Florida Interventional Pain Management, LLC

PATIENT INFORMATION AND AUTHORIZATION FORM

PATIENT INFORMATION

Name: ______________________ Race: ______________

Date of Birth: ____________ Age: ________ S.S. #: ______________

Address: ______________________ ______________

Home phone #: ____________ Work #: ____________ Cell #: ____________

Your Email Address: ______________________

Emergency Contact Name: ____________ Relationship: ____________

Emergency Contact Phone Number: ______________________

EMPLOYER

Name of employer: ______________________

Employer address: ______________________

Employer phone #: ______________________

PRIMARY CARE PHYSICIAN INFORMATION

Primary care physicians name: ______________________

Phone #: ______________________

PRIMARY INSURANCE INFORMATION

Plan name: ____________ ID#: ____________ Group #: ____________

Address: ______________________ Phone #: ____________

Subscriber's name: ____________ S.S. #: ____________ Birth date: ____________

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY INSURANCE INFORMATION

Plan name: ____________ ID#: ____________ Group #: ____________

Address: ______________________ Phone #: ____________

Subscriber's name: ____________ S.S. #: ____________ Birth date: ____________

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

AUTHORIZATION

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Florida Interventional Pain Management, LLC to release any information required to process my claims. I agree to pay all balances in full from copays, deductibles, any balances left from insurance company, etc. from services provided by the doctor within 15 days from receiving invoice.

Patient/Guardian signature: ______________________ Date: ____________

Name: ________________________________ Date: ________________

CHRONIC PAIN EVALUATION *(Continued)*

Please help us understand your medical history by answering the following questions:

Surgical History

List all surgeries you have had in the past:____

____

Blood Thinners

[ ] Aspirin [ ] Plavix [ ] Coumadin [ ] Aggrenox
[ ] Arixtra [ ] Pradaxa [ ] Xarelto [ ] Pletal
[ ] other bloods thinners–___________

Medications

List all medications you are currently taking.

____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________

Drug and Food Allergies

[ ] rhinitis/seasonal allergies [ ] hives [ ] penicillin [ ] latex [ ] drug allergic reactions
[ ] insect sting allergy [ ] angioedema [ ] nuts [ ] iodine [ ] allergy to shellfish
[ ] chocolate [ ] medication–________

Family History:

Do you have any medical problems that run in your family?
Please list. (ex: cancers, heart disease, strokes, etc.)

	Mother	Father	Spouse	Other
Medical Condition:_____________	_______	_______	_______	_______
_____________	_______	_______	_______	_______
_____________	_______	_______	_______	_______
_____________	_______	_______	_______	_______

Prior Doctor Visits

Have you ever been to a pain doctor before? [ ] yes [ ] No
Name of doctor: ______________________ Date of last visit: ______________________
Why did you stop seeing this doctor?____
Please list all pain medications you have taken in the past: ______________________________

____

Do you have a past history of chemical/substance abuse, including alcohol, illicit and/or illicit drugs? Yes or No
If yes please, please list:____

Occupational History:

What is your occupation? ______________________ Employer name:____________________
If you are retired, what was your previous occupation? ______________________
Is there currently any personal injury litigation due to your pain? [ ] yes [ ] no

Marital History:

Please circle one: Married, Single, divorced, other:_________________
Number of children:______________ Do the children live at home: Yes No

Name: ______________________________ Date: _______________

Please help us understand your medical history by answering the following questions:
Have you had any of the following medical illnesses (please check only the ones that apply)?

Cardiac

[ ] heart attack	[ ] cardiac arrhythmia	[ ] aortic regurg	[ ] defibrillator	[ ] pericarditis
[ ] hypertension	[ ] atrial fibrillation	[ ] bradycardia	[ ] mitral regurg	[ ] aortic stenosis
[ ] hypotension	[ ] cardiac stents	[ ]heart block	[ ] mitral valve prolapse	[ ] pacemaker
[ ] congestive heart failure	[ ]heart murmur	[ ] cardiac tamponade	[ ] mitral stenosis	
[ ] coronary artery disease	[ ] heart valve disease	[ ] sick sinus syndrome	[ ] heart valve replacement	

[ ] cardiomyopathy-type-_________

[ ] other cardiac condition-__________

Lung

[ ] COPD	[ ] emphysema	[ ] asthma	[ ] sleep apnea	[ ] asbestosis
[ ] cystic fibrosis	[ ] lung abscess	[ ] tuberculosis	[ ] chronic bronchitis	[ ] mesothelioma
[ ] bronchiectasis	[ ] DVT	[ ] pulmonary embolism	[ ] silicosis	[ ] sarcoidosis
[ ] interstitial lung disease	[ ] black lung disease	[ ] costochondritis	[ ] other lung disease_____________	

Blood conditions

[ ] Sickle cell disease	[ ] thalassemia	[ ] polycythemia	[ ] erythrocytosis	[ ] anemia
[ ] Raynaud's disease	[ ] immune deficiency	[ ] purpura	[ ] thrombocytopenia	[ ] ITP
[ ] thrombocytosis,	[ ] hemophilia	[ ] vitamin K deficiency	[ ] aortic aneurysm	[ ] TTP
[ ] Von Willebrand's disease	[ ] polycythemia vera	[ ] temporal arteritis	[ ] protein S deficiency	[ ] DIC
[ ] protein C deficiency	[ ] peripheral vascular disease		[ ] other vascular disease-___________	
[ ] anti-thrombin 3 deficiency	[ ] heparin induced thrombocytopenia		[ ] other blood disease-__________	

Gastrointestinal/biliary conditions

[ ] Reflux	[ ] Barrett's esophagus	[ ] esophageal stricture	[ ] achalasia	
[ ] scleroderma	[ ] lupus	[ ] paraesophageal hernia	[ ] gastritis	
[ ] peptic ulcer disease	[ ] gastric surgery	[ ] dumping syndrome	[ ] other gastric diseases_________	
[ ] intestinal adhesions	[ ] volvulus	[ ] strictures	[ ] celiac disease	[ ] colitis
[ ] Whipple's disease	[ ] Crohn's disease	[ ] ulcerative colitis	[ ] amyloidosis	[ ] anal fissures
[ ] ischemic bowel	[ ] diverticulitis	[ ] diverticulosis	[ ] familial polyposis	[ ] hemorrhoids
[ ] acute pancreatitis	[ ] chronic pancreatitis	[ ] pancreatic abscess	[ ] gallstones	[ ] cholecystitis
[ ] sclerosing cholangitis	[ ] gallstones hepatitis A	[ ] hepatitis B	[ ] hepatitis C	[ ] liver abscess
[ ] hepatitis D	[ ] liver cirrhosis	[ ] ascites	[ ] biliary cirrhosis	[ ] peritonitis
[ ] cardiac cirrhosis	[ ] polycystic liver disease	[ ] hemochromatosis	[ ] Gilbert syndrome	[ ] splenic infarct
[ ] mesenteric ischemia	[ ] nonalcoholic liver disease			
[ ] other colon diseases-___________		[ ] other liver disease–__________[		

Kidney

[ ] acute renal failure	[ ] chronic renal failure–stage_________	[ ] hydronephrosis	[ ] renal artery stenosis
[ ] dialysis	[ ] kidney stones	[ ] recurrent kidney infections	[ ] prostatitis
[ ] cystitis	[ ] pyelonephritis	[ ] Henloch Schonlein purpura	[ ] urethritis
[ ] glomerulonephritis	[ ] recurrent urinary tract infections	[ ] lupus nephritis	[ ] Buerger's disease
[ ] recurrent bladder infections		[ ] other kidney issues-_______	

Cancer

[ ] urethritis Cancer–type	[ ] brain	[ ] mouth	[ ] skin	[ ] lung,
[ ] stomach	[ ] colon	[ ] breast	[ ] cervical	[ ] vaginal
[ ] ovarian	[ ] uterine	[ ] bladder cancer	[ ] bone	[ ] blood
[ ] prostate	[ ] renal cancer	[ ] testicular cancer	[ ] radiation	
[ ] leukemia–type	[ ] lymphoma–type	[ ] chemotherapy	[ ] head and neck cancer	

[ ] other cancer– ___________

Name: ______________________________ Date: ______________

CHRONIC PAIN EVALUATION *(Continued)*

Please help us understand your medical history by answering the following questions:
Have you had any of the following medical illnesses (please check only the ones that apply)?

Infections

[ ] Meningitis
[ ] lung abscess
[ ] abdominal abscess
[ ] osteomyelitis
[ ] cellulitis
[ ] endocarditis
[ ] otitis recurrent eye infections
[ ] lymphogranuloma venerum
[ ] Rocky Mountain spotted fever
[ ] pneumonia
[ ] splenic abscess
[ ] hepatic abscess
[ ] skin ulcers
[ ] gonorrhea
[ ] scarlet fever
[ ] legionnaires disease
[ ] recurrent sinus infections
[ ] other infection–______________
[ ] fasciitis
[ ] Kawasaki disease
[ ] tuberculosis
[ ] Lyme disease
[ ] recurrent colds
[ ] CMV
[ ] pelvic inflammatory disease
[ ] HIV
[ ] encephalitis
[ ] peritonitis
[ ] urethritis
[ ] herpes simplex
[ ] toxic shock syndrome
[ ] syphilis
[ ] gangrene
[ ] prostatitis
[ ] chancroid

Endocrine/hormonal

[ ] pituitary tumor
[ ] hypopituitarism
[ ] hyperthyroid
[ ] thyroid cancer
[ ] Cushing syndrome
[ ] pheochromocytoma
[ ] Warner syndrome
[ ] hyperprolactinemia
[ ] thyroiditis
[ ] hyperparathyroidism
[ ] vitamin D deficiency
[ ] other hormonal–_________
[ ] adrenal insufficiency
[ ] SIADH
[ ] Hashimoto's thyroiditis
[ ] hypoparathyroidism
[ ] Addison's disease
[ ] hyperpituitarism
[ ] goiter
[ ] diabetes type1
[ ] diabetes type 2
[ ] adrenal hyperplasia
[ ] hypercalcemia
[ ] hypothyroid
[ ] malabsorption
[ ] hypocalcemia

Bone Conditions

[ ] osteoporosis
[ ] gout
[ ] psoriatic arthritis
[ ] SLE
[ ] other bone disease–_________
[ ] osteopenia
[ ] pseudogout
[ ] polyarticular arthritis
[ ] scleroderma
[ ] vertebral fractures
[ ] rheumatoid arthritis
[ ] septic arthritis
[ ] rainout syndrome
[ ] other skin disease-____________
[ ] hip fractures
[ ] ankylosing spondylitis
[ ] infectious arthritis
[ ] Sjogren's syndrome
[ ]knee replacement
[ ] Reiter syndrome
[ ] lupus

Nervous system/spine conditions

[ ] Migraine headache
[ ] spinal stenosis
[ ] spondylolisthesis
[ ] TIA
[ ] stroke
[ ] Parkinson's disease
[ ] subarachnoid hemorrhage
[ ] postherpetic neuropathy
[ ] degenerative disc disease of the cervical or lumbar spine
[ ] brain tumor-type ___________
[ ] neurofibromatosis Huntington's disease injury-level-_________
[ ] other neurologic disease–___________
[ ] trigeminal neuralgia
[ ] peripheral neuropathy
[ ] spondylosis
[ ] diabetic neuropathy
[ ] multiple sclerosis
[ ] Down syndrome
[ ] cluster headache
[ ] muscular dystrophy
[ ] stroke, seizure
[ ] aortic aneurysm
[ ] shingles
[ ] alcoholic neuropathy
[ ] myasthenia gravis
[ ] narcolepsy
[ ] spinal cord
[ ] brain aneurysm
[ ] RSD
[ ] tremor
[ ] idiopathic neuropathy
[ ] Alzheimer's disease
[ ] Guillain-Barré syndrome
[ ] cervical stenosis

Psychiatric conditions

[ ] insomnia
[ ] schizophrenia
[ ] recovering drug addiction
[ ] other psychiatric illness–____________
[ ] narcolepsy
[ ] psychosis
[ ] bipolar
[ ] anxiety
[ ] alcoholism
[ ] depression

The following information is required by State of Florida.

Social History:

What is your marital status? [ ] single [ ] married [ ] divorced [ ] separated [ ] widowed

Tobacco Control

Are you a

- [ ] current smoker
- [ ] former smoker
- [ ] nonsmoker
- [ ] current every day smoker
- [ ] current some day smoker
- [ ] Smoker, current status unknown
- [ ] unknown if ever smoked

If 'current smoker' : How often do you smoke cigarettes?

- [ ] every day
- [ ] some days, but not every day

If 'current smoker' : How many cigarettes a day do you smoke?

- [ ] 5 or less
- [ ] 6-10
- [ ] 11-20
- [ ] 21-30
- [ ] 31 or more

If 'current smoker' : How soon after you wake up do you smoke your first cigarette?

- [ ] within 5 minutes
- [ ] 6-30 minutes
- [ ] 31-60 minutes
- [ ] after 60 minutes

If 'current smoker' : Are you interested in quitting?

- [ ] Ready to quit
- [ ] Thinking about quitting
- [ ] Not ready to quit

Alcohol Control

Did you have a drink containing alcohol in the past year?

- [ ] Yes
- [ ] No

If 'Yes' : How often did you have a drink containing alcohol in the past year?

- [ ] Never (0 point)
- [ ] Monthly or less (1 point)
- [ ] 2 to 4 times a month (2 points)
- [ ] 2 to 3 times a week (3 points)
- [ ] 4 or more times a week (4 points)

If 'Yes' : How many drinks did you have on a typical day when you were drinking in the past year?

- [ ] 1 or 2 drinks (0 point)
- [ ] 3 or 4 drinks (1 point)
- [ ] 5 or 6 drinks (2 points)
- [ ] 7 to 9 drinks (3 points)
- [ ] 10 or more drinks (4 points)

If 'Yes' : How often did you have 6 or more drinks on one occasion in the past year?

- [ ] Never (0 point)
- [ ] Less than monthly (1 point)
- [ ] Monthly (2 points)
- [ ] Weekly (3 points)
- [ ] Daily or almost daily (4 points)

Do you use any street drugs? [ ] yes [ ] no
If yes, please list:____

CERTIFICATION
I certify that I have answered truthfully all the questions, and have not knowingly withheld any information concerning any of the above problems, either past or present.
Your Signature: ______________________________
Date: ______________________________
****WE DO NOT REFILL MEDICATIONS BY TELEPHONE. ALL MEDICATION REFILLS MUST BE DONE IN PERSON AT A SCHEDULED VISIT WITH YOUR PHYSICIAN. PLEASE BE SURE YOU ARE GIVEN SUFFICIENT MEDICATIONS TO LAST UNTIL YOUR NEXT APPOINTMENT.

Florida Interventional Pain Management, LLC

Office Policies

If you wish to be seen by the doctor, you must read and Initial at the end of each line.
By your signature and initials, you understand and agree to abide by our office policies and adhere to them

MISSED/CANCELLED APPOINTMENTS. A $50.00 charge will apply to missed appointments and appointments canceled without 24 hours notice. Appointment reminders are done as a courtesy and do not replace a timely phone call or failure to appear. Failure to show for scheduled appointments may result in the above charge or discharge from the practice. _____

Billing for Services and Advance Beneficiary Notice. We expect that Insurance providers and Medicare will pay for services and items provided to you during the course of your care. However, Insurance providers and Medicare may not pay for all your health care costs, even if there may be a good reason your doctor recommending it. The fact that Medicare or another insurance provider may not pay for a particular item or service does not mean that you should not receive it. Insurance providers and Medicare only pay for covered items and services when certain rules are met. In the even that your Insurance provider or Medicare may not pay for the Item(s) that are described above, you will be financially responsible for services provided to you. Be signing this form, you agree to receive the items or services performed by the physician and the staff. ______

I understand that Insurance companies and Meidcare will not decide whether to pay unless I receive these items of services. Please submit my claims to Medicare or to my other insurance providers. I understand that you may bill me for items or services that I may have to pay the bill while Medicare or my Insurance company is making its decision. If my Insurance provider or Medicare does pay for agreed upon services, the physician's office will refund to me any payments I made to you that are due to me. If Medicare or other Insurance provider denies payment, I agree to be personally and fully responsible for payment. If a bill is not paid after 3 attempts to collect, I understand that the bill we be referred to a collection agency.________

RETURNED CHECKS. We charge a standard $30.00 fee for any patient checks that are returned to our office for insufficient funds. _____

OUTPATIENT PROCEDURES Most procedures are performed at Palms West Surgicenter in which Florida Interventional Pain Mgt is a shareholder. _____

DRUG SCREEN: Blood/urine/salivary drug screens are required by state law, and if insurance fails to pay

for test, the the patient will be financially liable for a $30 charge. _____

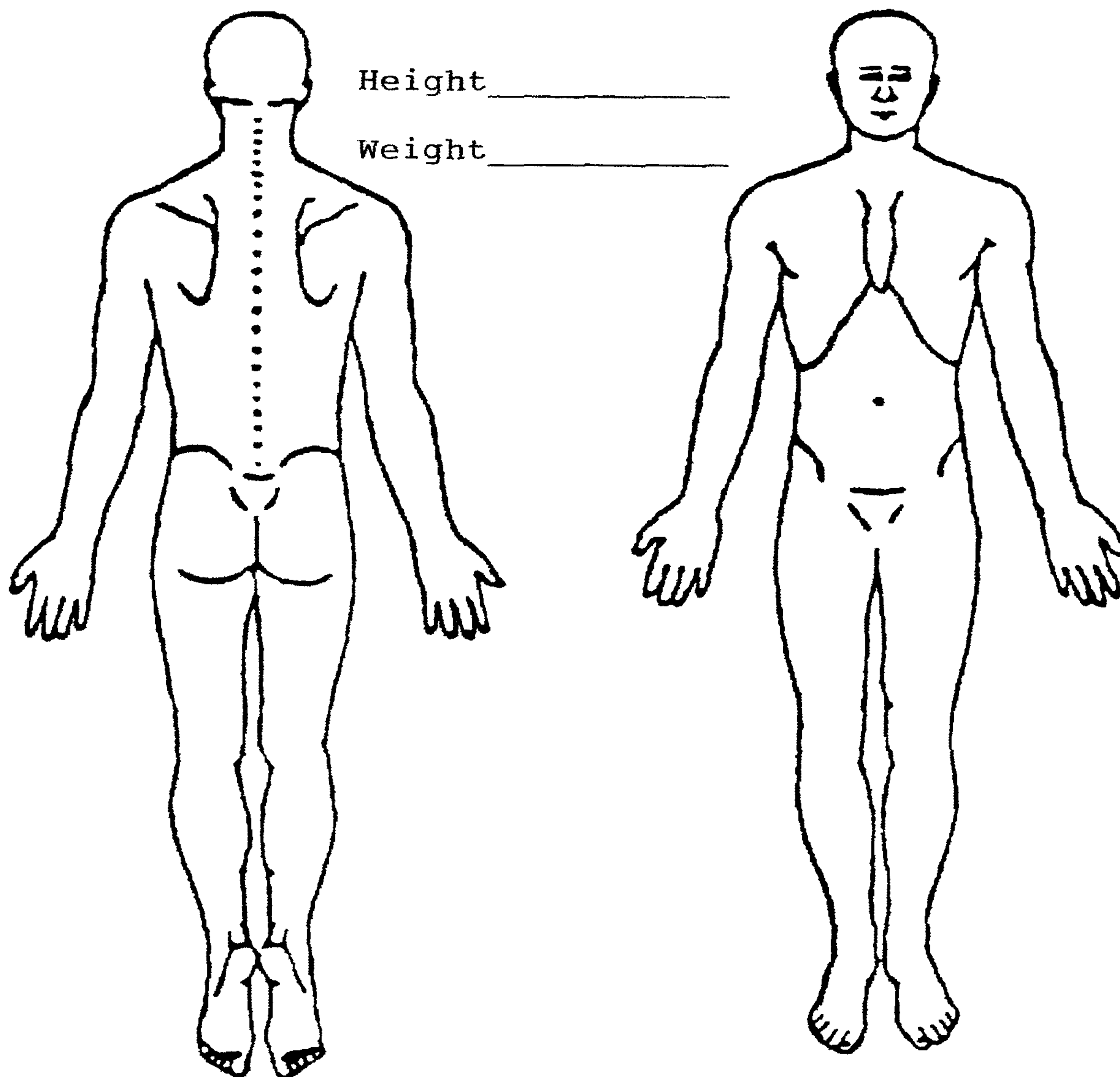
RECORDS. We charge a standard $35.00 fee for all copied records. _____

I understand all of the above information. No barriers to communication or comprehension exist which would prevent me from understanding the above information. _____

Patient's Printed Name: ____________________________
Patient's Signature: ____________________________

Date: ____________________________

Please help us to understand your pain history by completing this drawing:
A) Use the pictures below to show the origin of your pain (mark with an "X").
B) Does the pain travel or radiate anywhere (mark with a solid line)?



General medical symptoms

Height:________________ Weight:______________________

Please tell us about any other symptoms that you are having : (if you answer yes, please describe)

New weight loss or fatigue: yes no ________________________

New itching or rashes: yes no ________________________

New changes in vision: yes no ________________________

New breathing problems : yes no ________________________

New chest pain or palpitations: yes no ________________________

New problems eating or swallowing: yes no ________________________

New abdominal pain or rectal bleeding: yes no ________________________

New constipation: yes no ________________________

New bleeding or clotting problems: yes no ________________________

New weakness: yes no ________________________

New problems with balance: yes no ________________________

New feelings of depression, anxiety, hostility: yes no ________________________

New incontinence (wetting or soiling the bed or yourself): yes no ____________________

Preventative Medicine

Flu vaccine: yes no date: ________________________

Pneumonia vaccine: yes no date: ________________________

Colon cancer screening /colonoscopy: yes no date: ________________________

Bone scan for osteoperosis (DEXA scan): yes no date: ________________________

Mammagrom: yes no date last done: ________________________

Name: ____________________________ Date:_____________________

Pain History- please help us to understand your pain better

When did your pain start or worsen ? :_________________________________

(Please circle all that apply)

Location of pain: Neck middle back lower back other:_________________

Is one-side worse than the other?: Right left middle

How severe is your pain?: (0=no pain, 10=unbearable pain)

Severity of pain on a good day (1–10): 1–3 4–7 8–10

Severity of pain on a bad day (1–10): 1–3 4–7 8–10

What is the average severity of pain (1–10): 1–3 4–7 8–10

Does the pain move anywhere?: Shoulders arms hands head buttock hips groin legs ankle feet abdomen chest

Is the pain constant, or does It come and go?: Constant comes and goes

What is the character of the pain? (Please circle all that apply)

Aching stabbing throbbing burning electric pinching pressure spasm-like tightness soreness on fire cramping other:_________

What aggravates your pain (make sure pain worse)? (Please circle all that apply)

Standing walking bending twisting lifting sitting lying flat looking up looking down looking to the side Other:______________

What alleviates your pain (takes pain away or lessens your pain)? (Please circle all that apply)

Heat packs/heating blanket ice packs massage BenGay/tiger balm stretching sitting lying down changing position back brace neck brace standing other:________________

Are you having muscle cramps, spasms, or charley horses? (If yes, where): Yes no ______________

Are you having numbness, tingling, burning? (If yes, where): Yes no ______________

Are you having difficulty sleeping due to pain? : Yes no

Any new incontinence (wetting or soiling the bed)or new sexual dysfunction? Yes no

What home treatments have you taken for your pain and did they help?: rest motrin/aleve tylenol opiates muscle relaxers stretching ice heat back brace

What medical procedures treatments have you done for your pain & when last done?: chiropracter ___ physical therapy _______ epidurals______ joint injections ______ nerve blocks ______ rhizotomy_____ surgery ______ other:____________

Florida Interventional Pain Management, L.L.C.
Dr. Saulis Banionis, MD
Phone: 561-537-4817, Fax: 561-795-9594

Patient's Name:______________________________

Billing for Services and Advance Beneficiary Notice

We expect that Insurance providers and Medicare will pay for services and items provided to you during the course of your care. However, Insurance providers and Medicare may not pay for all of your health care costs, even if there may be a good reason your doctor is recommending it. The fact that Medicare or another insurance provider may not pay for a particular item or service does not mean that you should not receive it. Insurance providers and Medicare only pay for covered items and services when certain rules are met. In the event that your Insurance provider or Medicare may not pay for the Item(s) that are described above, you will be financially responsible for services provided to you. By signing this form, you agree to receive the items or services.
I understand that Insurance companies and Medicare will not decide whether to pay unless I receive these items of services. Please submit my claims to Medicare or to my other insurance providers. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare or my Insurance company is making its decision. If my Insurance provider or Medicare does pay for agreed upon services, the physician's office will refund to me any payments I made to you that are due to me. If Medicare or other Insurance provider denies payment, I agree to be personally and fully responsible for payment. If a bill is not paid after 3 attempts to collect, I understand that the bill will be referred to a collections agency.

Patient's Signature:______________________________

Date: ______________________

CONTRACT FOR USE OF CONTROLLED SUBSTANCES

(must be signed and initialed prior to receiving any controlled substance)

Controlled substance medications (narcotics, tranquilizers and some sleeping medications) are very useful, but have a high potential for misuse and are therefore, closely controlled by the local, state and federal government. They are intended to relieve pain to improve functions and/or ability to work, not to relieve all pain or to simply feel good. I understand the proper use of controlled substances and have been fully informed regarding psychological dependence (addiction) of a controlled substance and agree to use the medication only for its intended purpose only. _____

I understand that people may develop a tolerance, which is the need to increase the dose of the medication or a physical dependence to the medication. If I am taking controlled substances for several weeks, I agree to taper the medication slowly and under medical supervision so as to avoid symptoms of withdrawal. _____

I will not see any other physician for pain management while in the care of Florida Interventional Pain Management. _____

Because my Physician or medical provider at the Pain Service is prescribing controlled substances to me to help manage my pain, I agree to the following conditions:

1. I am responsible for my controlled substance medications. If the prescription of medication is lost, misplaced, or stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced. _____

2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from the Pain Service. Besides being illegal to do so, It may endanger my health. The only exception is if it is prescribed while I am admitted to a hospital and I agree to inform the pain service immediately upon discharge. _____

3. I will not consume alcohol or recreational drugs while taking controlled substance medications and I agree to random urine/blood testing. _____

4. Refill of controlled substance medication:

    a. Will be made only during regular office hours, in person, during a scheduled office visit. _____

b. Will not be made if I "Run Out Early", I am responsible for taking the medication in the manner prescribed and as directed by the physician and agree to keep track of the amount remaining. _____

c. I will call at least 24 hours ahead if I need assistance with a controlled substance medication prescription and "Emergency" calls will not be made on Friday afternoon because I suddenly realized I will "Run Out Tomorrow". _____

5. I will comply with all of the items below:

   a. If asked to do so, I will bring in all medications and containers prescribed by the Pain Service, each time I return for my appointment._____

   b. Fill my prescription at only one Pharmacy, not at multiple pharmacies._____

   c. Bring in written proof of compliance with all aspects of my treatment:
      1. Physical Therapy _____
      2. Psychological and/or substance abuse counseling_____
      3. General health care provided by a primary care physician _____

6. I understand that if I violate any of the above conditions, my controlled substance prescription and/or treatment with the Pain Service may be ended immediately. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to my primary care physician, medical facilities and other authorities. _____

7. I understand and agree that I may be tested for controlled or illegal substances at the physician's discretion and agree to the above. _____

8. I have fully read this contract and it has been explained to me. I fully understand the consequences of violating this contract. _____

9. **It is the patient's responsibility to obtain referrals for all office visits.** Patients who require referrals/authorization to see specialist, will need to have referrals faxed/sent to our office at least 48 hours prior to her/his scheduled appt. if we do not have a referral in place within 48 hours, the scheduled office visit will be cancelled and that appointment slot will be reassigned to another patient. Any medications that the patient requires, will need to be provided by the patient's primary care physician until such time as a referral is obtained and the patient can be seen in the office. _____

Patient Signature: ________________________ Date: ____________________
Witness Signature: ________________________ Date: ____________________

Florida Interventional
PAIN MANAGEMENT, LLC
PRP • Stem Cell • Regenerative Medicine

Circle each box that applies

Family history of substance abuse			
Alcohol	Yes	No	Male/Female
Illegal drugs	Yes	No	Male/Female
Prescription drugs	Yes	No	Male/Female
Personal history of substance abuse			
Alcohol	Yes	No	Age:
Illegal drugs	Yes	No	Age:
Prescription drugs	Yes	No	Age:
History of preadolescent sexual abuse	Yes	No	Age:
Psychological disease			
ADD	Yes	No	
OCD	Yes	No	
Bipolar	Yes	No	
Schizophrenia	Yes	No	

Florida Interventional Pain Management, L.L.C.

CONSENT FOR RELEASE OF RECORDS

To: ______________________________ **Date:** ________
Attention: ______________________________
Fax #: ______________________________

Patient Name: ______________________________
Date of Birth: ________________
Social Security Number: ________________

PURPOSE OR NEED FOR RELEASE OF INFORMATION/MEDICAL RECORDS:
____
____

FORM IN WHICH INFORMATION / RECORDS IS TO BE RELEASED:
Verbal: _____ **Written:** _____ **Fax:** _____ **Email:** _____ **Other:** _____

WHAT INFORMATION / REPORTS ARE TO BE RELEASED:
Initial Medical Examination: ____ **Progress Notes:** _____ **X-Ray/CT/MRI:** _____
Discharge Summary: ____ **Lab Results:** _____ **Other:** _____

PLEASE FAX RECORDS TO:
FLORIDA INTERVENTIONAL PAIN MANAGEMENT, LLC
FAX: (561) 795-9594

I understand by approving the release of information in the form of a fax, confidentiality cannot be assured. I accept the risk that confidentiality may be breached when faxing information.

I understand that this authorization shall expire ninety (90) days from the date on my signature below. I hereby release Florida Interventional Pain Management, LLC and its employees from any and all liability that may arise from this release of information:

Patient Signature: ____________________________________ **Date:** ________

Florida Interventional Pain Management, L.L.C.

1447 Medical Park Blvd. Suite 209

Wellington, Fl 33414

I understand I will receive an insurance statement, describing the procedures billed during my treatment process including random urine drug screens, which is called an explanation of benefits (EOB) and is not a bill; instead it is a detailed statement explaining the cost of each medically necessary procedure performed and then billed to my insurances(s) at allowable rates. Current law requires that random urine drug screens be performed by all patients that visit pain doctors, and I understand that if the insurance does not pay for urine drug screens that I will be financially responsible for a $30 fee for this service which will be performed according to state guidelines at random intervals.

X ______________________________ X ______________________________

Patient Signature Date

ACKNOWLEDGEMENT

I, ____, acknowledge that I have been provided with a copy of Florida Pain Management, LLC, privacy notice.

Date: ___________________________ Signature:__________________________

1447 Medical Park Blvd. Suite 209 - Wellington, Florida 33414 - Tel: 561-537-4817 - Fax: 561-795-9594

Florida Interventional Pain Management, L.L.C.

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

University Pain Management understands that your medical information s private and confidential. Further, we are required by law to maintain the privacy of "protected health information." "Protected health information" includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy notice from the Practice's Privacy Officer.

'ERMITTED USES AND DISCLOSURES

We can use or disclose your protected health information for purposes of treatment, payment and health care operations. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

- *Treatment* means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create the exercise regimen appropriate to your care.
- *Payment* means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide information to your Third Party Payor about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the Third Party Payor for the services rendered to you, we can provide the Third Party Payor with information regarding your care if necessary to obtain payment. Federal or State law may require us to obtain a written release from you prior to disclosing certain specially protected health information for payment purposes, and we will ask you to sign a release when necessary under applicable law.
- *Health care operations* means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your protected health information to evaluate the performance of our staff when caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. In addition, we may remove information that identifies you from your patient information so that others can use the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In addition to using and disclosing your information for treatment, payment and health care operations, we may use your protected health information in the following ways:

- We may contact you to provide appointment reminders for treatment or medical care.

- We may contact you to tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.

- We may disclose to your family or friends or any other individual identified by you protected health information directly relevant to such person's involvement with your care or payment for your care. We may use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are present or otherwise available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not present or otherwise available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.

- When permitted by law, we may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

- We will allow your family and friends to act on your behalf to pick-up filled prescriptions, medical supplies, X-rays, and similar forms of protected health information, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

- We may contact you as part of our efforts to market our practice's services as permitted by applicable law.

- Subject to applicable law, we may make incidental uses and disclosures of protected health information. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

- We may use or disclose your protected health information for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. All research projects are subject to a special approval process, which balances research needs with a patient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.

- We will use or disclose protected health information about you when required to do so by applicable law.

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your protected health information:

- Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- Military and Veterans. If you are a member of the Armed Forces, we may release health information about you as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

- Worker's Compensation. We may release health information about you for programs that provide benefits for work-related injuries or illnesses.

- Public Health Activities. We may disclose health information about you for public health activities, including disclosures:

  * to prevent or control disease, injury or disability;
  * to report births and deaths;
  * to report child abuse or neglect;
  * to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products;
  * to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  * to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the patient agrees or when required or authorized by law.

- Health Oversight Activities. We may disclose health information to Federal or State agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government benefit programs, and compliance with civil rights laws or regulatory program standards.

- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if the Practice is given assurances that efforts have been made by

the person making the request to tell you about the request or to obtain an order protecting the information requested.

- Law Enforcement. We may release health information if asked to do so by a law enforcement official:

    - In response to a court order, subpoena, warrant, summons or similar process;
    - To identify or locate a suspect, fugitive, material witness, or missing person;
    - About the victim of a crime under certain limited circumstances;
    - About a death we believe may be the result of criminal conduct;
    - About criminal conduct on our premises; and
    - In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.

- Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. Such disclosures may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

- National Security and Intelligence Activities. We may release health information about you to authorized Federal officials for intelligence, counterintelligence, or other national security activities authorized by law.

- Protective Services for the President and Others. We may disclose health information about you to authorized Federal officials so they may provide protection to the President or other authorized persons or foreign heads of state or may conduct special investigations.

- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

Note: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.

OTHER USES OF YOUR HEALTH INFORMATION

Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your permission in a written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request. To request a restriction, you must make your request in writing to the Practice's Privacy Officer.

2. You have the right to reasonably request to receive confidential communications of protected health information by alternative means or at alternative locations. To make such a request, you must submit your request in writing to the Practice's Privacy Officer.

3. You have the right to inspect and copy the protected health information contained in your medical and billing records and in any other Practice records used by us to make decisions about you, except:

(i) for psychotherapy notes, which are notes that have been recorded by a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record;

(ii) for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;

(iii) for protected health information involving laboratory tests when your access is restricted by law;

(iv) if you are a prison inmate, obtaining a copy of your information may be restricted if it would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you;

(v) if we obtained or created protected health information as part of a research study, your access to the health information may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;

(vi) for protected health information contained in records kept by a Federal agency or contractor when your access is restricted by law; and

(vii) for protected health information obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.

In order to inspect and copy your health information, you must submit your request in writing to the Practice's Privacy Officer. If you request a copy of your health information, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

We may also deny a request for access to protected health information if:

- a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person;

- the protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

- the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.

If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. You have the right to request an amendment to your protected health information, but we may deny your request for amendment, if we determine that the protected health information or record that is the subject of the request:

(i) was not created by us, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment;

(ii) is not part of your medical or billing records or other records used to make decisions about you;

(iii) is not available for inspection as set forth above; or

(iv) is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your health information, you must submit your request in writing to the Practice's Privacy Officer, along with a description of the reason for your request.

5. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you for the six years prior to your request, except for disclosures:

(i) to carry out treatment, payment and health care operations as provided above;

(ii) incident to a use or disclosure otherwise permitted or required by applicable law;

(iii) pursuant to a written authorization obtained from you;

(iv) to persons involved in your care or for other notification purposes as provided by law;

(v) for national security or intelligence purposes as provided by law;

(vi) to correctional institutions or law enforcement officials as provided by law;

(vii) as part of a limited data set as provided by law; or

(viii) that occurred prior to April 14, 2003.

To request an accounting of disclosures of your health information, you must submit your request in writing to the Practice's Privacy Officer. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

<u>COMPLAINTS</u>.

If you believe that your privacy rights have been violated, you should immediately contact the Practice's Privacy Officer. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

<u>CONTACT PERSON</u>

If you have any questions or would like further information about this notice, please contact the Practice's Privacy Officer.

This notice is effective as of April 14, 2003.