



Dear Patient,

Welcome to our practice. You will meet with one of our physicians at GLPC Bay City located at 4121 Shrestha Drive, Bay City, MI 48706-2171. **Your appointment is scheduled for**   date     time   **with Theron Grover, MD.**

We will contact you prior to your appointment to confirm the date and time. If you are not at home during regular business hours, please call us at **(877) 577-6227 and press 1**. If you have any questions or concerns, please feel free to address them at the time of the confirmation phone call.

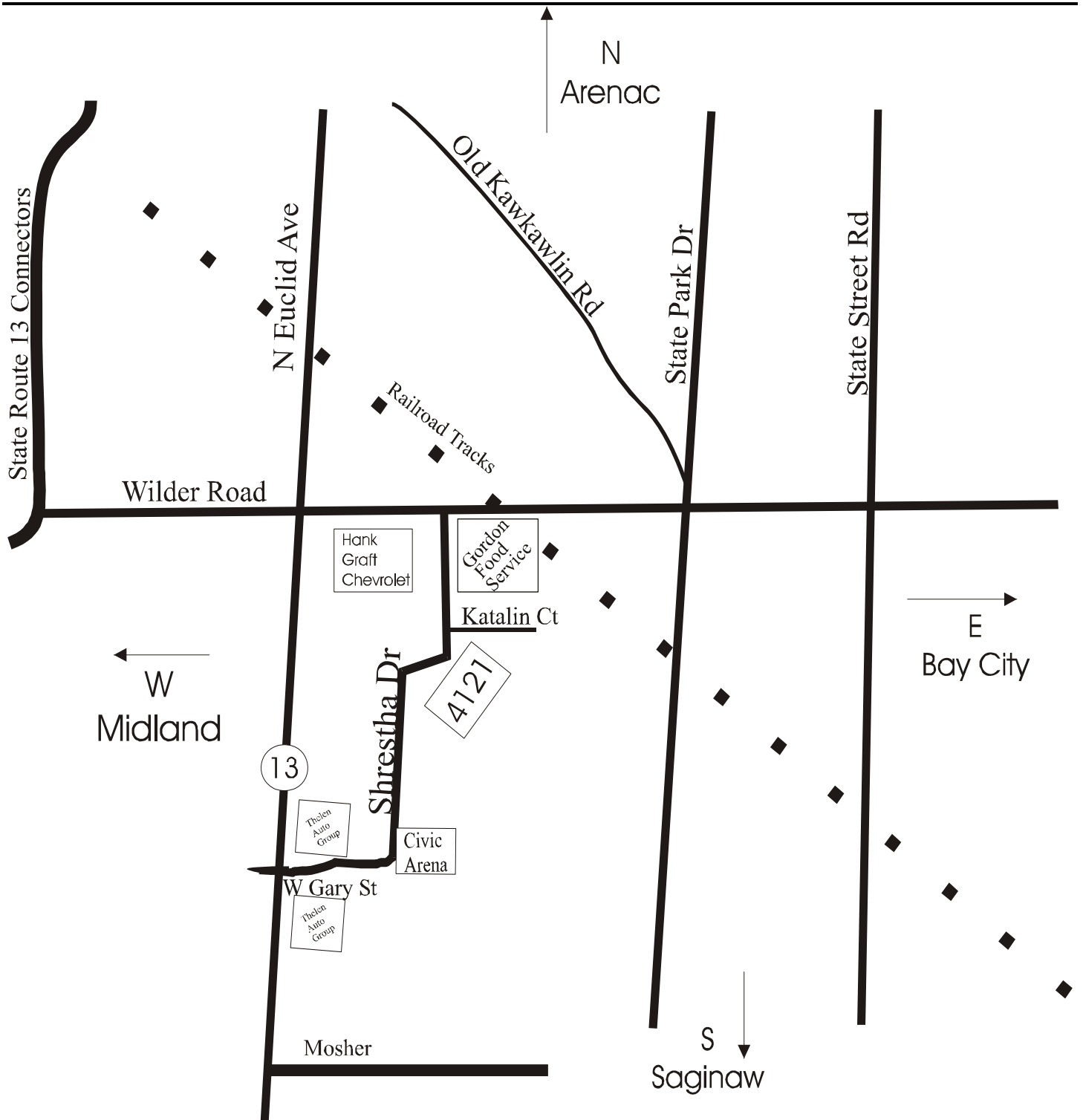
In order for us to address your needs at the time of your appointment, we ask that you follow these instructions:

1. Please bring your insurance card with you to your appointment.
2. Please complete the Patient Information Intake forms and bring them with you to your appointment. This will be used by the doctor during your examination.
3. To better serve your medical needs, our physicians will need the following information at the time of your scheduled appointment:
  - All written reports and films from X-rays, MRI's, EMG's, CT's, and bone scans that you have had in the last 6 months. Contact your referring doctor to see if this information has been sent.
4. Please arrange for a driver to arrive with you for your visit. Some procedures may require the use of light sedation. Please be aware that you must have a driver present in the waiting room in order to receive sedation.
5. Please anticipate being at our office for your initial visit for approximately two (2) hours.

Thank you for your cooperation in giving us all the necessary information in advance. By doing this, we hope to ensure your experience with our practice is a pleasant one. If you need to change your appointment, please call us at **(877) 577-6227 and press 1**. We look forward to assisting you with the management of your pain.

**See reverse side for directions**

GLPC PAIN MANAGEMENT CENTER  
4121 Shrestha Drive  
Bay City, MI 48706 ~ 989.686.6900





Dear Patient

Welcome to GLPC Bay City. The purpose of this letter is to let you know what to expect from me and our team and to answer some questions that we respond to on a regular basis.

My practice is not built on a single course of treatment, but on the best use of multiple team members and options. We are always looking for the best way to treat your pain and we are prepared to approach it in a variety of ways. Your treatment with us may involve medications, psychological or physical therapy and injections. Many times it is a combination of these techniques that ends up working the best. My goal is to do what works for you and my recommendations are always based on a thorough assessment of your current health and your goals for improvement.

You can probably imagine how medications might be used to help manage a pain problem; often times they are very effective and a key part of our treatment plan. However, we are always looking to find the root cause of the problem and not just make the symptoms go away. As pain can be a major hurdle to all kinds of daily activities, psychological therapy including biofeedback and counseling may be a vital component of your care. In addition, physical therapy can provide just the right touch to compliment your overall treatment goals. The use of injections is a key part of my training as a pain specialist and an area that usually brings up many questions. I will use the next couple of paragraphs to explain this very specialized form of treatment and to give you an idea of what to expect if this should become a part of your treatment plan.

I use injections for two main reasons. In many cases the injection is used as a diagnostic test to find the source of your pain. Additionally injections are effectively used as therapy to reduce pain. Back pain can provide a useful example. Although sometimes back pain has an obvious source, maybe a large disc herniation, many times the exact reason for the pain is uncertain. I can diagnose the source of pain when I put medications at different spots in the back. If the medications are put at the source of the problem, then you will feel better. If not, there is little to no relief. With that information, our team can develop a plan of care that specifically addresses your unique problem. As therapy, injections can initially be used to break the cycle of constant debilitating pain. As a continued treatment, longer lasting injections can be used to encourage activity and reduce the need for medications.

Not every patient is a good candidate for injections and some will respond better than others, but they can frequently be used to help people feel better. Injections are a key part of the very specialized environment that you will see in my office and a critical part of the training I received as a pain management specialist. As with all other forms of treatment, the use of injections will be based on your specific needs and your specific medical history. Whether we decide injections can help you or not, our goal is to help you feel better.

Again I welcome you to my practice and I hope this letter answers a few of your questions. I realize that you may have additional questions and I welcome the opportunity to address them when we meet on your first appointment. I appreciate the confidence you have by trusting your care to me and my entire team. We are all eager to meet you and to help you manage your pain.

Sincerely,

A handwritten signature in black ink, appearing to read "Theron Grover", with a small flourish at the end.

Theron Grover MD



## Welcome to Great Lakes Pain Consultants

Our staff is committed to providing you with the best medical care possible and to assisting you with the administrative process. We have a central billing office that you can contact anytime you have a question about your bill; the phone number is 1-800-281-3237. If you have questions regarding your insurance, we will try to help. However, questions relating to specific coverage issues must be directed to your insurance company's member services department. Their telephone number is probably on the back of your card.

Our office participates in a variety of insurance plans including, but not limited to the ones listed below:

- Medicare
- Blue Cross Blue Shield of Michigan
- BCN
- Health Plus
- United Healthcare
- Cofinity
- Aetna

If you do not have insurance, we do offer self pay options for you initial appointment and we will be happy to provide you with an estimate regarding the cost for subsequent treatment. However, if you do not have insurance, payment if full is expected at the time of service.

We accept cash, credit card and money order only, no personal checks for self-pay services  
The following apply to every visit.

- Bring your insurance card.
- Bring a picture ID
- Be prepared to provide us with updated personal information as needed
- For medical care not covered by your insurance, payment in full is due at the time of the visit.

**Co-payments and deductibles:** Since we are a specialty office sometimes your co-pay may not be due. Please be prepared to pay your co-payment amount at each visit if asked. We will not waive or discount co-payments or deductible payments that are required by your health insurance carrier. Personal checks will be accepted for co-pays and deductibles.

**Referrals:** Many insurance plans require a referral from your primary care physician to be seen by a specialist. We will contact your insurance carrier to arrange for a referral but ask that you follow up with them too. If you do not have a required referral, your visit may be rescheduled or you may be financially responsible.

**Financial assistance:** If you are unable to pay for necessary medical care, you may be eligible for financial assistance. It is your responsibility to inform us of any such concerns before your visit.

Great Lakes Pain Consultants  
History and Physical form

I Patient Data Exam Room: \_\_\_\_\_ Time in: \_\_\_\_\_

A. Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Family Physician: \_\_\_\_\_  
 List all allergies to medication and environment: \_\_\_\_\_  
 \_\_\_\_\_

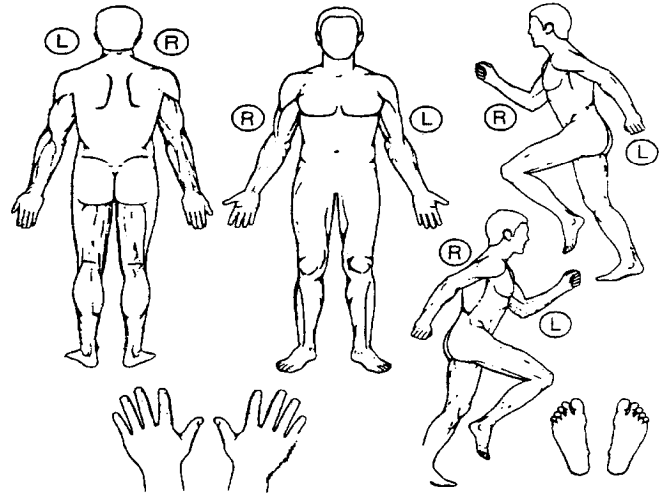
Have you ever reacted to x-ray dye? No . Yes

Latex allergic? No . Yes

B. Mark your pain on the diagrams:

C. What is your goal for pain management?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



II Description of Pain and Influencing Factors

How long have you had this problem? \_\_\_\_\_

Please describe how your pain first began:

(e.g. Accident, illness, \_\_\_\_\_  
 \_\_\_\_\_

My pain is: constant frequent occasional rare

Words that describe your pain:

dull sharp burn throb spasm other: \_\_\_\_\_

Pain Rating (Scale used 0-10 (10=worst pain))

Pain level TODAY /10

Average over the last month /10

My pain is worse in the: morning evening afternoon

What causes your pain to:

Increase? sitting standing walking lying down other: \_\_\_\_\_

Decrease? sitting standing lying down rest ice heat medication relaxation

Nurse Use Only	
BP	_____ P _____
R	_____ SPO2 _____
Temp	_____
Ht:	_____
Wt:	_____
Anticoagulant?	_____
Prescribed by:	_____
	_____



My pain travels into my: arms hands legs feet head groin buttock

Effects of pain (please note how pain affects all aspects of your life)

Quality of Sleep: \_\_\_\_\_ Total hours per night: \_\_\_\_\_

My Level of Physical Activity is reduced by: \_\_\_\_\_ %

Relationship with others: (e.g. irritability) \_\_\_\_\_

Emotions: (e.g. angry, sad, frequent crying) \_\_\_\_\_

Accompanying Symptoms: (e.g. nausea, headache, fatigue) \_\_\_\_\_

Does your pain affect your:

Eating  Yes  No

Bathing  Yes  No

Using the toilet  Yes  No

Getting out of bed or chair  Yes  No

III Tests or treatments for this problem:

Treatment	Yes/No	How Helpful was this?
Injections		
Physical Therapy		
Psychological Therapy Dr.		

Tests	Date and Place Done	Results
MRI		
CT		
EMG		
X-ray		

Are you falling? \_\_\_\_\_  
\_\_\_\_\_

IV Medical History (Have you ever, or do you now, have any of the following conditions?)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Heart Disease                             | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Intestinal                 |
| <input type="checkbox"/> Heart Attack                              | <input type="checkbox"/> Bleeding/Bruise Easily | <input type="checkbox"/> Cancer (type) _____        |
| <input type="checkbox"/> Irregular Heart Rate                      | <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Chest Pain                                | <input type="checkbox"/> Kidney Problems        | <input type="checkbox"/> High Blood Pressure        |
| <input type="checkbox"/> Thyroid Problems                          | <input type="checkbox"/> Seizures               | <input type="checkbox"/> Stomach                    |
| <input type="checkbox"/> Diabetes                                  | <input type="checkbox"/> Depression             | <input type="checkbox"/> Arthritis                  |
| <input type="checkbox"/> Cigarette Use ____packs/day for ____years |   | <input type="checkbox"/> Alcohol Use ____drinks/day |
|  |   | <input type="checkbox"/> Illicit Drug Use _____     |

V List Any Surgeries you have had:

Type of Surgery	Date



VI List Any Significant Family History: \_\_\_\_\_  
\_\_\_\_\_

VII List All Medications and doses you are currently using and how often you use them:

1. \_\_\_\_\_ 4. \_\_\_\_\_ 7. \_\_\_\_\_  
2. \_\_\_\_\_ 5. \_\_\_\_\_ 8. \_\_\_\_\_  
3. \_\_\_\_\_ 6. \_\_\_\_\_ 9. \_\_\_\_\_

Past Pain Medication: \_\_\_\_\_  
\_\_\_\_\_

VIII Review of Systems: (circle any that you have had recently)

General: fever, weight loss/gain, night sweats      Lungs: cough, wheezing, shortness of breath  
Eyes: vision loss, blurred or double vision      Ear/Nose/Throat: Pain, mass, hearing loss  
Cardio: chest pain, dizziness, irregular heartbeat      Neuro: seizures, strokes, paralysis  
Gastro: ulcers, stomach pain, diarrhea, constipation      GU: loss bladder control, frequent infections  
Blood: anemia, transfusions, easy bleeding      Skin: rash, dry skin, ulcers  
Other: \_\_\_\_\_

IX Occupation      Are you currently working?    Yes    No;      Full time    Part time  
What is/was your occupation? \_\_\_\_\_ Daily Duties: \_\_\_\_\_  
When and where did you last work? \_\_\_\_\_

X Litigation      Is Workers' Comp, disability, legal suit or an insurance settlement pending?  
 No     Yes, if yes, describe the current status of the litigation or settlement: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

XI Marital Status/Support  
 Single       Married       Widowed       Separated       Divorced  
Living arrangements: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_