CENTRAL FLORIDA
PAIN RELIEF CENTERS

Patient Information

Patient Name: _____
Last First M.
Mailing Address (incl. city & zip): _____

Permanent Address (incl. city & zip): _____

Daytime Phone: _____ Ext._____Evening Phone: _____

Date of Birth:_____ SSN: _____ Marital Status:_____

Current Employer: _____ Occupation: _____

(If workers' comp, indicate employer where accident occurred)
Employer Address: _____

Date of Injury/Accident/Illness: _____

Closest friend or relative not living with you:_____

Address: _____

Daytime Phone: _____Ext: _____Evening Phone: _____

Insurance Information

Primary Insurance Company: _____

Subscriber's Relationship to Patient: SELF SPOUSE PARENT OTHER

Spouse Name:_____
Last First M.
Spouse's Employer: _____ Telephone # _____

Spouse SSN: _____Spouse Date of Birth:_____

Secondary Insurance Company: _____

Third Insurance, if applicable: _____

Referral Information
(Please tell us how you were referred to our practice)

Referring Physician_____ Health Plan Provider List _____

Other Source_____(W/C Adjuster, Case Manager, Website, Friend etc)

Please read the following authorization. Initial and sign below for our files.

_____ I understand that any appointment changes must be made at least 24 hours in advance or a $30 fee will be applied.

Signature_____ **Date**_____
***** Please present this form and all insurance ID cards to the receptionist at this time. *****

I, the undersigned, do hereby agree and give my consent for ***Central Florida Pain Relief Centers*** to furnish medical care and treatment to myself, _____ considered necessary and proper in diagnosing or treating my/his/her physical and mental condition.

Patient/Guardian/Responsible Party_____ Date _____

Altamonte Springs 683 Douglas Avenue Suite 101 Altamonte Springs FL 32714
Downtown 100 West Gore Street Suite 500 Orlando FL 32806
Lake Mary 325 Waymont Court Suite 111 Lake Mary FL 32746
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Patient Name _____ Date of Birth _____ Age _____

Gender: ***(Please circle)*** Male / Female Race: ***(Please circle)*** White / Black / Hispanic / Asian / Other _____

Who referred you to us? _____ Who is your Family Doctor? _____

Is your visit related to an injury? YES/NO If Yes, specify: AUTO Work Comp OTHER

Have you been to any previous pain management? Yes or No (***circle one***)
Name of Physician(s) _____

WORK STATUS: ____ Regular Duty _____ Light Duty, Restrictions _____
___ Off Work: last worked: _____
___ Disabled: since _____ by what doctor _____
___ Retired: since what year _____

Location of Pain: _____

In the diagram below, please shade the areas of your pain

(***Circle your answer***)
Pain Scale: From 0 – 10 what is your pain level today?

(NO PAIN) **0 1 2 3 4 5 6 7 8 9 10** (WORST PAIN)

What is your range of pain in the past month?

(NO PAIN) **0 1 2 3 4 5 6 7 8 9 10** (WORST PAIN)

What treatments have you had for your pain? Check all that apply.

__ Physical Therapy	__ Favorable Results	__ Poor Results
__ Acupuncture	__ Favorable Results	__ Poor Results
__ Chiropractor	__ Favorable Results	__ Poor Results
__ Trigger Point Injections	__ Favorable Results	__ Poor Results
__ TENS Unit	__ Favorable Results	__ Poor Results
__ Nerve Blocks	__ Favorable Results	__ Poor Results

Type of Nerve Block _____

___Back or Neck Surgery Type_____ When _____

___Spinal Cord Stimulator Type_____ Date implanted _____

___Morphine Pump Type _____ Date implanted _____

___Other: _____

Allergies: _____ _____ _____

_____ _____ _____ _____

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Patient History: (check each that apply)

Tobacco:	___ do not smoke	___ smoke	___ pack(s) per day
Alcohol:	___ do not drink	___ drink	# of drinks per ____ day ____ week
Social History:	___ Married	___ Single	___ Divorced
Lives With:	___ Spouse	___ Children	___ Other ____Alone

___Blind ___Glasses ___Contacts ___Hard of Hearing ___Deaf ___HIV+

___Hearing Aids ___Cancer ___Thyroid Disease ___Gallbladder Disease ___Birth Defects

Under each Category, please check any symptoms that apply

Cardiovascular	**Gastrointestinal**	**Neurological**	**Musculoskeletal**	**Psychiatric**
___Hypertension (High)	__Chronic Diarrhea	__Migraines	__Arthritis	___Depression
___Hypotension (Low)	__Chronic Constipation	__Frequent Headaches	__Osteoarthritis	___Anxiety Disorder
___Anemia	__Incontinence	__Epilepsy	__Rheumatoid	___Bipolar
___Heart Disease	__Ulcers	__Sleeping Disorders	__Low Back Syndrome	___Alcoholism
___Stroke	__Hepatitis	__Restless Leg	__Cane	___Drug Addiction
___Swelling of Feet	__Ulcers	Syndrome	__Walker	___Suicide Attempt
___Chest Pain	__Liver Disease	__Other:_____	__Wheelchair	___Schizophrenia
___Shortness of Breath	__Diabetes		__Prosthesis	___Other:_____
___Rheumatic Fever	__Gout		Type:_____	
	__Other:_____		__Other:_____	

Genitourinary:

___ Urinary Incontinence

___Kidney Disease

___Other:_____

_____

Respiratory:

___ Asthma

___ COPD

____Chronic Cough

____O2 Therapy

Medications you are presently taking: **Include Over the Counter & prescription drugs**.
Pain Medications, Muscle Relaxants, Sleep Aid, Anti-anxiety, and Antidepressants.
Medications Dose Frequency (use back of paper if needed)

_____
_____
_____

All Others (including Over-the-Counter)
Medications

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_____
_____

SURGERIES
(Please list below)

DATE (month/year)

_____
_____
_____

FAMILY HISTORY

Relation	Current State of Health & History of Problems
Mother	_____
Father	_____
Siblings	_____

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

PATIENT: _____ **DATE:** _____

You have agreed to receive opioid/narcotic therapy for the treatment of chronic pain. You understand that these drugs are very useful, but have potential for misuse and are therefore closely controlled by local, state, and federal governments. The goal of this treatment is to: (a) reduce your pain; and (b) improve your level of function in performing your activities of daily living.

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

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

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

SIDE EFFECTS

Side effects are normal physical reactions to medications. Common side effects of opioid/narcotics include mood changes, drowsiness, dizziness, constipation, nausea, and confusion. Many of these side effects will resolve over days or weeks. Constipation often persists and may require additional medication. If other side effects persist, different opioid may be tried or they may be discontinued.

You should NOT:

a. Operate a vehicle or machinery if the medication makes you drowsy;

b. Consume ANY alcohol while taking opioids /narcotics; or

c. Take any other non-prescribed sedative medication while taking opioids/narcotics.

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

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

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

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

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PATIENT'S INITIALS: _____

RISKS

Dependence

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

Tolerance

Tolerance to the pain-relieving effect of opioids/narcotics is possible with continued use. This means that more medication is required to achieve the same level of pain control experienced when the opioid/narcotic therapy was initiated. When tolerance does occur, sometimes it requires tapering or discontinuation of the opioid/narcotic. Sometimes tolerance can be treated by substituting a different opioid/narcotic. When initiated, doses of medication must be adjusted to achieve a therapeutic, pain relieving effect; upward adjustments during this period are not viewed as tolerance.

Increased Pain (Hyperalgesia)

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

Addiction

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

- Impaired control over drug use;
- Compulsive use;
- Continued use despite harm; and/or
- Craving

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

Risk to Unborn Children

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

PATIENT'S INITIALS: _____

Long-Term Side Effects

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

PRESCRIPTIONS AND USE OF OPIOID/NARCOTIC MEDICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

PATIENT'S INITIALS: _____

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

For patients taking methadone: Methadone has significant interactions with many other medications. Some of these medications may reduce your body's ability to metabolize methadone, thus **INCREASING** the methadone in your body, which could be dangerous. Therefore, you **MUST** notify this office of **ALL** medications prescribed for **ANY** condition while taking methadone.

OPIOID/NARCOTIC THERAPY MAY BE DISCONTINUED IF YOU:

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

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By signing below, I acknowledge and agree that: (i) I have read and fully understand the Physician/Patient Informed Consent and Agreement for long-term opioid/narcotic therapy for the treatment of chronic pain, (ii) I have been given the opportunity to ask questions about the proposed treatment (including no treatment), potential risks, complications, side effects, and benefits; (iii) I knowingly accept and agree to assume the risks of the proposed treatment as presented; and (iv) I agree to abide by the terms of this agreement.

Patient Signature: _____ **Date** _____

Print Name: _____

Witness Signature _____ **Date** _____

Print Name: _____

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PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing _____ as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for her treatment and care.
- We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients are responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.
- Patients may incur, and are responsible for the payment of additional charges at the discretion of _____. These charges may include (but are not limited to):
    - Charge for returned checks.
    - Charge for missed appointments without 24 hours advance notice
    - Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions.
    - Charge for the copying and distribution of patient medical records.
    - Charge for extensive forms completion.
    - Any costs associated with collection of patient balances.

Patient Authorizations

- By my signature below, I hereby authorize_____ and the physicians, staff, and hospitals associated with _____ to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care.
- I understand that I must check one or more of the following types of health information to indicate that I authorize that information type to be released to the necessary insurance companies, third party payers, and/or other physicians and/or healthcare entities required to participate in my care. By checking one or more of the following boxes, the health information I authorize to be released may include any of the following:
    - □ Diagnosis, evaluation, and/or treatment for alcohol and/or drug abuse.
    - □ Records of HTLV-III or HIV testing (AIDS test) result, diagnosis, and/or treatment.
    - □ Psychiatric and/or psychological records, or evaluation and/or treatment for mental, physical, and/or emotional illness, including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluations.
- By my signature below, I hereby authorize assignment of financial benefits directly to _____ and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize _____ personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.

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BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to ***Central Florida Pain Relief Centers***. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Information Privacy: ***Central Florida Pain Relief Centers*** will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, and have copies available for distribution. The undersigned acknowledges receipt of this information.

*Patient/Guardian/Responsible Party*_____ *Date* _____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made due to policy termination, you will be responsible for the amount of money refunded to your insurance company. We reserve the right to assess a finance charge of 18% annually for balances carried over an extended period of time.

Benefits and eligibility are verified prior to your visit as a courtesy and as a result, we are not responsible for incorrect information provided by your insurance company as it relates to copay or benefit plan limitations. Your policy must be in effect at the time of service and subject to individual plan limitations and exclusions as mandated by your plan. An authorization is not a guarantee of payment.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to ***Central Florida Pain Relief Centers***.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

I UNDERSTAND MY RESPONSIBILTY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian/Responsible Party_____ Date_____

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____ _____

Signature of Patient or Guardian Date

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

_____ _____

Signature of Patient or Guardian Date

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Pain Disability Index Sheet

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (i.e. yard work) and errands or favors for other family members (i.e. driving the children to school).

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (i.e. taking a shower, driving, getting dressed, etc.)

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

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Life-Supporting Activities: This category refers to basic life supporting behaviors such as eating, sleeping, and breathing.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Signature _____ **Print Name** _____

Date _____

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