Brandon
428 W Brandon Blvd
Brandon, FL 33511

Wesley Chapel
27810 Summergate Blvd
Wesley Chapel, FL 33544

Zephyrhills
38011 Arbor Ridge Dr
Zephyrhills, FL 33540

Riverview
11946 Boyette Rd
Riverview, FL 33579

Carrollwood
7550 N Dale Mabry Hwy, Ste B
Tampa, FL 33614

FLORIDA PAIN MEDICINE DOES NOT PRESCRIBE ANY PAIN MEDICATIONS ON THE FIRST VISIT

We ask that you arrive 30 minutes early with paperwork completed or 1 (ONE) hour prior to your appointment time if paperwork is to be completed in office. This allows us to review your paperwork and prepare your chart for the doctor. We have allotted a substantial portion of our schedule to complete your history and examination, and provide you with an adequate consultation. Patients who do not show for their appointments may be charged an administrative loss fee which must be paid prior to being rescheduled. **Please call the office at 813-388-2948, extension 10000, at least 24 hours in advance if you need to reschedule.**

Please complete the enclosed patient information packet to the best of your ability. We have provided a checklist to ensure that you have all the information required for your first visit, even though we may already have some of the items. If our physician doesn't have sufficient information to perform an adequate pain consultation, we may be forced to reschedule your visit. Please help us by providing the following:

1. _____ New patient packet, including:
    a. Health History Questionnaire and Registration form (highlighted information only)
    b. Read and provide signature on Consent to Treat Form, Financial Policy, Certification, Patient Privacy Questionnaire, Opioid Consent (initial as well) and Special Notice from the University of South Florida and Florida Pain Medicine
2. _____ Relevant Medical records from referring and/or Primary Care Physician
3. _____ Relevant Medical records from other physicians, hospitals or previous pain physicians
4. _____ Relevant X-ray reports, MRIs, CT Scans/films, EMG Nerve conduction and any other pain studies
5. _____ Driver's license or other Photo identification and Insurance card
6. _____ Please bring a Formulary Medication List which can be found on your insurance company's website or in your insurance company's handbook

Please do not forget your paperwork, films, reports and pill bottles for your first appointment. Copies of the new patient packet forms are also available on our website at www.FloridaPainMedicine.com with further information about the practice, physician(s) and common pain problems should you need to reference that information. Should you have any questions or need any assistance with the new patient intake process please feel free to contact us anytime. We look forward to meeting you and serving your pain care needs, and want to thank you for allowing Florida Pain Medicine the opportunity to care for you.

FLORIDA PAIN MEDICINE
Restore Function Relive Life
INTERVENTIONAL SPINE & PAIN MANAGEMENT

PAIN HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name: *Last*	*First*	*MI*	
Today's Date:	**Reason for Visit:**		
Referring Doctor/Office:	**Prior Pain Doctor:**	**Patient sex :** ☐ M ☐ F	**DOB:**

IS THIS RELATED TO AN AUTO INJURY? Yes No

IS THIS A WORKMAN'S COMPENSATION CASE? Yes No

Has your workman's compensation case settled? Yes No

If so, what is the settlement date? _____

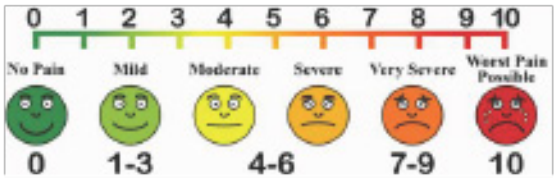
Do you have an attorney for this injury? Yes No

Attorney's Name: _____

Attorney's Phone Number: _____

Worst Pain Area Location? _____

Other Pain Areas? _____



WORST/HIGHEST Pain Score? _____

When did your pain start? _____

Pain is the result of an (How did your pain start?): - accident -illness -injury -other/unsure
Please describe: _____

Please circle the word(s) that best describe your pain:
-aching -burning -constant -deep -dull -electric -intermittent -itching -nagging -numbing -pins and needles -pressure -radiating -sharp -sore -spasms -stabbing -stiff -stinging -tight -tingling -throbbing
Other _____

Please circle the word(s) that make your pain BETTER:
-heat -ice -inactivity -injections -laying down -movement -NSAIDS -pain medication -physical therapy -rest -sitting -standing -stretching Other _____

Please Circle the word(s) that make your pain worse:
-activity -bending -inactivity -laying down -lifting -looking up and down -movement -sitting for long periods -standing for long periods -stress -twisting -use -walking for long periods -weather changes Other _____

Have you had diagnostic testing or imaging?
-X-ray Where/When? _____ -MRI Where/When? _____

-CT Scan Where/When? _____ -EMG/NCS Where/When? _____

Previous treatments tried: - acupuncture - chiropractor -injections -physical therapy - surgery
What injections were done? _____
If so, how much relief did they provide? _____
Have you seen a surgeon or had surgery for your pain ? -YES -NO
If so, what surgery and by whom? _____

PATIENT NAME:_____ DOB: _____

PERSONAL HEALTH HISTORY (PAST MEDICAL HISTORY)				
Conditions you have had in the past (check all that apply):				
☐ AIDS/HIV +	☐ Bulimia	☐ Goiter	☐ Liver Disease	☐ Stroke
☐ Alcoholism	☐ Cancer	☐ Gonorrhea	☐ Migraine Headache	☐ Suicide Attempt
☐ Anemia	☐ Cataracts	☐ Gout	☐ Mononucleosis	☐ Thyroid Problems
☐ Anorexia	☐ Chemical Dependency	☐ Heart Disease	☐ Multiple Sclerosis	☐ TB
☐ Arthritis	☐ Chicken Pox	☐ Hepatitis	☐ Pneumonia	☐ Ulcers
☐ Asthma	☐ Diabetes	☐ Hernia	☐ Polio	LIST ANY OTHERS
☐ Bleeding Disorders	☐ Emphysema	☐ Herpes	☐ Prostate Problem	☐
☐ Breast Lump	☐ Epilepsy	☐ High Cholesterol	☐ Rheumatic Fever	☐
☐ Bronchitis	☐ Glaucoma	☐ Kidney Disease	☐ Scarlet Fever	☐

Past Surgeries		
Year	**Reason**	**Hospital**

Other Past Hospitalizations		
Year	**Reason**	**Hospital**

Have you ever had a blood transfusion?	☐	**Yes**	☐	**No**

Do you know your blood type? ☐ Yes ☐ No **Type:** _____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Strength	Frequency Taken	Drug Name	Strength	Frequency Taken
1			9		
2			10		
3			11		
4			12		
5			13		
6			14		
7			15		
8			16		

Allergies to medications

Drug Name	Reaction You Had	Drug Name	Reaction You Had
1		3	
2		4	

HEALTH HABITS AND PERSONAL SAFETY (SOCIAL HISTORY)					
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Exercise	☐ Sedentary (No exercise) ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	**Are you dieting?**	☐	**Yes**	☐	**No**
	If yes, are you on a physician prescribed medical diet?	☐	**Yes**	☐	**No**
	# of meals you eat in an average day?				

Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol? Yes No If yes, what kind?_____			
	How many drinks per week?			
Tobacco	Do you use tobacco?			☐ Yes ☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day ☐ Cigars - #/day
	☐ # of years	☐ Or year quit		

Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Physical and/or mental abuse have become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your doctor or his staff?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

Relation	AGE	AGE AT DEATH	SIGNIFICANT HEALTH PROBLEMS
Father			
Mother			
Brothers			
Sisters			

MENTAL HEALTH

Do you have a history of any substance abuse or addiction? (Alcohol, Marijuana, Illicit Drugs)	☐ Yes	☐ No
Do you feel like you are addicted to pain medications?	☐ Yes	☐ No
Have you ever sold or abused (IV use, crushed, etc) you pain medications?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Have you ever thought of seriously hurting yourself? Any suicidal attempts?	☐ Yes	☐ No

Please list any other items critical physical or mental health issues you are having:

_____

Patient Signature _____

Physician/Extender Signature_____

Date_____

Review Of Systems (check all that apply to you)

CONSTITUTIONAL
- ☐ Change in appetite
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Lightheadedness
- ☐ Night sweats
- ☐ Sleep Disturbances
- ☐ Weight Gain
- ☐ Weight Loss

ALLERY/IMMUNE
- ☐ Blistering of Skin
- ☐ Congestion
- ☐ Cough
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Sneezing
- ☐ Watery Eyes
- ☐ Wheezing

OPHTALMOLOGIC (EYES)
- ☐ Blurry vision
- ☐ Diminish Visual Acuity
- ☐ Discharge
- ☐ Dry Eyes
- ☐ Flashes of light in visual field
- ☐ Floaters in visual field
- ☐ Itching and Redness
- ☐ Pain
- ☐ Red Eye
- ☐ Vision Screen

ENT/MOUTH
- ☐ Blocked Ear(s)
- ☐ Decreased hearing
- ☐ Decreased sense of smell
- ☐ Difficulty swallowing
- ☐ Dry mouth
- ☐ Ear pain
- ☐ Hearing screen
- ☐ Nosebleed
- ☐ Ringing in ears
- ☐ Sinus pain
- ☐ Sore throat
- ☐ Swollen glands

ENDOCRINE
- ☐ Cold Intolerance
- ☐ Difficulty Sleeping
- ☐ Dizziness
- ☐ Excessive Sweating
- ☐ Excessive Thirst
- ☐ Frequent Urination
- ☐ Heat Intolerance
- ☐ Irregular Menses
- ☐ Weakness
- ☐ Weight Loss

RESPIRATORY
- ☐ Chest tightness
- ☐ Breathing Pattern
- ☐ Chest Pain
- ☐ Cough
- ☐ Hemoptysis
- ☐ Pain with Inspiration
- ☐ Shortness of breath at rest
- ☐ Shortness of breath with exertion
- ☐ Sputum Production
- ☐ Wheezing

BREAST
- ☐ Bloody nipple discharge
- ☐ Breast lump
- ☐ Breast pain
- ☐ Breast swelling
- ☐ Fever
- ☐ Gland swelling
- ☐ Nipple discharge
- ☐ Red skin
- ☐ Weight loss

CARDIOVASCULAR
- ☐ Chest Pain at rest
- ☐ Chest pain with exertion
- ☐ Claudication
- ☐ Cyanosis
- ☐ Difficulty lying flat
- ☐ Dizziness
- ☐ Dyspnea on exertion
- ☐ Fluid accumulation in legs
- ☐ Irregular heartbeat
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Weakness
- ☐ Weight Gain

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Blood in stool
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Decreased appetite
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Exposure to hepatitis
- ☐ Heartburn
- ☐ Hematemesis
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Vomiting
- ☐ Weight loss

HEMATOLOGY
- ☐ Breast Lump
- ☐ Dizziness
- ☐ Easy bruising
- ☐ Groin mass
- ☐ Prolonged bleeding
- ☐ Recent transfusion
- ☐ Swollen glands
- ☐ Weakness
- ☐ Weight loss

Women Only
- ☐ Breast lump
- ☐ Breast pain
- ☐ Discharge from breast
- ☐ Heavy bleeding during menses
- ☐ Hot flashes
- ☐ Irregular menses
- ☐ Missed Period
- ☐ Painful intercourse
- ☐ Painful Menses
- ☐ Vaginal bleeding between periods
- ☐ Vaginal discharge/itching

GENITOURINARY
- ☐ Abdominal Pain/Swelling
- ☐ Blood in urine
- ☐ Difficulty Urinating
- ☐ Frequent Urination
- ☐ Pain in lower back
- ☐ Painful Urination
- ☐ Bladder incontinence

MUSCULOSKELETAL
- ☐ Carpal tunnel
- ☐ Joint Stiffness
- ☐ Leg cramps
- ☐ Muscle aches
- ☐ Pain in shoulder
- ☐ Painful joints
- ☐ Sciatica
- ☐ Swollen joints
- ☐ Trauma to arm(s)
- ☐ Trauma to hip(s)
- ☐ Trauma to knee(s)
- ☐ Trauma to ankle(s)
- ☐ Weakness

PERIPHERAL VASCULAR
- ☐ Absent pulses in hands
- ☐ Absent pulses in feet
- ☐ Blanching of skin
- ☐ Cold extremities
- ☐ Decreased sensation in extremities
- ☐ Pain/cramping in legs after exertion
- ☐ Painful extremities
- ☐ Ulceration of feet

PODIATRIC
- ☐ Achilles pain
- ☐ Achilles swelling
- ☐ Ankle Pain
- ☐ Ankle swelling
- ☐ Ball of foot pain
- ☐ Big toe pain
- ☐ Big toes swelling
- ☐ Burning
- ☐ Difficulty Walking
- ☐ Fever
- ☐ Foot numbness
- ☐ Foot pain
- ☐ Joint dislocation
- ☐ Redness over Achilles
- ☐ Sole pain
- ☐ Wound oozing

SKIN
- ☐ Acne
- ☐ Blistering of skin
- ☐ Discoloration
- ☐ Dry skin
- ☐ Eczema
- ☐ Hives
- ☐ Itching
- ☐ Keloid formation
- ☐ Mole(s)
- ☐ Nodule(s)
- ☐ Photosensitivity
- ☐ Rash
- ☐ Rash on feet
- ☐ Scaly lesions of skin/scalp
- ☐ Skin Cancer
- ☐ Skin oozing
- ☐ Sun sensitivity

NEUROLOGIC
- ☐ Balance difficulty
- ☐ Coordination
- ☐ Difficulty speaking
- ☐ Dizziness
- ☐ Fainting
- ☐ Gait abnormality
- ☐ Headache
- ☐ Irritability
- ☐ Loss of strength
- ☐ Loss of use of extremity
- ☐ Low back pain
- ☐ Memory loss
- ☐ Pain
- ☐ Seizures
- ☐ Tics
- ☐ Tingling/Numbness
- ☐ Transient loss of vision
- ☐ Tremor

PSYCHIATRIC
- ☐ Anxiety
- ☐ Auditory/visual hallucinations
- ☐ Delusions
- ☐ Depressed mood
- ☐ Difficulty sleeping
- ☐ Eating disorder
- ☐ Loss of appetite
- ☐ Mental or physical abuse
- ☐ Stressors
- ☐ Substance Abuse
- ☐ Suicidal thoughts

HEALTH EDUCATION
- ☐ Blood pressure screening
- ☐ Diabetes screening
- ☐ Family planning/safe sex teaching
- ☐ Healthy weight education
- ☐ Hepatitis vaccination
- ☐ Influenza vaccination
- ☐ Lipid screening
- ☐ Pneumovax vaccination
- ☐ Smoking cessation

CANCER SELF MANAGEMENT
- ☐ Breast self exam
- ☐ Colonoscopy
- ☐ Mammogram
- ☐ PAP testing
- ☐ PSA testing
- ☐ Skin Exam
- ☐ Smoking Cessation
- ☐ Sun Screen

Patient Name:_____ Date:____/____/_____

Please answer each question as honestly as possible by putting the corresponding number in the box to the right (ie, if "Seldom" write "1", if "Sometimes" write "2", etc). There are no right or wrong answers.

SCORE	COLOR	Initials of Reviewer

SOAPP®-R	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in your home?					
6. How often have you counted pain pills to see how many are remaining?					
6. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
16. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					
Has any relative had a problem with: **(Please circle Y/N for each item below)** Alcohol: Y/N Addiction: Y/N Mental Illness: Y/N					

Green = less than 9	***Yellow = 10-21***	***Red = 22 and over***

Please include any additional information you wish about the above answers. Thank you.
STOP: Hand first 6 pages of packet to front desk if filling out paperwork in office

FLORIDA PAIN MEDICINE
Restore Function Relive Life
INTERVENTIONAL SPINE & PAIN MANAGEMENT

REGISTRATION FORM

Please print and complete all sections below

Today's date:			☐ Office ☐ Facility ☐Home	
PATIENT INFORMATION				
Patient's Name Last:		First:	MI:	Single / Mar / Div / Sep /Wid
Date of Birth:	Age	☐ M ☐ F	Social Security #	Driver's License #
Street address:			City, State, Zip	
Phone (day)			Phone (evening, cell)	
Race:	Ethnicity:		Primary Language:	

Primary Care Provider (PCP):_____ **Phone:** _____

Referring Provider: _____ **Phone:** _____

Referral Source: _____

AUTHORIZATION TO RELEASE INFORMATION

Name_____ Relationship to Patient _____

Name_____ Relationship to Patient _____

PRIMARY INSURANCE INFORMATION

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Relationship to Patient: _____

SSN: _____

Insurance Name:_____

Subscriber ID:_____

Group#:_____

Group#:_____

SECONDARY INSURANCE INFORMATION

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Relationship to Patient: _____

SSN: _____

Insurance Name:_____

Subscriber ID:_____

Group#: _____

PT Pharmacy _____

Pharmacy Address: _____

Pharmacy Phone :_____

Pharmacy Fax: _____

FLORIDA PAIN MEDICINE
Restore Function Relive Life
INTERVENTIONAL SPINE & PAIN MANAGEMENT

PATIENT PRIVACY QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name:_____ Name: _____

Address:_____ Address:_____

Phone Number:_____ Phone Number: _____

Relationship:_____ Relationship: _____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

- Name: _____ Phone #: _____
- Name: _____ Phone #: _____

III. Please indicate your understanding that all correspondence from our office will be sent in a sealed envelope marked "CONFIDENTIAL": ☐ Check here to indicate that this statement was read.

IV. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? ☐ **Yes** ☐ **No**

V. Please print the phone number where you want to receive calls about your appointments _____

☐ I am fully aware that a cell phone is not a secure and private line.

_____ _____
PLEASE *PRINT* PATIENT NAME **DATE OF BIRTH**

_____ _____
LEGAL REPRESENTATIVE **RELATIONSHIP TO PATIENT**

_____ _____, 20___
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE **TODAY'S DATE**

FLORIDA PAIN MEDICINE
Restore Function
Relive Life
INTERVENTIONAL SPINE & PAIN MANAGEMENT

CERTIFICATION

PATIENT NAME:_____DOB: _____

I certify that I have answered all the questions truthfully and have not knowingly withheld any information concerning any problems, either past or present.

I understand that the physicians and staff of FLORIDA PAIN MEDICINE will only be evaluating my condition as it relates to my pain. Any condition which is not specifically pain-related must be followed and evaluated by my primary care physician.

I understand that the procedures and medications which may be prescribed by FLORIDA PAIN MEDICINE can potentially have adverse effects on the status of one's fertility as well as a developing fetus. I will notify my pain management physician if there is any change in my fertility status or pregnancy status.

I understand that the procedures and medications which may be prescribed by FLORIDA PAIN MEDICINE can potentially impair my ability to drive and operate machinery. I pledge to never drive impaired.

I understand that it may be at times difficult to obtain prompt consultation with the physicians or staff of FLORIDA PAIN MEDICINE. If there is ever a significant deterioration on my function or progression of symptoms, I will seek prompt medical attention elsewhere.

Patient Printed Name:_____DOB: _____

Signature or Patient/Guardian:_____Date:_____

Signature of Witness:_____Date:_____

Reviewing Physician:_____Date:_____

FLORIDA PAIN MEDICINE
Restore Function Relive Life
INTERVENTIONAL SPINE & PAIN MANAGEMENT

CONSENT TO TREAT

Patient Full Name:_____Date of Birth: _____

I, the undersigned voluntarily give consent to my Florida Pain Medicine medical professional to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

Signature of patient/legal representative **Date** _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, have received/reviewed a copy of the Florida Pain Medicine Notice of Privacy Practices and the Florida Patient Bill of Rights.

Signature of Patient/Legal Representative **Date** _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date	Initials	Reason

AUTHORIZATION AND ASSIGNMENT

I hereby authorize my Florida Pain Medicine practice location to release any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to Florida Pain Medicine (or named physicians or affiliates) for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to cross-over medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above-named entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.

_____ _____

Signature of Patient/Legal Representative **Date**

FLORIDA PAIN MEDICINE
Restore Function
Relive Life
INTERVENTIONAL SPINE & PAIN MANAGEMENT
A Division of Advanced Pain Management

FINANCIAL POLICY

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 a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

All patients must complete our "Patient Information Form" before seeing the doctor.

THE REQUIRED PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash or credit/debit cards.

REGARDING INSURANCE

We accept assignments from Medicare and other major Health Insurance; however, we do require the 20% co-pay from Medicare members or the co-payment for any insurance. We cannot bill your insurance unless you bring all your insurance information and an original claim form. Your insurance policy is a contract between you and your insurance company, and we are not part of the contract. In the event we do accept assignment of benefits, we require that you be pre-approved for our Extended Payment Plan with the authorization to bill that account for the balance. If your Insurance has not paid your account in full within 45 days, the balance of your account will be automatically billed to you. Please be aware some and perhaps all of the services provided may be "non-covered" services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Our practice is committed to providing the best treatment possible for our patients, and we charge what is usual and customary for our area.

MISSED APPOINTMENTS

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $50.00. Please help us serve you better by keeping your scheduled appointments.

Thank you for understanding our Financial Policy. In the event the account is referred to a Collection Agency or Attorney, you agree to pay all costs involved of any collection efforts. Please let us know if you have any questions or concerns.

I have read the Financial Policy (above). I understand and agree to this Financial Policy.

_____ _____
Printed Name of Patient or Responsible Party Date of Birth

_____ _____
Signature of Patient or Responsible Party Date

FAILURE TO FOLLOW PHYSICIAN ORDERS

"Physician Orders" are meant to improve and/or resolve the patient's medical condition and / or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician care and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can include but is not limited to missing, postponing, or refusal of additional tests to rule out, confirm, or discover illness. Also, missing, postponing or refusal of making scheduled appointments can be considered failing to follow physician's orders. I have read, understand and agree with the above.

Patient / Guardian Signature:_____Date: _____

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

Information on Nonopioid Alternatives for the Treatment of Pain Acknowledgment Page

I have received the Pamphlet issued by the Florida Department of Health, and my physician has reviewed with me the advantages and disadvantages of the use of non- opioid alternatives for the treatment of pain.

Patient Name: _____

Patient's Signature: _____

Date:_____ **Time:** _____

Witness: _____

Physician Name: _____

A Division of Advanced Pain Management

PHYSICIAN/PATIENT INFORMED CONSENT AND AGREEMENT FOR LONG-TERM OPIOID/NARCOTIC THERAPY FOR TREATMENT OF CHRONIC PAIN

PATIENT NAME:_____**DOB:** _____

You have agreed to or may potentially receive opioid/narcotic therapy for the treatment of chronic pain. You understand that these drugs are very useful but have a potential for misuse and are therefore closely controlled by local, state and federal governments. The goal of this treatment is to: (a) reduce your pain; and (b) improve your level of function in performing your activities of daily living. Our goal at Florida Pain Medicine is to not initiate or continue opioid therapy whenever possible, but sometimes this may be warranted for more effective pain management.

Alternative therapies and medications have been explained and offered to you. You have chosen opioid/narcotic therapy as one component of treatment.

The use of cigarettes demonstrates a dependence on nicotine. This complicates opioid therapy. If you are a smoker, you have agreed to a smoking cessation program.

You must be aware of the potential side effects and risks of these medications. They are explained below. If you have any questions or concerns during the course of your treatment, you should contact your physician.

SIDE EFFECTS

Side effects are normal physical reactions to medications. Common side effects of opioids/narcotics include mood changes, drowsiness, dizziness, constipation, nausea, and confusion. Many of these side effects will resolve over days or weeks. Constipation often persists and may require additional medication. If other side effects persist, different opioids may be tried or they may be discontinued.
You should **NOT**:

a. operate a vehicle or machinery if the medication makes you drowsy;
b. consume **ANY** alcohol while taking opioids/narcotics; or
c. take any other non-prescribed sedative medication while taking opioids/narcotics.

The effects of alcohol and sedatives are additive with those of opioids/narcotics. If you take these substances in combination with opioids/narcotics, a dangerous situation could result, such as coma, organ damage or even death.

Driving while taking opioids for chronic pain is considered medically acceptable as long as you do not have side effects such as sedation or altered mental status. These side effects usually do not occur while taking opioids/narcotics chronically. However, it is **possible** that you could be considered DUI if stopped by law enforcement while driving.

Opioids have also been known to cause decreased sexual function and libido. This is due to their effects on suppression of certain hormones such as testosterone and DHEA which can cause these side effects. Your hormone levels can be monitored during your treatment.

PATIENT'S INITIALS: _____

Constipation is a well-known side effect of opioid therapy and can usually be treated with stool softeners or gentle laxatives. Constipation is a side effect that usually does not go away and requires treatment.

RISKS

Dependence

Physical dependence is an expected side effect of long-term opioid/narcotic therapy. This means that if you take opioids/narcotics continuously, and then stop them abruptly, you will experience a withdrawal syndrome. This syndrome often includes sweating, diarrhea, irritability, sleeplessness, runny nose, tearing, muscle and bone aching, gooseflesh, and dilated pupils. Withdrawal can be life-threatening. To prevent these symptoms, the opioids/narcotics should be taken regularly or, if discontinued, reduced gradually under the supervision of your physician.

Tolerance

Tolerance to the pain-relieving effect of opioids/narcotics is possible with continued use. This means that more medication is required to achieve the same level of pain control experienced when the opioid/narcotic therapy was initiated. This may occur even though there has been no change in your underlying painful condition. When tolerance does occur, sometimes it requires tapering or discontinuation of the opioid/narcotic. Sometimes tolerance can be treated by substituting a different opioid/narcotic. When initiated, doses of medications must be adjusted to achieve a therapeutic, pain-relieving effect; upward adjustments during this period are not viewed as tolerance.

Increased Pain (Hyperalgesia)

The long-term effects of opioids/narcotics on the body's own pain-fighting systems are unknown. Some evidence suggests that opioids/narcotics may interfere with pain modulation, resulting in an **increased** sensitivity to pain. Sometimes individuals who have been on long-term opioids/narcotics, but who continue to have pain, actually note decreased pain after several weeks off of the medications.

Addiction

Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing the development and manifestations. It is characterized by behaviors that include one or more of the following:

- impaired control over drug use;
- compulsive use;
- continued use despite harm; and/or
- craving.

Most patients with chronic pain who use long-term opioids/narcotics are able to take medications on a scheduled basis as prescribed, do not seek other drugs when their pain is controlled, and experience improvement in their quality of life as the result of opioid therapy. Therefore, they are **NOT** addicted. **Physical dependence** is **NOT** the same as addiction.

Risk to Unborn Children

Children born to women who are taking opioids/narcotics on a regular basis will likely be physically dependent at birth. Women of childbearing age should maintain safe and effective birth control while on opioid/narcotic therapy. Should you become pregnant, immediately contact your physician and the medication will be tapered and stopped.

PATIENT'S INITIALS: _____

Long-Term Side Effects

The long-term effect of opioid/narcotic therapy is not fully known. Most of the long-term effects have been listed above. If you have additional questions regarding the potential long-term effects of opioid/narcotic therapy, please speak with your physician.

PRESCRIPTIONS AND USE OF OPIOID/NARCOTIC MEDICATIONS

Your medication will be prescribed by your physician for control of pain. Based on your individual needs, you will be provided with enough medication on a monthly basis, two-month basis, or three- month basis. New injuries or pain problems will require reevaluation. Prescriptions for opioids/narcotics will **not** be "called in" to the pharmacy.

You agree that you must be seen by your physician at a minimum of every three months during the course of your therapy.

You agree and understand that increasing your dose without the close supervision of your physician could lead to drug overdose, causing severe sedation, respiratory depression and/or death.

You agree and understand that opioid/narcotic medication is strictly prescribed for you, and your opioid/narcotic medication should **NEVER** be given to others.

You agree to fill opioid/narcotic prescriptions at one pharmacy.

You agree to secure your opioid/narcotic medications in safe, locked source to prevent loss or theft. You are responsible for any loss of theft.

You agree that lost, stolen or destroyed prescriptions or drugs **will not** be replaced, and may result in discontinuation of treatment.

You agree to obtain opioid/narcotic medication from one prescribing physician or that physician's substitute if your prescribing physician is not available and your prescribing physician has authorized his or her substitute to provide treatment.

You agree to submit to an initial examination and evaluation, to routine examination and evaluation on a monthly basis or regular basis (but no less than once every three months), and to examination and evaluation at the direction of your physician.

You agree to submit to blood and/or urine testing to monitor the levels of medication or other drugs and any organ side effects. **You also agree** that other doctors and law enforcement may be notified of the results.

You agree NOT to call the physician for refills or replacement medications during evening hours or on weekends/holidays. Medication refill and/or replacement requests will be addressed during regular business hours only.

You understand and agree that if you lose your medication or run out early due to overuse, you may experience and go through withdrawal from opioids/narcotics. **You further understand and agree that you are solely responsible for your own medications.**

You agree to bring all prescription medications in their bottles or containers to the office during regularly scheduled visits**.**

You agree to provide a list from your pharmacy detailing all medications received from that pharmacy and to provide updated lists as requested by your physician.

For patients taking methadone: Methadone has significant interactions with many other medications. Some of these medications may reduce your body's ability to metabolize methadone, thus

INCREASING the methadone in your body, which could be dangerous. Therefore, you **MUST** notify this office of **ALL** medications prescribed for **ANY** condition while taking methadone.

OPIOID/NARCOTIC THERAPY MAY BE <u>DISCONTINUED</u> IF YOU:

- develop progressive tolerance which cannot be managed by changing medications;
- experience unacceptable side effects which cannot be controlled;
- experience diminishing function or poor pain control;
- develop signs of addiction;
- abuse any other controlled substance (this may be determined by random blood/urine testing);
- obtain and or use street drugs (this may be determined by random blood/urine testing);
- increase your medication without the consent of your physician;
- either refuse to stop or resume smoking;
- obtain opiates/narcotics from other physicians or sources;
- fill prescriptions at other pharmacies without explanation;
- sell, give away, or lose medications;
- fail to submit to routine examination and evaluation on a monthly basis or regular basis (but no less than once every three months), or as directed by your physician;
- fail to bring your prescription medications to your regularly scheduled visits;
- fail to submit to blood/urine testing as directed;
- call for refills during evenings, weekends or holidays; or
- violate any of the terms of this agreement.

By signing below, Patient acknowledges and agrees that: (i) I have read and fully understand the Physician/Patient Informed Consent and Agreement for Long-Term Opioid/Narcotic Therapy for the Treatment of Chronic Pain; (ii) I have been given the opportunity to ask questions about the proposed treatment (including no treatment), potential risks, complications, side effects, and benefits; (iii) I knowingly accept and agree to assume the risks of the proposed treatment as presented; and (iv) I agree to abide by the terms of this agreement.

Patient Signature: _____ **Date** _____

Print Name: _____

Witness Signature: _____ **Date** _____

Print Name: _____

Physician Signature:_____ **Date** _____

Print Name: _____

PATIENT'S INITIALS: _____

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: _____

Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____

Street Address

_____

City, State and Zip Code

Phone Number:_____ Fax Number: _____

RE: Patient Name: _____

Date of Birth:_____Social Security Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

☐ All physical, occupational and rehab requests, consultations and progress notes.

☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

☐ All employment, personnel or wage records.

☐ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period_____to _____.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: _____

_____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

_____
Name of Representative

_____
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

Phone Number:_____ Fax Number: _____

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.
This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____
Signature of Patient or Legally Authorized Representative Date
(See 45CFR § 164.508(c)(1)(vi))

_____
Name and Relationship of Legally Authorized Representative to Patient
(See 45CFR §164.508(c)(1)(iv))

_____ _____
Witness Signature Date

SPECIAL NOTICE FROM THE UNIVERSITY OF SOUTH FLORIDA AND FLORIDA PAIN MEDICINE

(This notice is required by law. If you have any questions or concerns, please let us know before signing.)

I acknowledge that I have been given this separate written conspicuous notice by the University of South Florida/University of South Florida Board of Trustees, a public body corporate of the State of Florida ("USF") and Florida Pain Medicine ("FPM") that some or all of the care and treatment I receive will or may be provided by physicians who are employees and/or agents of USF, and liability, if any, that may arise from that care is limited as provided by law. I hereby certify that I am the patient or a person who is authorized to give consent for the patient.

_____ _____

Witness Date

Signature of Patient Date
or authorized representative of patient

_____

Printed Name

_____

Relationship to Patient

FLORIDA PAIN MEDICINE
Restore Function Relive Life
INTERVENTIONAL SPINE & PAIN MANAGEMENT

PATIENT HEALTH CARE DIRECTIVE (LIVING WILL)

I, _____, want everyone who cares for me to know what healthcare I want, when I cannot let others know what I want.

SECTION 1:
I want my doctor to try treatments that may get me back to an acceptable quality of life. However, if my quality of life becomes unacceptable to me and my condition will not improve (is irreversible), I direct that all treatments that extend my life to be withdrawn.

A quality of life that is unacceptable to means (Check all that apply to you) o Unconscious

(chronic coma or persistent vegetative state) o Unable to communicate my needs o

Unable to recognize my family or friends o Total or near total dependence on other for

care. o Other:

_____ Check only one:

- o Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV). o If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

SECTON 2: (You may leave this section blank)

Some people do not want certain treatments under any circumstances, even if they might recover.

Check the treatments below that you do not want under any circumstances:

- o Cardiopulmonary Resuscitation (CPR) o Ventilations (Breathing machines) o Feeding tube o Dialysis
- o Other: _____

SECTON 3

When I am near death, it is important to me that: _____
_____
_____ _____
_____

(Such as hospice care, place of death, funeral arrangements, cremation, burial preferences, etc.)

BE SURE TO SIGN PAGE TWO (2) OF THIS FORM

- If you only want a Health Care (Medical) Power of Attorney, draw a large X through this page.
- Give a copy of these forms to your doctor(s), family, and friends.
- Take a copy of this form with you whenever you go to the hospital or on a trip.
- You should review this form often.
- You can cancel or change this form at any time.

Patient Signature_____

FLORIDA PAIN MEDICINE
Restore Function Relive Life
INTERVENTIONAL SPINE & PAIN MANAGEMENT

HEALTH CARE (MEDICAL) POWER OF ATTORNEY WITH MENTAL HEALTH AUTHORITY

It is important to choose someone to make healthcare decisions for you when you cannot. **TELL THE PERSON (AGENT) YOU CHOOSE WHAT YOU WANT.** The person you choose has the right to make any decision to ensure that your wishes are honored. If you **DO NOT** choose someone to make decisions for you, write **NONE** LQ WKH OLQH IRU WKH DJHQW¶V name.

I, _____, as principal, designate _____ as my agent for all matters relating to my health (including mental health) and including, without limitations, full power to give or refuse consent to all medical, surgical, hospital, and related health care. This power of attorney is affective on my inability to PDNH RU FRPPXQLFDWH KHDOWK FDUH GHFLVLRQV $OO RI P\ DJHQW¶V DFWLRQV XQGHU WKLV SRZHU RI DWWRUQH\ GXULQJ DQ\ SHULRG when I am unable to make or communicate my health care decisions or when there is uncertainty whether I am dead or alive have the same affect on my heirs, devisees, and personal representatives as if I were alive, competent, and acting for myself.

_____ By initialing here, I specifically consent to giving my agent the power to admit me to an inpatient or partial psychiatric hospitalization program if ordered by my physician.

_____ By initialing here, this Health Care Directive including Mental Health Care Power of Attorney may not be revoked if I am incapacitated.

Print Agent Address and Phone Number Below:
_____ _____
If my agent is unwilling or unable to service or continue to service, I hereby appoint:
_____ _____ _____ _____ Print alternate agent address and phone number below:
_____ _____ _____ _____ _____

I intend for my agent to be treated as I would regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applied to any information government by Health Insurance Portability and Accountability Act of 1996 (AKA HIPPA), HIPPA 45 CFR 164.502(g) and 45 CFR 164.524; HiTECH ACT Section 13410(d) and 1176(b)

_____

SIGN HERE for the Health Care (Medical) Power of Attorney and/or the Health Care Directive Forms

Please ask one person to witness your signature who is not related to you or financially connected to you or your estate. Signature: _____ Date: _____/_____/_____

The above-named person is personally known to me and I believe him/her to be of sound mind and to have completed this document voluntarily. I am at least 18 years old, not related to him/her by blood, marriage, or adoptions and not an agent named in this document. I am not to my knowledge a beneficiary of his/her will or codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

Provider Signature: _____ Date: ____/____/_____

This document may be notarized by patient.
On this _____ day of _____, in the year of _____, personally appeared before me, the person signing, known by me to be the person completed this document and acknowledged it as his/her free act and deed IN WITNESS THERE OF I have set my hand and affixed my official seal in the County of _____, State of _____on the date written above.

Notary Public Signature: _____ **Patient Signature_____**