FLORIDA MEDICAL PAIN MANAGEMENT

☐ 6333 54th Avenue North
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Ph: (727)914-3995
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To help us understand your problem, please complete <u>ALL QUESTIONS</u> on <u>ALL</u> of the attached forms.

Date _____

Name _____ Age _____ Date of Birth _____

Height: _____Weight:_____ Eye color _____ Tattoos/site_____ Scars/site_____

Who referred you to us? _____

Family/Primary Care Physician _____ Phone_____

Which part of your body hurts the most? _____

How long have you had this pain? _____

Was pain caused from MVA/Trauma: ☐ Yes ☐ No Illness: ☐ Yes ☐ No Unknown Cause: ☐ Yes ☐ No

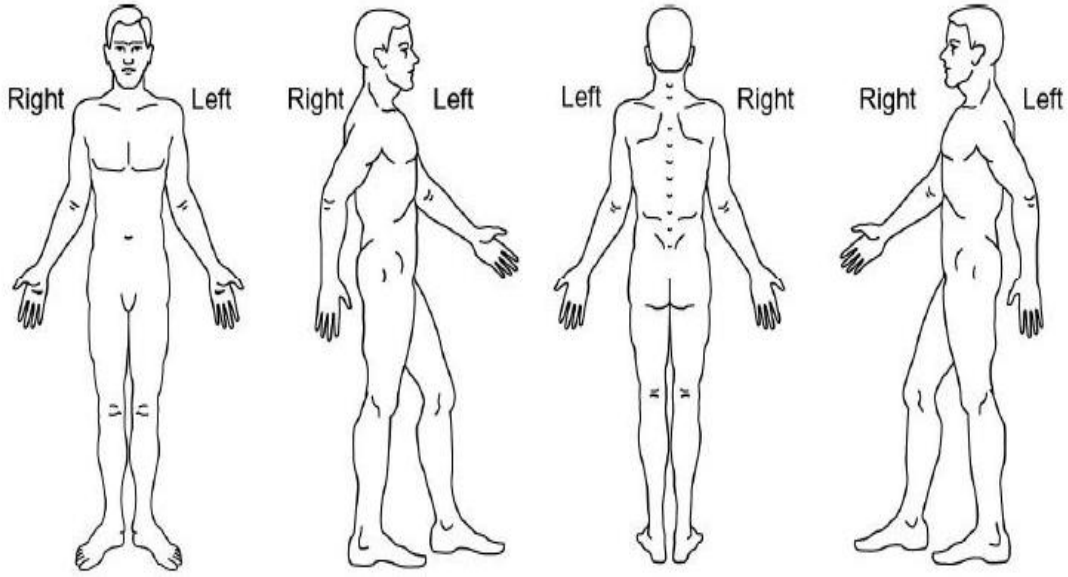
If MVA/Trauma please explain and give dates: _____

Are you involved in any litigation or lawsuit as a result of your pain? ☐ Yes ☐ No

Are you seeking Workers Compensation as a result of your pain? ☐ Yes ☐ No

On a scale of 0 to 10, "0" being no pain and "10" being the worst pain imaginable, circle the number that describes your level of pain:

No pain = 0 1 2 3 4 5 6 7 8 9 10 = Worst pain imaginable.



Shade in areas above where you have pain and check **ALL** the words that best describe your pain:

☐ Aching	☐ Shooting	☐ Tingling	☐ Stabbing	☐ Frequent
☐ Dullness	☐ Stinging	☐ Burning	☐ Constant	☐ Other _____
☐ Excruciating	☐ Coldness	☐ Sharpness	☐ Tightness	☐ Other _____
☐ Intermittent	☐ Occasional	☐ Radiating	☐ Numbness	☐ Other _____

Patient Name: _____Date: _____

Please indicate the factors or activities of daily living that increase or decrease your pain:

Factors	Increase	Decrease	No Effect		Factors	Increase	Decrease	No Effect
Weather Change					Sneeze, cough			
Heat					Sitting			
Cold					Sleep			
Physical Activity					Travel			
Posture					Communication			
Walking					Urination			
Lying down					Medications			
Appetite					Exercise			
Occupation					Standing			
Pressure					Medications			
Sexual Activity					Relaxation			
Bowel movement					Thinks about something else			
Bright light/noise					Other			

Do you have any of the following?

Neuropathic/Nerve pain ☐ Yes ☐ No If yes, were symptoms present before pain began? ☐ Yes ☐ No

Numbness/Tingling ☐ Yes ☐ No If yes, were symptoms present before pain began? ☐ Yes ☐ No

Weakness ☐ Yes ☐ No If yes, were symptoms present before pain began? ☐ Yes ☐ No

Bowel/ Bladder Incontinence ☐ Yes ☐ No If yes, were symptoms present before pain began? ☐ Yes ☐ No

Headache: ☐ Yes ☐ No

Pain site: _____ Nature of pain: _____ Duration of pain: _____

Pain triggers: ☐Tobacco ☐Alcohol ☐Exercise ☐Noise ☐Sex ☐Weather ☐Menstrual Cycle ☐Other

Pain symptoms: ☐Nausea / Vomiting ☐Photophobia / Phonophobia ☐ Myosis / Ptosis ☐Lacrimal / Nasal congestion

Pain relievers: ☐ Quiet ☐ Dark Room ☐ Other _____

Please list any physicians you have seen for your pain:

Name	Specialty	Recommendations
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check and give details of any of the following treatments you have received for this pain problem:

	Approximate Date/Details	Improved Pain Yes	No
☐ Nerve Blocks			
☐ Physical Therapy			
☐ Acupuncture			
☐ Chiropractor			
☐ Psychiatrist/Psychologist			
☐ Surgery			
☐ Other			

Patient Name: _____Date: _____

Which **DIAGNOSTIC PROCEDURES/TESTS** have you had for this pain problem:

	Body Part	Approximate Date	Facility Performed
□ MRI Scan			
□ CT/Myelogram			
□ X-Ray			
□ EMG/NCS			
□ Discogram			
□ Bone Scan			
□ Other			

Please List PAST AND CURRENT MEDICAL PROBLEMS:

Cardiac/Heart Disease □Hypertension □Hypercholesterolemia □Angina Pectoris □Prior myocardial infarction (heart attack) □Stroke syndrome □ Mini stroke (TIA)	**Pulmonary/Lung Disease** □Chronic cough □Tuberculosis □CPAP ventilation □Long-term oxygen therapy □Sleep apnea □COPD □Emphysema □Asthma	**Endocrine** □Diabetes mellitus I □Diabetes mellitus II **Thyroid disorders** □Hyperthyroidism □Hypothyroidism □Hashimoto's thyroiditis □Graves' disease	**Urology/nephrology** Renal Disorders □ Kidney stones (renal calculi) □Urinary tract infection (UTI) **Liver/Hepatology** □Hepatic disorders □Hepatitis
Gastrointestinal □GERD □Ulcer **Neurological** □Headaches □Migraines headache	**Psychiatric Therapy** □Anxiety □Bipolar disorder □Depression □History of suicidal ideations □Psychiatric therapy/treatment	**Infection/Disease** □Open wound □Recent infection □Herpes (Shingles) □HIV infection	**Cancer** □History of cancer Location_____ □Treatment □Chemotherapy_____ □Radiation Therapy_____

PLEASE CIRCLE any of the following medications you have tried in the past:

Aspirin Ibuprofen Advil Motrin Aleve Indocin Toradol
Mobic Celebrex Naproxen _____ _____ _____ _____

Please list **ALL** medications you are currently taking:

1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12.

Are you taking narcotics from any physician? □ Yes □ No
Do you have any allergies to medication or food? □ Yes □ No

Current Pharmacy Location & Phone
_____
_____

List allergies and the reaction below:

Medication	Reaction	Medication	Reaction
1.		4.	
2.		5.	
3.		6.	

Have you ever taken or been given any of the following? Adverse Reaction?

Anticoagulants, Blood-thinners, Coumadin, Plavix, Pletal □ Yes □ No _____
Cortisone or Steroids □ Yes □ No _____

Please List any **SURGERIES:**

Surgery/Date	Surgery/Date
1.	4.
2.	5.
3.	6.

Patient Name: _____Date: _____

REVIEW OF SYSTEMS: Please check if you currently have any of the following:

CARDIOVASCULAR	RESPIRATORY	GASTROINTESTINAL	GENITOURINARY
Palpitations	Chronic cough	Nausea	Change in bowel control
Chest pain/angina	Wheezing	Vomiting	Change in bladder control
Fast heart rate	Sputum production	Difficulty swallowing (dysphagia)	Blood in urine/hematuria
Shortness of breath	COPD	Appetite	Painful urination/dysuria
Hypertension	Asthma	Recent wt loss [reported]	Urinary loss of control
Leg/Ankle Swelling	Shortness of breath	Recent wt gain [reported]	Increased urinary frequency
Other	Difficulty breathing at rest	Heart Burn/GERD	Using incontinence devices
	Difficulty breathing during exertion	Constipation	Urinary frequency x___ during night
	Sleep apnea	Self treated with laxatives	Genital lesion
	Other -	Diarrhea	Other
		Rectal Bleeding	
		Liver Disease	
		Bowel movement frequency x week	
		Other	

CONSTITUTIONAL	OTOLARYNGEAL	PSYCHOLOGICAL	HEAD RELATED
Weight change	Mouth sores	Depression	Headache
Recent weight loss ___lbs	Difficulty swallowing(dysphagia)	Anxiety	Facial pain
Recent weight gain ___lbs	Difficulty chewing	Stress	Sinus pain
Fever	Dentures	Sleep abnormalities/disturbances	Other
Chills	Currently wearing	Syncope with needles/procedures	
Night sweats	Improperly fitting	Previous psychiatric treatment	**IMPLANTED DEVICES**
Feeling tired/poorly(malaise)	Other	Other	Intravenous catheter
Visual change			AICD
Hearing change			Previous pacemaker placement
Other			Surgical screws, pins, plates, clips)

ENDOCRINE	SKIN SYMPTOMS	MUSCULOSKELETAL	NEUROLOGY
Excessive sweating	Skin lesions	Neck pain	Epilepsy/Seizures
Excessive thirst (polydipsia)	Rashes	Back pain	Vertigo
Libido changes	Pruritis	Arthritis/joint disease	Dizziness
Heat /cold intolerance	Other	Muscle aches	Fainting (syncope)
Change in appetite		Joint pain, localized	Motor disturbances
Frequent urination	**HEMATOLOGIC**	Joint stiffness, localized	Sensory disturbances
Other	Easy bleeding	Swelling of joints	Numbness
	Easy bruising tendency	Redness in joints	Weakness
	Poor blood clotting	Frequent muscle spasm	Headache
	Bleeding disorder	Other	Decreased concentration
	Other		Memory lapses or loss
			Other

Have you been tested for HIV Virus? □ Yes □ No Date _____ □ Positive □ Negative

Have you been diagnosed with any of the following?

Hepatitis? □ Yes □ No Any sexually transmitted disease? □ Yes □ No

Is there any possibility that you are pregnant? □ Yes □ No

FAMILY HISTORY: Describe current health, age, cause of death, illness, diabetes, cancer, hypertension, etc.

HEART DISEASE □ Father □ Mother	**LUNG DISEASE** □ Father □ Mother	**DEPRESSION** □ Father □ Mother	**Living, Age, Cause of Death** □ Father _____ □ Mother _____ □ Brother_____ □ Brother_____ □ Sister_____ □ Sister_____ Other_____ _____
DIABETES MELLITUS □ Father □ Mother	**KIDNEY DISEASE** □ Father □ Mother	**SUICIDE** □ Father □ Mother	
HYPERTENSION □ Father □ Mother	**LIVER DISEASE** □ Father □ Mother	**HEART ATTACK** □ Father □ Mother	
CANCER □ Father □ Mother	**ALZHEIMER'S** □ Father □ Mother	**STROKE SYNDROME** □ Father □ Mother	

Patient Name: _____Date: _____

SOCIAL HISTORY:

Do you currently work? □ Yes □ No What is/was your occupation _____

Marital status: □ Married □ Divorced □ Single □ Widowed Number of children _____

Education_____ Dominate Hand: □ Right □ Left

Do you use any of the following? □ Cigarettes □ Alcohol □ Cocaine □ Marijuana □ Heroin □ Club Drugs

□ Methamphetamine □ Prescription drugs □ Other If yes, the last time used:_____

CAGE:

Have you ever felt the need to cut down on your drinking or drug use? □ Yes □ No

Have people annoyed you by criticizing your drinking or your drug use? □ Yes □ No

Have you ever felt bad or guilty about your drinking or your drug use? □ Yes □ No

Have you ever needed an "eye opener" the first thing in the morning to steady your nerves or get rid of a hangover?

□ Yes □ No

Are you currently in a relationship in which you are being hurt, threatened, or made to feel afraid? □ Yes □ No

OPIOID RISK TOOL (ORT):		Male	Female
Family history of Abusing	Alcohol	3	1
	Illegal Drugs	3	2
	Prescription Drugs	4	4
Personal history of Abusing	Alcohol	3	3
	Illegal Drugs	4	4
	Prescription Drugs	5	5
Mental Health Diagnosis of ADD, OCD, BiPolar, Schizophrenia		2	2
	Depression	1	1
Age 16 to 45 Years Old		1	1
History of Preadolescence Sexual Abuse		0	3
	TOTAL	_____	_____

Have you had or do you have suicidal thoughts? □ Yes □ No □ Any Plans □ Number of Attempts

Treating Psychiatrist/Therapist's Name _____

Phone Number _____

MAST

1.	Do you feel you are a normal drinker?	YES	0	NO	2
2.	Do friends or relatives think you are a normal drinker?	YES	0	NO	2
3.	Have you ever attended a meeting of Alcoholics Anonymous (AA)	YES	5	NO	0
4.	Have you ever lost friends or girlfriends/boyfriends because of drinking?	YES	2	NO	0
5.	Have you ever gotten into trouble at work because of drinking?	YES	2	NO	0
6.	Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?	YES	2	NO	0
7.	Have you ever had delirium tremens (DTs), severe shaking, heard voices, or seen things that weren't there after heavy drinking?	YES	2	NO	0
8.	Have you ever gone to anyone for help about your drinking?	YES	5	NO	0
9.	Have you ever been in a hospital because of drinking?	YES	5	NO	0
10.	Have you ever been arrested for drunk driving or driving after drinking?	YES	2	NO	0

TOTAL YES _____ NO _____

COMMON OPIOID MISUSE MEASURE QUESTIONNAIRE

Name: _____ Date: _____

Please answer each question as honestly as possible. Keep in mind that we are only asking about the past 30 days. There are no right or wrong answers. If you are unsure about how to answer the questions, please give the best answer you can.

Please answer the questions using the following scale:	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?					
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e. doing things that need to be done such as going to class, work or appointment?					
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e. another doctor, the emergency room, friends, street sources)					
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?					
5. In the past 30 days, how often have you seriously thought about hurting yourself?					
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?					
7. In the past 30 days, how often have you been in an argument?					
8. In the past 30 days, how often have you had trouble controlling your anger (e.g. road rage, screaming, etc.)?					
9. In the past 30 days, how often have you needed to take pain medications belong to someone else?					
10. In the past 30 days, how often have you been worried about how you're handling your medications?					
11. In the past 30 days, how often have others been worried about how you're handling your medications?					
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?					
13. In the past 30 days, how often have you gotten angry with people?					
14. In the past 30 days, how often have you had to take more of your medication than prescribed?					
15. In the past 30 days, how often have you borrowed pain medication from someone else?					
16. In the past 30 days, how often have you used your pain medication for symptoms other than for pain (e.g. to help you sleep, improve your mood, or relieve stress)?					
17. In the past 30 days, how often have you had to visit the Emergency Room?					

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Consent for Chronic Opioid Therapy

□ Kazi Hassan M.D/ □ Sardha Perera M.D./ □ Jose Rivera, M.D. / □ Neil Ellis, M.D. is prescribing opioid medicine, sometimes called narcotic analgesics, to me. This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it. including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids.

I will tell my doctor about all other medicines and treatments that I am receiving.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I am aware that certain other medicines such as nalbuphine (Nubain ™), pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time.

I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

_____

Patient Name

(Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(Females Only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I understand that I must remain a patient of my primary medical doctor. If I switch doctors or no longer am treated by this physician, I must notify Florida Medical Pain Management immediately, then the doctor will make a decision about continuing to treat my pain management requirements.

I have read this form or have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.

Please be aware that your first visit to our clinic is only an evaluation and that narcotic pain medication will not be prescribed.

Patient Printed Name _____

Patient signature: _____ Date: _____

Witness Signature: _____ Date: _____

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STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed **-** The information covered by this authorization includes:
Patient's entire medical history, mental or physical condition, diagnoses, treatment including psychiatric, drug or alcohol abuse treatment.

Persons Authorized to Use or Disclose Information **-** Information listed above will be used or disclosed by:
Physicians and Personnel of Florida Medical Pain Management

Persons to Whom Information May be Disclosed:
Please list anyone that Florida Pain Management will be able to release medical information to regarding your care:

1. My referring physician	4. Spouse
2. My primary care physician	5.
3. Mental health care provider	6.

Expiration date of Authorization
This authorization is effective indefinitely unless revoked or terminated by the patient or the patient's personal representatives.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Florida Medical Pain Management. You should contact the Florida Medical Pain Management Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it was sent. The privacy of this information may not be protected under the federal privacy regulations.

Overall, by signing this form you are giving Florida Medical Pain Management permission to release or receive your medical records to or from any physician office, hospital, attorney, or any persons name from above you approved us to disclose information to. Your signature confirms that you have received a Notice of Privacy Practices.

_____ _____
Name of Patient (please print) DOB

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative Relationship to Patient

_____
Signature of Florida Medical Pain Management employee confirming that this was explained and signed by patient.

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PAIN MANAGEMENT AGREEMENT

Our goal in the field of Pain Management Medicine is to assist patients with the treatment of their chronic pain. We achieve this goal through various modalities, including injections or nerve blocks, physical therapy, exercise programs, psychological counseling when needed, and referrals to surgeons or other specialists as required. I strive to manage pain through means other than medications to allow patients to live a relatively pain free life. I seek to treat the cause of the pain and not the symptoms. **However, I also understand that strong narcotic analgesic and other prescription medications may be indicated for the treatment of certain chronic pain conditions.**

The purpose of this Agreement is to clarify the conditions under which Florida Medical Pain Management's Physicians will prescribe medications for you. This agreement will help you and the Physician comply with the laws regarding controlled pharmaceuticals and prevent misunderstandings about the medicines you may take for your pain condition. **Please read each and every item in this agreement very carefully.**

I UNDERSTAND AND AGREE TO THE FOLLOWING TERMS AND CONDITIONS IN CONNECTION WITH MY TREATMENT AND PARTICIPATION IN THE PAIN PROGRAM AND AS A CONDITION TO RECEIVING PAIN MEDICATION:

1. I WILL USE MY MEDICATION(S) AT A RATE NO GREATER THAN THAT PRESCRIBED BY THE PHYSICIAN. IF I DO OVER-USE MY MEDICATION, THAT MEDICATION WILL NOT BE REFILLED EARLY, AND I MAY BE WITHOUT PAIN MEDICATION FOR SOME PERIOD OF TIME.

2. I WILL NOT SHARE, SELL, OR TRADE MY MEDICATION WITH ANYONE. I WILL NOT ATTEMPT TO OBTAIN ANY CONTROLLED MEDICINES, INCLUDING OPIOID PAIN MEDICINES, CONTROLLED STIMULANTS, OR ANTI-ANXIETY MEDICINES FROM ANY OTHER DOCTOR. I WILL SAFEGUARD MY WRITTEN PRESCRIPTIONS AND PAIN MEDICINE FROM LOSS OR THEFT. I UNDERSTAND THAT LOST OR STOLEN WRITTEN PRESCRIPTIONS OR MEDICINES WILL NOT BE REPLACED.

3. SUDDEN DISCONTINUATION OF A NARCOTIC PAIN MEDICATION MAY LEAD TO UNPLEASANT OR DANGEROUS WITHDRAWAL SYMPTOMS.

4. THE POTENTIAL RISKS AND SIDE EFFECTS OF MEDICATIONS TAKEN FOR PAIN EITHER SHORT TERM OR LONG TERM CAN INCLUDE: DROWSINESS, NAUSEA, CONSTIPATION, ITCHING, DIFFICULTY WITH URINATION, TOLERANCE, DEPENDENCE, ADDICTION, AND OVERDOSE.

5. IN THE EVENT THAT THE PHYSICIAN FEELS THAT MY DOSE OF PAIN MEDICATION IS EXCESSIVE OR MAKES THE DIAGNOSIS OF ADDICTION OR OVERDOSE, HE/SHE WILL REDUCE THE MEDICINE OVER A PERIOD TIME (DAYS, WEEKS, MONTHS) AS NECESSARY TO AVOID WITHDRAWAL SYMPTOMS. ALSO, A DRUG-DEPENDENCE TREATMENT OR DETOXIFICATION PROGRAM MAY BE RECOMMENDED.

6. I UNDERSTAND AND AGREE THAT I AM NOT TO RECEIVE ANY TYPE OF PRESCRIPTION PAIN OR SEDATIVE MEDICATION FROM ANY OTHER PHYSICIAN UNLESS THERE IS A SPECIFIC MEDICAL NECESSITY. SHOULD MY CAREGIVER OR I RECEIVE ANY PAIN OR SEDATIVE MEDICATIONS FROM ANY OTHER PHYSICIAN, MY CAREGIVER OR I MUST INFORM FLORIDA MEDICAL PAN MANAGEMENT EITHER BY TELEPHONE OR IN WRITING WITHIN 72 HOURS OF HAVING FILLED THE PRESCRIPTIONS.

7. REFILLS OF MY PRESCRIPTIONS WILL BE ISSUED ONLY AT THE TIME OF AN OFFICE VISIT, DURING REGULAR OFFICE HOURS, OR IMMEDIATELY FOLLOWING A PROCEDURE.

_____

Patient Name

8. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KEEP TRACK OF MY SUPPLY OF PAIN MEDICATION AND TO MAKE TIMELY APPOINTMENTS WITH MY PHYSICIAN TO HAVE MY PRESCRIPTION(S) REFILLED. **LAST-MINUTE REQUESTS FOR PRESCRIPTION REFILLS ARE NOT WELCOME.**

9. MY PHYSICIAN MAY, AT HIS DISCRETION, ISSUE A REFILL OF MY MEDICATION (S) BASED ON A TELEPHONE CONVERSATION THAT WE HAVE REGARDING MY PAIN CONDITION AND THE EFFECTS THAT PRESCRIBED MEDICATIONS HAVE ON THIS CONDITION.

10. I WILL COMMUNICATE FULLY AND TRUTHFULLY WITH MY PHYSICIAN ABOUT THE CHARACTER AND INTENSITY OF MY PAIN, THE EFFECT OF THE PAIN ON MY DAILY LIFE, AND HOW WELL THE MEDICINE IS HELPING TO RELIEVE THE PAIN. I UNDERSTAND THAT I, OR MY CAREGIVER IS RESPONSIBLE FOR INFORMING THE PHYSICIAN EITHER IN PERSON, AT FOLLOW-UP, OR BY TELEPHONE AT THE PAIN CENTER TELEPHONE NUMBER (727-548-6100) DURING REGULAR BUSINESS HOURS (9:00 A.M. TO 4:30 P.M., MONDAY THROUGH FRIDAY) REGARDING ANY PROBLEMS OR SIDE EFFECTS ENCOUNTERED WITH THE MEDICATION.

11. I HAVE BEEN ADVISED TO ABSTAIN FROM OR SIGNIFICANTLY MODERATE MY USE OF ALCOHOLIC BEVERAGES WHILE TAKING THIS MEDICATION FOR MY PAIN CONDITION. I WILL NOT USE ANY ILLEGAL CONTROLLED SUBSTANCES, INCLUDING MARIJUANA, COCAINE, HEROIN, ECSTASY, ETC. IF I SMOKE CIGARETTES, I UNDERSTAND THAT I WILL BE ASKED TO QUIT. CIGARETTE SMOKERS TYPICALLY HAVE A DECREASED RESPONSE TO PAIN TREATMENT BECAUSE OF THE EFFECTS OF SMOKING ON OXYGEN DELIVERY TO THE PERIPHERAL TISSUES. THE PAIN CENTER WILL DO WHAT IT CAN TO ASSIST YOU IN SMOKING CESSATION. ADDITIONALLY, OBESITY IS ONE OF THE MOST IMPORTANT CAUSES OF FAILED TREATMENT FOR CHRONIC PAIN. EVERY TEN POUNDS OF EXCESS WEIGHT THAT ONE CARRIES ON HIS/HER BODY RESULTS IN ONE HUNDRED POUNDS OF INCREASED PRESSURE ON THE SPINE, VERTEBRAL DISCS, AND SPINAL NERVES. EXCESSIVE WEIGHT WILL THEREFORE RESULT IN AN INCREASE IN PAIN. IF YOU ARE OVERWEIGHT YOU WILL NEED TO ENROLL IN A WEIGHT LOSS PROGRAM. THE PAIN CENTER WILL ASSIST YOU IN DIETARY MEASURES TO HELP YOU LOSE WEIGHT, AND PHYSICAL THERAPY WILL ALSO BE DIRECTED IN THIS AREA AS WELL.

12. IF PHYSICAL THERAPY IS PRESCRIBED, I AGREE TO ATTEND AND PARTICIPATE TO THE FULLEST EXTENT POSSIBLE. IF THERE ARE ANY PROBLEMS WITH MY PHYSICAL THERAPY, I AGREE TO COMMUNICATE THIS TO MY PHYSICIAN SO THAT HE CAN MAKE THE APPROPRIATE CHANGES IN MY THERAPY PROGRAM.

13. I AGREE THAT I WILL SUBMIT TO A BLOOD OR URINE TEST IF REQUESTED BY MY PHYSICIAN TO DETERMINE MY COMPLIANCE WITH MY REGIMEN OF PAIN MEDICATION. FURTHERMORE, AT MY PHYSICIAN'S DISCRETION, THE PRIMARY CAREGIVER WHOSE SIGNATURE APPEARS BELOW SHALL ALSO BE SUBJECT TO PERIODIC URINE AND/OR BLOOD TESTING.

14. IF REQUESTED, I WILL BRING ALL UNUSED PAIN MEDICINE TO AN OFFICE VISIT FOR A "PILL COUNT." MY PHYSICIAN MAY REQUEST ADDITIONAL "PILL COUNTS" AT ANY TIME, AND I AGREE TO COMPLY WITH THESE REQUESTS. I AGREE THAT I OR MY CAREGIVER WILL BRING THE MOST RECENT PRESCRIPTION CONTAINER FOR EACH MEDICATION TO EACH VISIT WITH MY PHYSICIAN. THESE CONTAINERS MUST CORRESPOND TO THEIR LAST PRESCRIPTION RECORDED IN THE MEDICAL RECORD WITH THE PRESCRIPTION LABELS INTACT AND LEGIBLE SO THAT THE PHYSICIAN IN THE MEDICAL RECORD MAY DOCUMENT APPROPRIATE CONTROL INFORMATION. SPECIFICALLY, THE PRESCRIPTION REGISTRATION NUMBER AND PHARMACY TELEPHONE NUMBER WILL BE NOTED AND VERIFIED.

15. I WILL USE ONLY ONE PHARMACY TO FILL PRESCRIPTIONS FOR MY PAIN MEDICATIONS. I AUTHORIZE MY PHYSICIAN AND MY PHARMACY TO COOPERATE FULLY WITH ANY CITY, STATE OR FEDERAL LAW ENFORCEMENT AGENCY, INCLUDING THIS STATE'S BOARD OF PHARMACY, IN THE INVESTIGATION OF ANY POSSIBLE MISUSE, SALE OR OTHER DIVERSION OF MY PAIN MEDICINE. I AUTHORIZE MY DOCTOR TO PROVIDE A COPY OF THIS AGREEMENT TO MY PHARMACY. I AGREE TO WAIVE ANY APPLICABLE PRIVILEGE OR RIGHT OF PRIVACY OR CONFIDENTIALITY WITH RESPECT TO THESE AUTHORIZATIONS. I FURTHER CONSENT TO MY PAIN MANAGEMENT PHYSICIAN CONTACTING OTHER PHYSICIANS AND/OR OBTAINING THE RESULTS OF DIAGNOSTIC TESTING (PAST OR PRESENT) IN ORDER TO OBTAIN ADEQUATE INFORMATION ABOUT MY CONDITION.

_____

Patient Name

16. I UNDERSTAND THAT FURTHER PRESCRIPTIONS ARE SOLELY AT THE DISCRETION OF MY PAIN MANAGEMENT PHYSICIAN.

17. I FURTHER UNDERSTAND THAT THIS AGREEMENT IS ESSENTIAL TO THE TRUST AND CONFIDENCE NECESSARY IN A DOCTOR-PATIENT RELATIONSHIP AND THAT MY PAIN MANAGEMENT PHYSICAIN UNDERTAKES TO TREAT ME BASED ON THIS AGREEMENT. I UNDERSTAND THAT IF I BREAK THIS AGREEMENT OR PROVIDE ANY FALSE INFORMATION, MY FLORIDA MEDICAL PAIN MANAGEMENT PHYSICIAN WILL STOP PRESCRIBING THESE PAIN-CONTROL MEDICINES AND I MAY BE IMMEDIATELY REMOVED FROM THE CLINIC.

I agree to follow all of the guidelines that are described above. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given to me upon request. I voluntarily consent to participation in the pain medication program described in this Agreement.

Patient signature: _____ Date: _____

Florida Medical Pain Management, LLC

- 6333 54th Avenue North
  St. Petersburg, Florida 33709
  Ph: 727-548-6100
  Fax: 727-545-0960
- 8139 State Rt. 54
  New Port Richey, Florida 34655
  Ph: 727-484-6999
  Fax: 727-484-6996
- 5270 Apple Gate Drive
  Spring Hill, Florida 34606
  Ph: 352-340-5990
  Fax: 352-340-5991
- 2201 Central Avenue, Suite 302
  St. Petersburg, Florida 33713
  Ph: 727-914-3995
  Fax: 727-914-3996

Patient Name: _____

SSN: _____Date of Birth: _____

ASSIGNMENT OF BENEFITS

For treatment provided and other goods and valuable consideration,

I, _____,
(Hereinafter Patient) hereby assign all rights and benefits that PATIENT has under any group health, HMO plan, individual health, PIP, disability or any other health or medical insurance policy or reimbursement plan that may pay benefits for services and treatment that PATIENT has received or will receive.

This assignment includes but is not limited to, all rights to collect benefits directly from PATIENT'S insurance company or HMO for services and treatment that PATIENT has received and all rights to proceed against PATIENT'S insurance company or HMO in any action including legal suit if for any reason PATIENT'S insurance company or HMO fails to make payments of benefits to which PATIENT is due. This assignment also includes the right to recover attorney's fees and cost for such action brought by the provider as PATIENT'S assignee.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date: _____

_____ _____

Signature of Policyholder **Witness**

_____

Signature If Other Than Policyholder

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Payment Policy

It is the policy of Florida Medical Pain Management that all services be paid for at the time of visit. We accept Cash, Check, Visa and MasterCard. However if we have made other arrangements with you the following outlines our billing and collection policy.

Insurance Advance Notice Form

This is a provider notice to the beneficiary regarding the services that may or may not be covered by your insurance company. Medical insurance is for your protection against the cost of medical care. Your insurance policy is a contract between you and your insurance company. There are literally thousands of insurance programs in existence. It is impossible for us to be familiar with all the programs. It is your responsibility to know if our office is covered by your insurance. If our office is not covered by your insurance, upon leaving our office we will supply you with a bill for the services that you received. It is then your responsibility to file the claim with your insurance company. You may contact your insurance company for information on submitting your claim.

If we elect to accept your insurance and file your claim, it does not guarantee that your insurance will pay the claim. **You are still responsible for any unpaid balance**. **All balances that remain unpaid for a period of 90 (ninety) days or longer will be considered delinquent and turned over to our collection agency.**

☐ **I understand my insurance may not pay for Anesthesia, Urine Drug Screening, Psychological Testing, and/or Durable Medical Equipment.**

☐ **I understand my insurance may not pay for facility charges.**

☐ **I understand I may be billed for any other charges not covered by my insurance.**

Medicare

Our office accepts assignment on Medicare claims, that we will file your claim with Medicare and accept the approved Medicare rate as our total charge. However, **by law we must collect the applicable co-insurance and deductible.** If you have a Medicare supplement that Medi-Gaps over, we will file with them for your deductible and co-insurance. If your supplemental policy does not cover the deductible and co-insurance or other non-covered services, Payment for these services will still be your responsibility. Also you may be billed for additional services that are not covered by Medicare, which may include Hot & Cold packs, Trigger Point Injections, and Massage Therapy etc.

☐ **I understand I have a right to appeal directly to my insurance company, not to Florida Medical Pain Management.**

Workers Compensation

We will bill your workers compensation insurance carrier and accept this as payment in full. However, if your worker's compensation carrier denies benefits (such as determination that the injury is not work related), then you will be responsible for any unpaid balance. If you have any questions concerning the payment policy, please feel free to contact Florida Medical Pain Management, Monday-Friday 8:30am to 5:00pm @ (727) 548-6100.

_____

Patient Name

_____ _____

Signature of Patient Date

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NOTICE TO ALL PATIENTS
REGARDING CANCELLATION POLICY

You MUST give 24-hour advance notice for any appointment cancellation. No charge will be posted to your account if appointment is cancelled within 24 hours with a valid reason. Failure to inform us 24-hours prior to scheduled appointment will result in a service charge of $50 for office visits or $150 for procedures. All future appointments will be cancelled until the fee is paid. I understand that I may be discharged from the care of FMPM if I cancel with less than 24 hours notice, or no-show more than 3 times in a 6 month period.

You must call between the hours of 9:00 am and 4:30 pm Monday through Friday and speak to an attendant. Do not leave a message with our answering service.

This policy is enforced with the consideration of all other patients who are currently on the waiting list. Enforcement of this cancellation policy will lead to better overall patient care.

Method of payment: Cash, check, or credit card only. We cannot accept insurance as a mode of payment.

Please sign and date below and a copy of this notice will be kept in your chart.
By signing, you are agreeing to our policy.

_____
PRINT NAME

_____
SIGNATURE

_____
DATE

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PATIENT INFORMATION

Date:_____ Chart #: _____

Name: _____ Phone#: _____

Address: _____ Apt#: _____

City: _____ State _____ Zip: _____

Employer's Name: _____

Employer's Address: _____

Soc Sec#: _____ Date of Birth: _____

Marital Status: _____ Spouse's Name: _____

Spouse's Employer: _____

INSURANCE INFORMATION

Is this treatment related to an automobile accident: Yes □ No □ Date of Accident: _____

Is this treatment related to Worker's Compensation: Yes □ No □ Date of Injury: _____

Primary: _____ Policy/Group#: _____

Address: _____ Phone: _____

Subscriber: _____

Secondary: _____ Policy/Group#: _____

Address: _____ Phone: _____

Subscriber: _____

FINANCIAL INFORMATION

Patients who carry any form of medical insurance should know that all services furnished are charged directly to the patient and he or she is responsible for payment. We will prepare any necessary forms to assist in making collections from your primary insurance company and will credit such collections to your account. You will also be expected to pay any benefit proceeds from your insurance to this office. However, we cannot render services on the assumption that your charges will be paid solely by your insurance. Most misunderstandings about insurance can be avoided if you understand what your policy provides. Many insurance policies pay according to a schedule of benefits that is based on various criterions. This office charges fees which are reasonable in this community. Not all insurance will pay 100% of our charges. The patient (and/or spouse/guarantor) is responsible to pay all sums unpaid by insurance. If it becomes necessary to collect any sum due through an attorney, then the patient (and/or spouse/guarantor) agrees to pay all reasonable costs of collection, including attorney's fees and appellate attorney's fees, whether suit is filed or not. All past due balances will accrue interest at the rate of 1½ % per month (18% per annum). The patient authorizes the release of any information acquired in the course of treatment as necessary to file insurance claims and for the collection of their account.

Patient: _____ Witness: _____

Parents or Guarantors: _____

FLORIDA MEDICAL PAIN MANAGEMENT, LLC

NOTICE OF PRIVACY PRACTICES

Florida Medical Pain Management Duties

Florida Medical Pain Management (FMPM) is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected
health information may be used and how FMPM keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health
information. As part of the company's legal duties this Notice of Privacy Practices must be given to you. The company is required to follow the terms of the Notice of Privacy Practices
currently in effect. Florida Medical Pain Management may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted at all Florida Medical Pain Management buildings and will be available by email upon request.

Uses and Disclosures of your protected health information

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person. Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. Florida Medical Pain Management can act as each of the above business types. This medical information is used by Florida Medical Pain Management in many ways while performing normal business activities. Your protected health information may be used or disclosed by Florida Medical Pain Management for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. Florida Medical Pain Management may use or disclose your health information for case management and services.*

Your information may be used by certain personnel to improve the company's health care operations. The company also may send you appointment reminders, information about treatment options or other health-related benefits and services. Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the company.
- Investigations and audits by the state's Inspector General and Auditor General and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes including vital statistics, disease reporting, public health surveillance, investigations, interventions and regulation of health professionals.
- District medical examiner investigations.
- Court orders, warrants, or subpoenas.
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes. Certain uses and disclosure of psychotherapist notes will also require your written authorization.

Individual Rights

You have the right to request Florida Medical Pain Management to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The company is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. Florida Medical Pain Management may mail or call you with health care appointment reminders. We will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the company.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. Florida Medical Pain Management may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the company,
- Is not protected health information,
- Is by law not available for your inspection, or
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The company will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures Florida Medical Pain Management may have made of your protected health information. This summary does **not** include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures for health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to January 1, 2013.

This summary **does** include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6-year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

For Further Information

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of Florida Medical Pain Management facility where you received the notice.

HIPAA compliance officer: Laura Kohler

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the: Florida Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/telephone 850-245-4141 and with the Secretary of the U.S. Department of Rights and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The company will not retaliate against you for filing a complaint.

Effective Date

This Notice of Privacy Practices is effective beginning March, 2008 and updated January 1, 2013, and shall be in effect until a new Notice of Privacy Practices is approved and posted.