Weight**:_____

Is this visit due to a JOB RELATED INJURY? ☐**YES** ☐**NO**

- Date of Accident: _________ Was an accident report filed? ☐**YES** ☐**NO**

Is this visit related to an AUTOMOBILE ACCIDENT? ☐**YES** ☐**NO**

- Date of Accident: ____________________
- Were you a driver or passenger? ________________
- Were you wearing a seat belt? ☐**YES** ☐**NO**
- How was your car hit? ☐**STRUCK FROM REAR** ☐**RIGHT SIDE** ☐**LEFT SIDE** ☐**HEAD-ON**
- How fast was your car traveling? ________ How fast was the other care traveling? ________
- How much damage was done to the car? ______________________________________

Describe How Your Pain Began: ____

____

Date Symptoms Began: ______________________

- Is your pain: ☐**BETTER** ☐**WORSE** ☐**STAYING THE SAME**

Where is Pain Located? ☐LOW BACK ☐MID BACK ☐NECK

☐LEG(S): ☐Left ☐Right ☐Both Legs

☐ARM(S): ☐Left ☐Right ☐Both Arms

☐OTHER: ___________________________

WHICH PAIN IS WORSE? __________________________

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Describe Your Pain: ☐BURNING ☐NUMBNESS ☐STABBING

☐ACHING ☐PINS AND NEEDLES

How Often Do You Suffer From This Pain?

☐CONSTANTLY ☐FREQUENTLY ☐OCCASIONALLY

Please Circle The Number That Best Represents Your Pain:

- How bad is your **low back** pain now?
  No pain 1 2 3 4 5 6 7 8 9 10 worse

- How bad is your **leg/foot** pain now?
  No pain 1 2 3 4 5 6 7 8 9 10 worse

- How bad is your **middle back** pain now?
  No pain 1 2 3 4 5 6 7 8 9 10 worse

- How bad is your **neck or upper back** pain now?
  No pain 1 2 3 4 5 6 7 8 9 10 worse

- How bad is your **arm/hand** pain now?
  No pain 1 2 3 4 5 6 7 8 9 10 worse

Associated Signs and Symptoms:

☐ALTERED GAIT ☐INCREASED PAIN AT NIGHT

☐PAIN THAT AWAKENS ME FROM SLEEP ☐LEG GIVE-WAY

☐TROUBLE WITH BLADDER: ☐**CAN'T EMPTY BLADDER** ☐**LOSS OF CONTROL**

☐TROUBLE WITH BOWELS: ☐**CONSTIPATION** ☐**LOSS OF CONTROL**

I Experience Leg/Foot Weakness: ☐**NO** ☐**YES:** ☐LEFT ☐RIGHT ☐BOTH SIDES

I Experience Arm/Hand Weakness: ☐**NO** ☐**YES**: ☐LEFT ☐RIGHT ☐BOTH SIDES

NAME: ______________________________

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DATE: ________________________

For Patients With Leg Weakness: How do you notice the leg weakness?

☐WALKING SHORT DISTANCES ☐WALKING LONG DISTANCES

☐WALKING STAIRS ☐LEG GIVE WAY ☐OTHER:__________________________

For Patients With Arm Weakness: Do you have any of the following:

☐DROPPING OF OBJECTS ☐LOSS OF BALANCE ☐LOSS OF CONTROL IN ARMS

☐OTHER: ____________________________________

How Far Can You Walk Without Leg Pain?

☐LESS THAN 1 BLOCK ☐LESS THAN 2 BLOCKS

☐LESS THAN 5 BLOCKS ☐1/2 MILE OR LONGER

What Can You Do To Relieve The Leg Pain?

☐STAND ☐USE A CANE OR WALKER ☐LEAN ON A SHOPPING CART

☐SIT ☐BEND FORWARD ☐BEND BACKWORD ☐OTHER: ________________________

MODIFYING FACTORS

Activities That Increase Your Neck/Back Pain:

☐SITTING ☐SNEEZING ☐WALKING ☐LIFTING ☐STANDING ☐COUGHING

☐RIDING IN A CAR ☐BENDING FORWARD ☐BENDING BACKWARD ☐INTERCOURSE

☐TWISTING/TURNING ☐OVERHEAD LIFTING/WORK ☐OTHER: __________________

Activities That Decrease YourNeck/Back Pain:

☐LYING DOWN ☐HOT BATHS ☐HEAT ☐MASSAGE ☐BRACE

☐OTHER: ______________________________

NAME: ______________________________

DATE: ________________________

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Prior Treatments You Have Had:

☐MUSCLE RELAXANTS ☐ANTI-INFLAMMATORIES ☐EPIDURAL INJECTIONS

☐BED REST ☐CORTISONE ☐TENS UNIT ☐PAIN MEDICATION ☐PHYSICAL THERAPY

☐EXERCISE PROGRAM ☐CHIROPRACTIC INTERVENTION ☐EPIDURAL BLOCKS

☐BRACE ☐OTHER: ______________________________

Physicians Who Have Treated Your Neck/Back Pain:

____

____

Are There Any Activities You Cannot Do or Have Difficulty Doing Because of Your Pain?

	CANNOT	VERY DIFFICULT
Dress without Assistance	☐	☐
Go Out Socially	☐	☐
Fix a meal independently	☐	☐
Make a bed	☐	☐
Grocery shop	☐	☐
Lift	☐	☐
Walk Around a Mall	☐	☐
Carry (example: laundry basket)	☐	☐
Shovel (example: snow)	☐	☐
Push (example: lawnmower)	☐	☐
Vacuum	☐	☐
Participate in sports	☐	☐
Drive	☐	☐

Please List All Diagnostic Studies You Have Had:

X-rays: ☐NO ☐YES: DATE:________ LOCATION: ______________________________

MRI: ☐NO ☐YES: DATE:________ LOCATION: ______________________________

CAT Scan: ☐NO ☐YES: DATE:________ LOCATION: ______________________________

Myelogram: ☐NO ☐YES: DATE:________ LOCATION: ______________________________

EMG: ☐NO ☐YES: DATE:________ LOCATION: ______________________________

Discogram: ☐NO ☐YES: DATE:________ LOCATION: ______________________________

NAME: ______________________________

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DATE: ____________________

How is the Quality of Your Life? ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR ☐BAD

Rate the Quality of Your Life PRIOR to Your Neck/Back Pain: ____________________

PAST MEDICAL HISTORY

Please List All Spine Surgeries (Neck and Back):

DATE/OPERATION	DOCTOR'S NAME	LOCATION/HOSPITAL	DURATION OF IMPROVEMENT	RETURN TO WORK? FOR HOW LONG?

NON-Spine Surgeries (Please List Type of Surgery and Approximate Year):

____
____
____

Medication Allergies (List Medication and Reaction):

____
____
____

Allergies to Metal or Other Things (List Reaction):

____
____

REVIEW OF SYSTEMS

☐**Weight: Loss** _______**lbs.** ☐**Weight: Gain** ____________**lbs.** ☐**Fevers** ☐**Chills**

☐**Night Sweats** ☐**Skin Disorders** ☐**Eye Problems** ☐**Breathing Problems**

☐**Ear Problems** ☐**Breast masses/discharge** ☐**Nosebleeds** ☐**Diarrhea** ☐**Sinus Trouble**

☐**Blood in Stools** ☐**Sore Throat** ☐**Urinary Burning** ☐**Urinary Discharge**

☐**Problems Tolerating Heat/Cold** ☐**Headaches** ☐**Chest Pain** ☐**Change in Appetite**

☐**Shortness of Breath** ☐**Sleeping Difficulty** ☐**Cough** ☐**Thoughts of Suicide**

☐**Depression: treating Dr.**___________ ☐**Loss of Energy** ☐**Need to see a psychiatrist**

NAME: ____________________

DATE: ____________________

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PAST MEDICAL HISTORY

☐**Heart Trouble** ☐**Heart Attack** ☐**Valve Disease** ☐**Blood Pressure**

☐**Stroke** ☐**Vericose Veins** ☐**Stomach Ulcers** ☐**Hepatitis (Type A, B, or C)**

☐**Kidney Infections** ☐**Tuberculosis** ☐**Asthma/Shortness of Breath** ☐**COPD/emphysema**

☐**Anemia** ☐**Bronchitis** ☐**Bleeding Tendency** ☐**Leukemia**

☐**Glaucoma** ☐**Rheumatoid Arthritis** ☐**Depression** ☐**Psychosis**

☐**Cancer** ☐**Sexual Dysfunction** ☐**Kidney Disease** ☐**Prostate Problems**

☐**Gout** ☐**Vaginal Bleeding** ☐**Vaginal Discharge** ☐**Menstrual Problems**

☐**Date of Last Menstrual Period:** ____________________ **Regular?** ☐**yes** ☐**no**

☐**Cirrhosis** ☐**Diabetes (Insulin: ☐YES ☐NO)** ☐**Irritable Bowel Syndrome** ☐**Degenerative arthritis**

****In consideration of x-rays and medications that may be prescribed, is there a possibility that you may be pregnant?** ☐**YES** ☐**NO** ☐**UNSURE**

*****IF THERE IS ANY CHANCE YOU MAY BE PREGNANT, PLEASE ALERT CLINICAL PERSONNEL!!*****

Please List ALL Current Medications:

MEDICATION/STREGNTH	**DOSE PER DAY**	**PRESCRIBING** M.D./REACTION

NAME: ____________________

DATE: ____________________

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FAMILY MEDICAL HISTORY

Mother: ☐ALIVE / AGE: ____________ GOOD HEALTH? ☐YES ☐NO

SUFFERS WITH: ____

☐DECEASED / AGE: ________ CAUSE: ________________________________

Father: ☐ALIVE / AGE: ____________ GOOD HEALTH? ☐YES ☐NO

SUFFERS WITH: ____

☐DECEASED / AGE: ________ CAUSE: ________________________________

I have ______ living brothers / sisters and ______ deceased brothers / sisters
Cause(s): ____

Members of my family suffer with the following (please indicate: brother, sister, mother, father or grandparent):

☐Stroke ____________________ ☐High Blood Pressure ____________________

☐Arthritis ____________________ ☐Diabetes ____________________

☐Heart Trouble ____________________ ☐Lung Disease ____________________

☐Back Problems ____________________ ☐Other ____________________

SOCIAL HISTORY

☐**MARRIED** ☐**SEPERATED** ☐**DIVORCED** ☐**WIDOWED** ☐**SINGLE**

Number of Children at home: ____ away: ____; other dependents: ____________________
I live with: __________________________________

I work as a __________________________. I am employed by: ________________________

Job Description: ____

Previous Occupation(s): ____

I am retired _______ years from _________________________________.

NAME: ______________________________

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Have you Missed Work due to your Pain? ☐**YES** ☐**NO**

Are you currently working? ☐**NO** ☐**YES, regular duty** ☐**YES, light duty**

WORKERS COMPENSATION? ☐**YES** ☐**NO** ☐**APPLYING**

LEGAL PROCEEDINGS? ☐**YES** ☐**NO** ☐**PENDING**

DISABILITY? ☐**YES** ☐**NO** ☐**APPLYING**

ATTORNEY'S NAME: ________________________ **PHONE:** ______________________

EDUCATION

☐Grade School ☐High School ☐Vocational School

☐Technical School ☐College ☐Graduate Education

I Have Special Needs (i.e. hearing deficit, decreased vision, etc.)

Explain: ____
____

I drink: ☐**Beer** ☐**Wine** ☐ **"Hard"drinks** ☐**None**

Frequency: ☐**Rare** ☐**Socially** ☐**Daily**

Tobacco use: ☐**Cigarettes** ☐**Cigar/pipe** ☐**Smokeless/leaf** ☐**None**

Frequency: __ packs per day for _____ years ☐**I QUIT!!!! When?** _____________

How Does Your Pain Affect Your Lifestyle?

- My work setting is supportive of me at this time: ☐YES ☐NO
- My pain has impacted my relationships with family and friends: ☐YES ☐NO
- My job has been affected by my back pain: ☐YES ☐NO
- Do you like your job? ☐YES ☐NO
- Ability to enjoy activities: ☐EXCELLENT ☐VERY GOOD ☐GOOD ☐POOR

NAME: ______________________________

DATE: ____________________

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What Do You Want To Happen as a Result of This Visit?

____

____

____

____

thank you for taking the time to answer these questions thoroughly and truthfully. we appreciate the opportunity to engage in a healthcare relationship with you as we work to help you in your current situation.

NAME: ______________________________

DATE: ____________________

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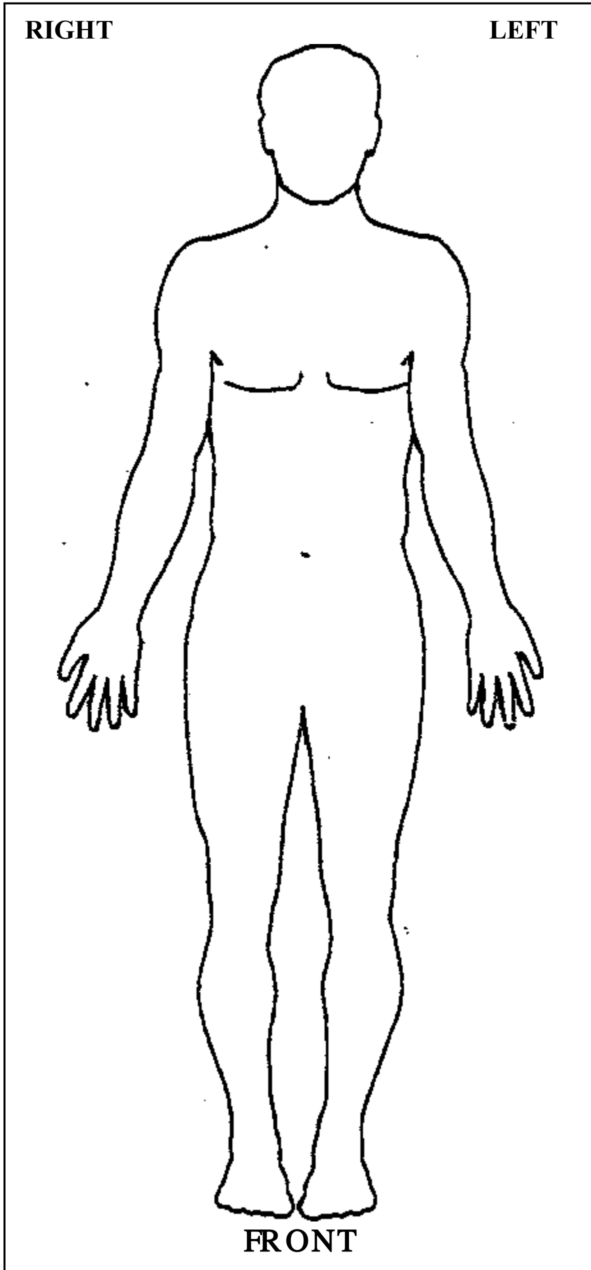
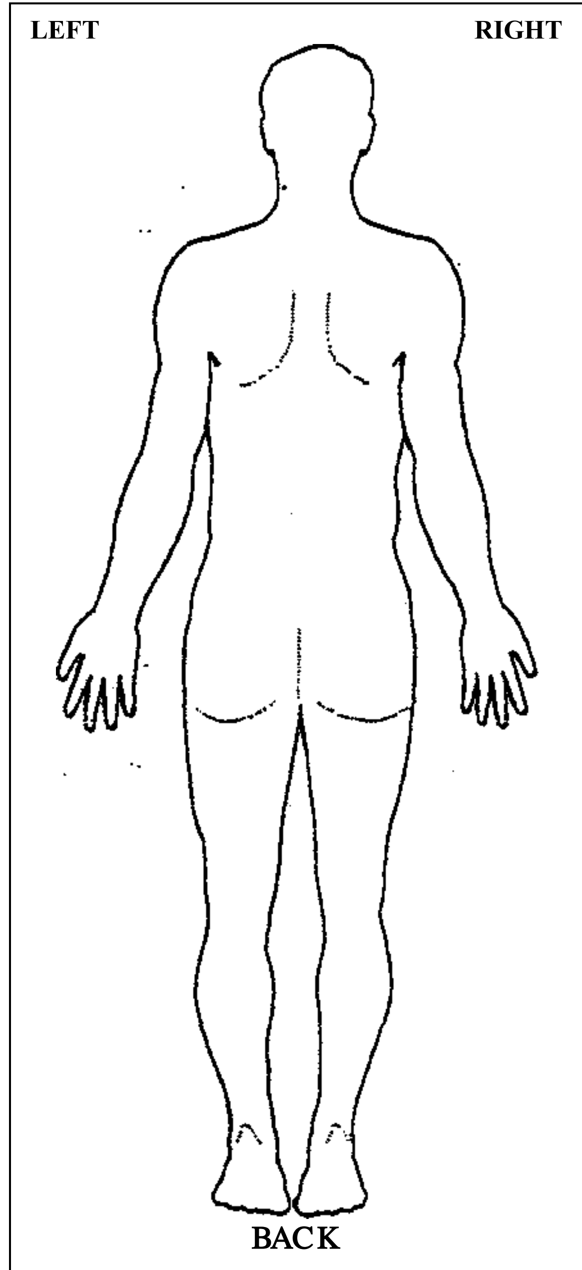
Mark all areas on your body where you feel the described sensations:

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
AAAA	oooo	____	xxxx	////
AAAA	oooo	____	xxxx	////





NAME: ______________________________ **DATE:** ______________

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Request for Medical Records

Date: ______/______/______

I, ____ authorize the release of
(Printed name of patient)

my medical records and/or films to David H. McCord, M.D.

Patient Signature: ____

PATIENT INFORMATION

Patient Name: ____________________________________

Address: ____

City & State: ____

Zip Code: _____________________ Phone: ______________________________

Date of Birth: ______/______/______

Social Security Number: ______-______-________

DAVID H. MCCORD, M.D., P.C.
NOTICE OF PRIVACY PRACTICES

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 takes effect on April 15, 2004, and remains in effect until we replace it.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Notification. We may use and disclose medical information to notify or help notify a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief. We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Research in Limited Circumstances. We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Court Orders and Judicial and Administrative Proceedings. We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Victims of Abuse, Neglect, or Domestic Violence. We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or who has escaped from legal custody.

Workers Compensation. We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities. We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Alternative and Additional Medical Services. We may use and disclose medical information to furnish you with information about health-related benefits and services that may be have interest to you, and to describe or recommend treatment alternatives.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Our Legal Duty

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting a front desk clerk. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by completing the form provided at the front desk located in suite A and dropping it in the locked box provided there in suite A.

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the contact person named below.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Kimberly Coleman
David H. McCord, M.D., P.C.
1718 Charlotte Avenue, Suite A
P.O. Box 331109
Nashville, TN 37203

MEDICATION GUIDELINES

RX LINE: (615) 329-4488

DAVID H. McCORD, M.D., P.C.
1718 Charlotte Avenue
P. O. Box 331109
Nashville, TN 37203-7510

Office: (615) 329-0333
Fax: (615) 329-3585

Prescribing pain medications is just one of the many services provided by David H. McCord, M.D., P.C. This office strictly adheres to all rules and regulations set forth by the Drug Enforcement Agency (DEA) and Tennessee Bureau of Investigation (TBI). **It is not a medical obligation to prescribe medication to a patient at any time.** It is important to understand that this office will NOT tolerate any unauthorized deviation from the medication policy. If it has been determined that a patient has been non-compliant with the medication policies, he/she will automatically be prohibited from further medication privileges. If any of the policies described are a concern, it is the patient's responsibility to discuss any and all questions or issues with the medical staff **prior to surgery. The ultimate goal is to decrease the need for pain medication.**

MEDICATION GUIDELINES

As it is the goal of this office to effectively minimize or relieve pain, medication is considered a short-term tool. It is also common practice to refer patients to a pain management specialist.

Listed below are some important key reminders in regards to our medication guidelines:

a) All medication requirements, prior to surgical intervention by this office, will be referred to the patient's primary care physician (PCP) or a referral given for a pain management specialist.
b) NO medications will be authorized after business hours (8:00 a.m. – 5:00 p.m.), weekends or holidays.
c) Medication issues will not be addressed by the answering service.
d) Medications will not be refilled early without prior authorization from the physician.
e) It is the patient's responsibility to inform this office of any medications being prescribed from any other physician's office. It is essential for our staff to assess the "full body effect" for the patient's safety. Failure to properly and accurately inform this office may jeopardize your well being, as well as, your medical privileges at this office. Furthermore, it is unacceptable and potentially hazardous to receive the same categories of medications from two or more physicians.
f) All medications must be taken as prescribed. Misuse or self-medication will not be tolerated. It is the patient's responsibility to inform the medical staff if the prescribed medication is not effective.
g) In the event of side effects, discontinue use immediately and contact this office. If a medication change is necessary, the patient will be responsible for returning all unused medication to the pharmacist before the new medication will be issued. Only the amount returned will be refilled. Payment for the new prescription will be the patient's responsibility.
h) It is the patient's responsibility to protect and, at all times, be in control of prescriptions and medications. Lost or damaged prescriptions or medications will not be refilled prior to the expiration date. If your prescription or medication is stolen, our office must obtain a signed police report before a refill is considered. No facsimiles or copies will be accepted.

i) Pain management referrals are offered when medication requirements exceed that which the physician has prescribed. Failure to comply may result in a patient being discharged from this practice.

MEDICATION REFILL GUIDELINES

In an effort to offer quality service, and in conjunction with the DEA and TBI, the office of David H. McCord, M.D., P.C. has a dedicated telephone number for medication refill requests. Please note the following medication refill guidelines:

1) All telephone requests for medication must be received through the voice mail system of the prescription line at **(615) 329-4488**. There will be no exceptions. This is a direct line and cannot be connected through the office; therefore, telephoning the receptionist, secretary or nurse's station will only delay the process.

2) Patients are required to notify the prescription line 2 business days prior to requiring a refill. Every effort will be made to handle all medication calls as quickly and efficiently as possible.

3) Unless further information or discussion is required, you will not receive a return telephone call from our staff. It is the patient's responsibility to contact his/her pharmacy.

4) Medication refill requests will only be accepted from the patient. No requests will be accepted from family members, significant others or close personal friends.

5) It is requested that the patient have available the following information prior to telephoning the prescription line:

    a) your complete name and date of birth
    b) time and date of the request
    c) last date of office visit or surgery
    d) pharmacy name and number (with area code if out of state)
    e) medication(s) requested
    f) home and business telephone numbers

6) Once you have received your medication from the pharmacy, it is essential that you review your prescription in reference to dosage and frequency. As it is the goal to diminish medication requirements, these factors may have changed from your last prescription.

8) No prescriptions will be mailed. There will be no exceptions to this policy.

9) If it has been more than three (3) months since your last office visit, no medication request(s) will be considered. For further medical care, you will be required to make an appointment, at which time any and all medication options will be assessed and discussed.

POST OPERATIVE MEDICATION GUIDELINES

Most often narcotics are prescribed following surgery. Narcotics are most effective when prescribed for a short period of time. Every attempt will be made to prescribe the lowest dosage possible to assist in pain control. Long term or excessive use of narcotics can be life threatening.

As it is the ultimate goal of this office to assist the post surgical patient in achieving a drug free lifestyle as quickly as possible, our policy is as follows:

***Pain medicine will be considered for a maximum of 90 days following surgery.**

If deemed medically necessary, the physician will refer a patient to a pain specialist or request the patient's primary care physician (PCP) to manage medications for pain control.

WARNING! Federal law prohibits the transfer of any prescription drug to any person other than the patient for whom it is prescribed.

WARNING! It is hazardous to operate a motor vehicle when taking narcotics or other controlled substances because of their tendency to induce drowsiness, and it is illegal to operate a motor vehicle while *under the influence* of narcotics and other controlled substances, *even when a physician prescribes them.*

DAVID H. MCCORD, M.D., P.C.

ACKNOWLEDGMENT OF RECEIPT OF
MEDICATION GUIDELINES

I have read and understand the medication guidelines for the office of David H. McCord, M.D., P.C.

____
Name of Patient (Please Print)

______________________________ ____________________
Signature of Patient Date

PLEASE RETURN THIS PAGE ONLY TO THE OFFICE WITH YOUR NEW PATIENT PACKET.