KNOW® PAIN **OrthoMed**
Pain & Sports Medicine

PATIENT NAME: _____ DOB: _____

HOME ADDRESS: _____

PHONE#: _____ EMAIL: _____

SS#:_____ DRIVER LICENSE#:_____

GENDER (CHECKMARK) MALE___ FEMALE___ MARITAL STATUS:_____

PRIMARY RACE: (CHECK ALL THAT APPLY)

WHITE___ AFRICAN AMERICAN___ AMERICAN INDIAN___ HISPANIC___ DECLINE TO SPECIFY

ETHNICITY: ___ HISPANIC OR LATINO ___ NOT HISPANIC OR LATINO ___DECLINE TO SPECIFY

EMERGENCY CONTACT:_____ PHONE#: _____

EMPLOYER NAME:_____ OCCUPATION: _____

PRIMARY CARE DR: _____ PHONE#:_____

HOW DID YOU HEAR ABOUT THE OFFICE?: _____

PRIMARY INSURANCE **SECONDARY INSURANCE**

INS NAME:_____ INS NAME: _____

MEMBER ID: _____ MEMBER ID: _____

INS PHONE#: _____ INS PHONE#: _____

WORKERS COMP/ AUTO BILL INFORMATION

INS CARRIER: _____ PHONE#: _____

ADDRESS: _____

CLAIM#: _____ DATE OF ACCIDENT: _____

ADJUSTER: _____ PHONE#: _____

NURSE CASE MGR: _____PHONE#: _____

ATTORNEY: _____ PHONE#: _____

I CERTIFY THAT THE INFORMATION I HAVE REPORTED IS CORRECT

SIGNATURE: _____ DATE: _____

KNOW® PAIN **OrthoMed** Pain & Sports Medicine

PLEASE COMPLETELY FILL OUT THIS BOX

NAME : _____

DOB : _____

DATE : _____

PCP : _____

REFERRAL SOURCE : _____

PRIMARY INS : _____

PHARMACY :

_____

PHARMACY LOCATION :

_____

Allergies (Please list *or* write "NONE" if applicable)

1)_____ 2)_____ 3)_____

Current Medications (Attach additional paper, as needed)

drug name_____**dose**_____**freq**_____
drug name_____**dose**_____**freq**_____
drug name_____**dose**_____**freq**_____
drug name_____**dose**_____**freq**_____
drug name_____**dose**_____**freq**_____

Medical History (If you have had these conditions, check ones that apply)

	ALCOHOLISM		BLEEDING DISORDER		HEART ATTACK		KIDNEY DISEASE		SEIZURES
	ARTHRITIS/RA/OA		DIABETES I OR II		HEART DISEASE		DRUG ABUSE		STROKE
	ASTHMA		EMPHYSEMA		HIGH BLOOD PRESSURE		DEPRESSION		TB
	GOUT		HIV/AIDS		THYROID DISEASE		REFLEX (GERD)		SHINGLES
	SPINAL STENOSIS		CANCER:				OTHER:		

Surgical History (If you have had surgery, circle, and list all that apply. Include the year of surgery.)

	HEART	BYPASS	ANGIOPLASTY	STENTS		FRACTURE	WHERE:	WHEN:	OTHER? LIST BELOW
	SPINE	CERVICAL	THORACIC	LUMBAR		CANCER	WHERE:	WHEN:	

Social History (Circle all that apply) Smoking Alcohol Drugs Do you live alone? YES or NO

Occupation? _____ **Number of children?**_____ **Retired? From:** _____

Family History (circle all that apply. Please specify relationship, Mother, Father, etc...)

	ALCOHOLISM		BLEEDING DISORDER		HEART ATTACK		KIDNEY DISEASE		SEIZURES
	ARTHRITIS/RA/OA		DIABETES I OR II		HEART DISEASE		DRUG ABUSE		STROKE
	ASTHMA		EMPHYSEMA		HIGH BLOOD PRESSURE		DEPRESSION		TB
	GOUT		HIV/AIDS		THYROID DISEASE		REFLEX (GERD)		SHINGLES
	SPINAL STENOSIS		CANCER:				OTHER:		

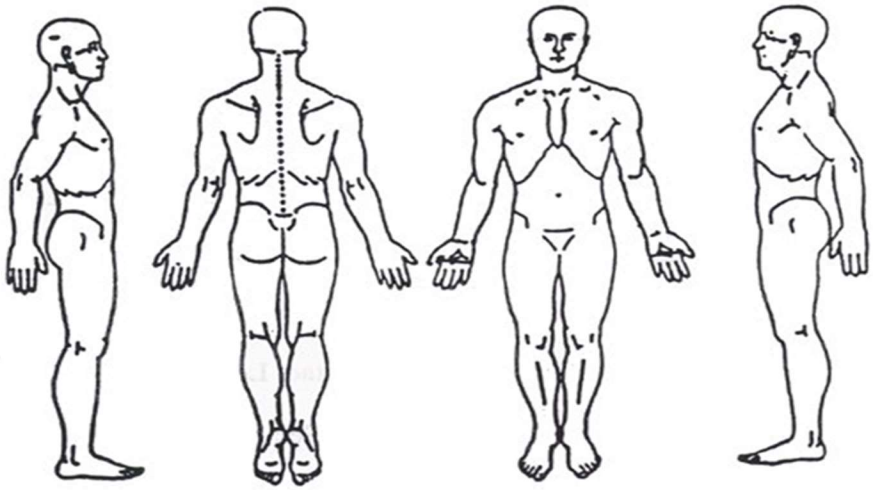
Review of Systems (How are you feeling? Check off all that currently apply)

	HEADACHES		FAINTING
	SHORTNESS OF BREATH		NEURO ISSUES
	BLOOD IN URINE		HEARTBURN
	KIDNEY DISORDER		KIDNEY STONES
	SHINGLES		CONSTIPATION
	BLADDER/BOWEL		BLACK OUTS
	DENTURES		COPD/LUNG ISSUES
	CHEST PAIN		VERTIGO
	PALPITATIONS		DIARRHEA
	WHEEZING		NAUSEOUS
	SKIN DISORDER		VOMITING
	CARDIAC DISORDER		OTHER LIST BELOW
	HEARING LOSS		
	VISION CHANGES		
	TROUBLE URINATING		

PAIN TYPE AND LOCATION:

SHARP STABBING DULL ACHING BURNING NUMBNESS/TINGLING

^^^^ XXXX :::: NNNN



KNOW® PAIN OrthoMed
Pain & Sports Medicine

PATIENT CONSENT TO RECEIVE MAIL OR PHONE CALLS

Do we have your permission to:		YES	NO
1	Mail appointment reminders to your home?		
2	Call you at home?		
3	Call you at work?		
4	Leave a message on your home phone?		
5	Leave a message on your work phone?		
6	Share appt info with the person that answers your phone?		
7	Share appt info with the person that answers your work phone?		

☐ ☐ ☐

Preferred method for appt reminders: TEXT EMAIL PHONE

Phone#: _____ Email: _____

****

AUTHORIZATION FOR FAMILY OR FRIENDS TO RECEIVE INFOR1'1ATION ABOUT YOUR MEDICAL CONDITION OR BILL

I authorize the following individual(s) to receive written and/or oral communications about my medical condition, care, appointments, and the status of my bill. I understand that they need to provide the last four digits of my social security number for oral communication. If they should come to pick up a prescription or to discuss my care or thestatus of my bill, they will need to bring a photo ID.

_____ _____
Name/Relationship Name/Relationship

_____ _____
Name/Relationship Name/Relationship

_____

PATIENT SIGNATURE

KNOW® PAIN OrthoMed Pain & Sports Medicine

RESPONSIBILITY AGREEMENT

(initial) _____ I understand that fees for services rendered are due at the time of the appt unless other financial arrangements have been made prior to my appt date and time. This includes insurance deductibles and patient's portion not payable by insurance.

(initial) _____ I understand that my insurance is an agreement between my insurance company and myself. I also understand that I am responsible for any balance on my account regardless of my insurance.

(initial) _____ I understand that after 45 days. If my insurance has not responded to a request for payment, I am responsible for any fees acquired in full.

(initial) _____ I assign benefit payments to be paid directly to OrthoMed Pain Relief Centers from my insurance company.

(initial) _____ I understand there will be a charge of $30 for any check returned due to insufficient funds.

(initial) _____ I authorize OrthoMed Pain Relief Centers to furnish me or my insurance company, and physicians or health care providers with my medical records or information requested regarding my past or present conditions or treatments.

(initial) _____ I have been given a copy of the Summary Notice of Privacy Practices from OrthoMed Pain Relief Centers.

(initial) _____ I understand that I must give notice of at least 72 hours to cancel an appt or I will incur charges of $100 per office visit, $100 per procedural appt, $150 per fluoroscopic procedure appt.

Please note: if you have an emergency/sickness and you call us within the 72 hours you will not be charged if you contact the office and speak to the front desk, this will be handled on a case-by-case basis.

(initial) _____ I authorize OrthoMed Pain Relief Centers to initiate an insurance/ physician authorization and I understand that an authorization does not guarantee payment.

MEDICATION RENEWAL POLICY

(initial) _____ I understand that medication renewals require a notice to our office at least two business days prior to the end date. **To expedite renewals, call your pharmacist first and thy will send a request to our office.**

By signing below, I agree to all terms listed above. If further attest to all information provided within this four-page document (registration and update forms) as complete and correct.

_____ _____ _____

PRINT NAME **SIGNATURE** DATE

KNOW® PAIN OrthoMed Pain & Sports Medicine

MEDICAL RECORD RELEASE

DATE .....

PATIENT NAME .....

RECORDS REQUESTED FROM .....
NAME

SPECIFIC RECORDS _____

☐ ALL MEDICAL RECORDS

I hereby authorize and request you to release the medical records requested above to OrthoMed Pain & Sports Medicine. I understand that they may contain information regarding my illness and/or treatments. They may also contain psychiatric, alcohol, HIV, or drug abuse information.

DATES FROM ..... TO .....

_____ _____

PATIENT SIGNATURE **DOB**

Requested by Dr. William J Cole Jr. D.O.

OrthoMed Pain & Sports Medicine, LLC

ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains participant rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office at (941) 371-7171.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. OrthoMed Pain & Sports Medicine provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The participant understands that:

· Protected health information may be disclosed or used for treatment, payment or health care operations.
· OrthoMed Pain & Sports Medicine has a Notice of Privacy Practices and that the participant has the opportunity to review this notice.
· OrthoMed Pain & Sports Medicine reserves the right to change the Notice of Privacy Practices.
· The participant has the right to request restrictions to the uses of their information but OrthoMed Pain & Sports Medicine does not have to agree to those restrictions.
· The participant may revoke this Consent in writing at any time and full disclosures will then cease.
· OrthoMed Pain & Sports Medicine may condition receipt of treatment upon the execution of this consent.

I have received a copy of the Summary Notice of Privacy Practices. I understand that I may also request a copy of the practice's complete Notice of Privacy Practices if I so desire.

_____

NAME (PRINT)

_____ _____

SIGNATURE **DATE**

_____ _____

SIGNATURE OF REPRESENTATIVE DATE

NO SHOW POLICY & PROCEDURES

I. Purpose

A. To assure that patients have access to care when needed by maximizing the utilization of available appointments.
B. To provide a mechanism for appropriately managing the patient that fails to utilization of available appointments.

II. Cancellation/ No Show Policy for New patient consultation, Office Visits, Med. Refill, OMT, Procedures, TPI.

A. If a patient is unable to keep their appointment, they are required to cancel their appointment with appropriate prior notice (72 hours).
B. Failure to the patient to cancel their appointment without a 72-hour notice is considered a "No Show" for purpose of this policy.

III. Cancellation/ No Show Policy for Radio Frequency Ablation (RFA)

Due to the large block of time needed for Radio Frequency Ablation (RFA), last minute cancellations can cause problems and added expenses for the office.
If Radio Frequency Ablation (RFA) is not cancelled at least five (5) business days in advance you will be charged a two hundred dollars ($200) fee; this is will not be covered by your insurance company.

IV. *Same Day/ Acute "NO SHOWS"

The patient who fails to keep a same day or an acute appointment, and does not cancel appointment with appropriate notice, is counted and managed as other "No Show".

APPOINTMENT	NO SHOW FEE
New Patient Consultation	$100
Office Visit	$100
Medication Refill	$100
OMT	$100
Procedures/PRP	$150
RFA	$200
TPI	$100

_____ _____

PATIENT SIGNATURE **DATE**

KNOW® PAIN **OrthoMed**
Pain & Sports Medicine

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT PHOTOGRAPHIC &/OR VIDEO IMAGES

AUTHORIZATION:

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPPA privacy regulations.

PURPOSE:

The photographic/video images, and/or testimonial will be used for: *social media and/or advertising.*

REVOCABILITY:

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

If desired, copy provided.

☐ "YES, I would like a copy of this form." form given to patient by _____ (initial)

☐ NO I DO NOT CONSENT FOR DISCLOSURE OF IMAGES/VIDEO

(IF YOU DO NOT CONSENT, PLEASE MARK NO ABOVE AND STILL SIGN THIS FORM)

_____ _____

PATIENT SIGNATURE **DATE**

IF PERSONAL REPRESENTATIVE/GUARDIAN:

_____ _____

PRINTED NAME RELATIONSHIP TO PATIENT

_____ _____

SIGNATURE DATE

KNOW® PAIN OrthoMed Pain & Sports Medicine

PATIENT-PHYSICIAN AGREEMENT FOR OPIOID USE

There is a possibility that my doctor will prescribe opioids (morphine-like medications), also called narcotics, as part of my treatment for chronic pain. I understand that these medications can be very useful but have a potential for misuse and are therefore closely controlled by the local, state, and federal government. I understand my physician is prescribing this medication to help manage my pain and increase my function. By signing this agreement, I agree to follow the rules and regulations listed below.

1. I am responsible for my opioid pain medications. I agree to take the medications only as directed. I understand that increasing my dose without the supervision of my physician could lead to drug overdose. Drug overdose can cause severe sedation (sleepiness), slowed breathing and possible death. I understand that decreasing or stopping my opioid medication without the supervision of my physician could lead to withdrawal. Withdrawal symptoms may include yawning, "gooseflesh", abdominal cramps, and diarrhea. These symptoms can occur 24 to 48 hours after the last dose of medication and can last up to 3 weeks.
2. I will not request or accept opioid pain medication from any other physician or individual while I am receiving this medication from OrthoMed Pain & Sports Medicine unless it is an emergency and that I am responsible for notifying OrthoMed Pain & Sports Medicine within 24 hours or the next business day.
3. I understand that there are side effects related to opioid medication. Common side effects include nausea and vomiting (similar to motion sickness), drowsiness and constipation. If I experience constipation, I may need to take stool softeners. Less common side effects are mental slowing, flushing, sweating, itching, urinary difficulty, and jerkiness. These side effects would occur at the beginning of my treatment and often go away within a few days without treatment. It is my responsibility to notify my physicians of any side effects that continue or are severe (such as drowsiness, severe constipation, or confusion).
4. (FEMALES ONLY) I am responsible for notifying my pain physician immediately if I become pregnant or plan to become pregnant.
5. I understand the opioid medication is strictly for my own use. The opioid medication should never be given to others. If children are in the house, a childproof top is necessary, and the medication should be kept in a safe place out of reach of children.
6. I understand that I must contact my pain physician before taking benzodiazepines (such as Valium, Xanax or Ativan), sedatives (such as Soma, Fiorinal or sleep medications) and antihistamines (such as Benadryl). The use of these medications or alcohol with opioid medication may produce drowsiness, slowed breathing, blood pressure drop, or death.
7. I agree to submit to urine or blood screens at any time as determined by my physician to detect both the use of prescribed and non-prescribed medications.
8. I will not use street drugs (such as marijuana, cocaine, heroin, etc.) while on opioid medications. If I do, the opioid medication will be discontinued.
9. During the time my dose is being adjusted, I will be expected to return to OrthoMed Pain & Sports Medicine for my scheduled visits which will never exceed a three (3) month period between visits. Once I have been placed on a stable dose, I will return to OrthoMed Pain & Sports Medicine or my primary care physician as instructed.

CONTINUED

10. I am responsible for my opioid prescription, I understand:
    - Prescriptions should be filled at the same pharmacy
    - Prescriptions will only be filled during regular office appointments.
    - Prescriptions cannot be obtained at night, on holidays, or on weekends.
    - If a conflict arises such as extensive travel plans or moving, I am responsible for notifying OrthoMed Pain & Sports Medicine well in advance (at least 14 days) to discuss a plan for my prescriptions.
    - Prescriptions will not be given if I am out early or "lose a prescription", spill or misplace my opioid medication. I am responsible for taking my medications in the dose prescribed and for keeping track of the amount remaining.
    - If my medication is stolen, I will notify the police and obtain a stolen item report listing the medication name on the report. At the discretion of my physician, replacement prescriptions may or may not be given. I am responsible for keeping my medication in a safe place.
11. While physical dependence is to be expected after long-term use of opioids, signs of addiction and psychological dependence is to be interpreted as a need for weaning or slowly discontinuing the opioid medication.
    - **PHYSICAL DEPENDENCE** is common to many medications such as blood pressure medications, anti-seizure medications and opioids. Taking these types of medications results in biochemical changes in your body (your body becomes used to these medications). Should you abruptly stop taking the opioid medication you may go through withdrawal.
    - **ADDICTION** is a psychological and behavioral syndrome that is recognized when a patient abuses the opioid medication to obtain mental numbness or "get high" or drug craving behavior such as "doctor shopping" or being rude or manipulative to the physicians or staff in attempts to obtain opioid medication.
12. If it appears to the physician that there is no improvement in my daily function or quality of life from the opioid medication, my opioids may be tapered down and discontinued.
13. A primary care physician (PCP) is important for my continuing healthcare needs. I am responsible to have a primary care physician and should I change my PCP, I will notify OrthoMed Pain & Sports Medicine.

Pursuant to The Health Insurance Probability and Accountability Act (H.I.P.P.A.), 45 C.F.R. 164.508, and Florida Statute 456.057, the undersigned knowingly and voluntarily agrees to the release of any and all protected health information for any and all purposes regardless of whether any particular purpose is mentioned including but not limited to all prescriptions including drug, dosage, and quantity; all notes regarding past, present, or future treatment; any document considered a medical record under Florida or federal law; and any other document pe1taining to the treatment of the undersigned at any future date upon either request by law enforcement, the State Attorney's Office or any other prosecuting authority, or code enforcement, or at any time the physician believes that a criminal violation of federal or Florida law has occurred. The undersigned further knowingly and voluntarily agrees to waive any doctor-patient privilege and any information protected by such p1ivilege, at any future date upon either request by law enforcement, the State Attorney's Office or any other prosecuting authority, or code enforcement, or at ai1y time the physician believes that a criminal violation of federal or Florida law has occurred. The undersigned acknowledges that no provisions for treatment, payment, enrollment in a health plan, or eligibility for benefits is a condition of this authorization. The undersigned understands that this authorization can be revoked in writing at any time unless the covered entity has taken ac tion in reliance thereon. The undersigned understands that any re- leased information pursuant to the authorization may be re-disclosed by the recipient and thus no longer protected under state or federal law. By signing this authorization, the undersigned affirms that a signed copy of this authorization has been provided to the undersigned and understands that a signed copy of the authorization is available at any time in the future, upon request.

I further understand that if I do not follow the above agreement, I will no longer receive any opioid medication from OrthoMed Pain & Sports Medicine. It is my responsibility to contact OrthoMed Pain & Sports Medicine to clarify or discuss any issues before a problem or crisis arises. I understand I will be required to make a follow up appointment to see the physician.

I _____ have read the above information (or it has been read to me). I have received a copy of the contract and my questions regarding the treatment of chronic pain with opioids have been answered.

☐ I hereby give my consent to participate in opioid medication therapy.

☐ I **DO NOT** give my consent to participate in opioid medication therapy.

_____ _____

PATIENT SIGNATURE **DATE**

_____ _____

PHYSICIAN SIGNATURE PRIMARY CARE PROVIDER

KNOW® PAIN OrthoMed Pain & Sports Medicine

OPIOID RISK TOOL

NAME: _____ DATE: _____

AGE: _____ SEX: M F

FAMILY HISTORY OF SUBSTANCE ABUSE

(CHECK ONLY BOXES THAT APPLY)	YES	NO
FAMILY HISTORY OF ALCOHOL?		
FAMILY HISTORY OF ILLEGAL DRUGS?		
FAMILY HISTORY OF RX DRUGS?		

PERSONAL HISTORY OF SUBSTANCE ABUSE

(CHECK ONLY BOXES THAT APPLY)	YES	NO
PERSONAL HISTORY OF ALCOHOL?		
PERSONAL HISTORY OF ILLEGAL DRIGS?		
PERSONAL HISTORY OF RX DRUGS?		
AGE BETWEEN 16-45 YEARS?		
HISTORY OF PREADOLESCENT SEXUAL ABUSE?		

PSYCHOLOGIC DISEASE

(CHECK ONLY BOXES THAT APPLY)	YES	NO
ADD, OCD, BIPOLAR, SCHIZOPHRENIA?		
DEPRESSION?		

PATIENT HEALTH QUESTIONAIRE (PHQ-9)

KNOW® PAIN OrthoMed Pain & Sports Medicine

(USE "X" TO INDICATE YOUR ANSWER)

OVER THE PAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING QUESTIONS:	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
	0	1	2	3
LITTLE INTREST OR PLEASURE IN DOING THINGS				
FEELING DOWN, DEPRESSED OR HOPELESS				
TROUBLE FALLING OR STAYING ASLEEP, OR SLEEPING TOO MUCH				
FEELING TIRED OR HAVING LITTLE ENERGY				
POOR APPETITE OR OVEREATING				
FEELING BAD ABOUT YOURSELF OR THAT YOU ARE A FAILURE, OR HAVE LET YOURSELF OR FAMILY DOWN				
TROUBLE CONCENTRATING ON THINGS, SUCH AS READING THE NEWSPAPER OR WATCHING TV				
THOUGHTS THAT YOU WOULD BE BETTER OFF DEAD OR HURTING YOURSELF IN SOME WAY				
MOVING OR SPEAKING SO SLOWLY THAT OTHER PEOPLE COULD HAVE NOTICED; OR THE OPPOSITE, BEING SO FIGITEY OR RESTLESS THAT YOU HAVE BEEN MOVING AROUND MORE THAN USUAL				