TAMPA PAIN RELIEF CENTERS

New Patient Database:

Name: _____ Date: _____

Date of Birth _____

Referring Physician: _____

Primary Care Physician: _____

Height: _____ Weight: _____ Age: _____

Marital Status: Married _____ Single _____ Divorced _____ Widowed _____

Education level: High school grad ____ Associate Degree ____ College Degree _____ Advanced Degree _____

Occupation: _____ Are you a left or right handed person? _____

Do you wear glasses? Yes No Contact Lenses? Yes No Eye color _____ Hair Color _____

Hobbies: _____ Do you exercise: Yes No How often? _____

Tattoos: Yes No Where: _____ Have you ever been arrested? Yes No when? _____

DUI: Yes No Violent Crimes Yes No Are you employed at this time? Yes No Where: _____

Scars: Yes No where: _____

Did you serve, or are you currently in the Armed Forces? Yes No If Yes, branch: _____Honorable Discharge Yes No

Where is your pain? _____

Work related: Yes No Current restrictions: _____

Do you consider yourself: Caucasian/Hispanic/Latino/Spanish/African-American/Asian/Native-American/Other ____ _____

Date of Pain Onset: _____

Secondary to (please circle one): Illness Accident Work Other: _____

Please describe when or how your pain started (include dates and who treated you).

_____

_____

Describe how injury occurred: _____

_____

_____

Pain Quality (circle all that apply):

Aching	Stabbing	Sore	Intense	Radiating	Burning	Shooting
Sharp	Annoying	Cramping	Tingling	Dull	Transient	Severe
Numbing	Hot	Tight	Throbbing	Unbearable	Stinging	Intermittent
Heavy	Constant	Excruciating	Tender	Nagging	Cold	
Squeezing	Penetrating	Gnawing	Miserable	Tiring	Exhausting	

Other pain description: _____

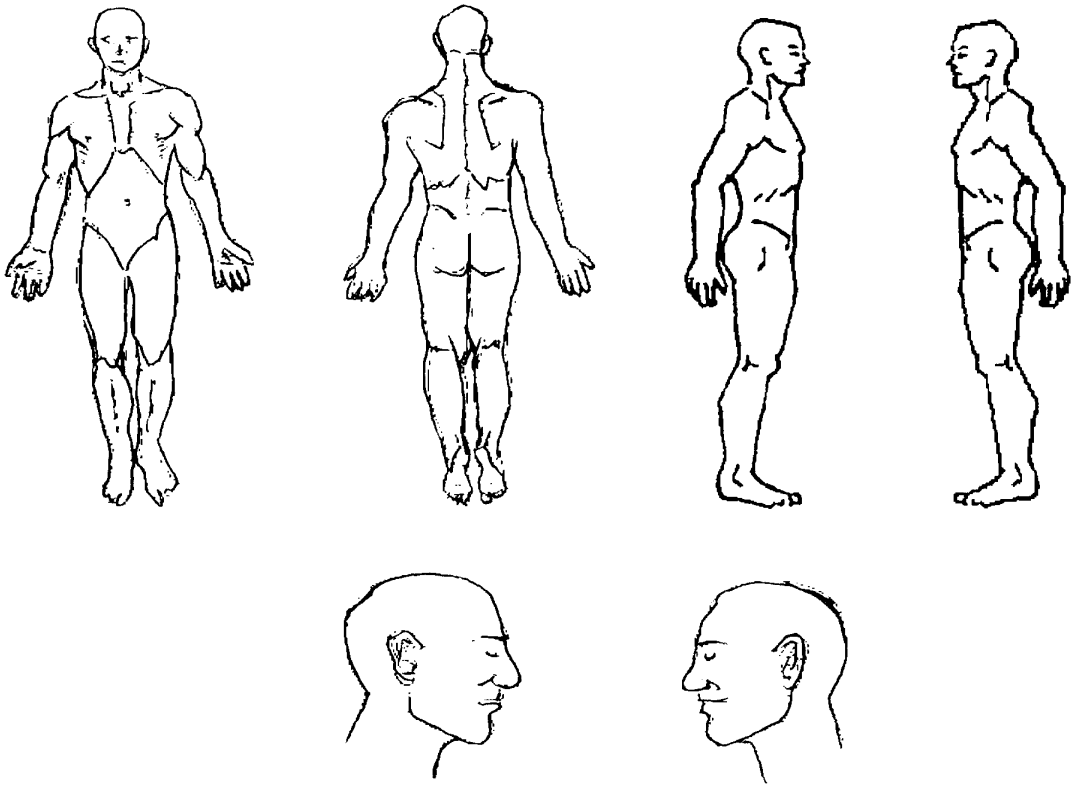
Goals to be accomplished by treatment: Ex: return to work; attend children's activities, clean house, shop, etc.

_____

TAMPA PAIN RELIEF CENTERS

Name: _____ Date: _____

Please indicate where your pain is, does the pain affect other parts of your body?



-In the area that you do have pain, do you also have pins and needles, tingling or prickly sensations? **... YES NO (5)**
-Does the painful area change color when the pain is particularly bad? ……....**YES NO (5)**
-Does your pain make the affected skin area sensitive to touch? ……..**YES NO (3)**
-Does your pain come on suddenly for no apparent reason, when you are completely still?…… **YES NO (2)**
-In the area where you have pain, does your skin feel unusually hot like a burning pain? ……. **YES NO (1)**
-Gently rub the painful area with your index finger, and then rub a non-painful area. How does this rubbing feel in the painful area?

A. The painful area feels no different from the non-painful area.
B. I feel discomfort, like pins and needles, tingling or burning in the painful area that is different from the non-painful area. (3)

-Gently pressed on the painful area with your fingertip, and then gently press in the same way onto the non-painful area. How does this feel on the painful area?

A. The painful area does not feel different from the non-painful area.
B. I feel numbness or tenderness in the painful area that is different from the non-painful area. (3)

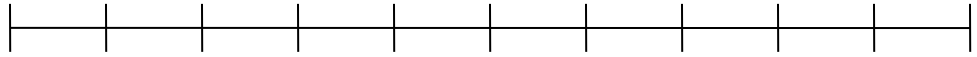
LANSS Score: _____

TAMPA PAIN RELIEF CENTERS

Patient Name: _____ Date: _____

On a scale of 0-10, zero means NO pain / ten is THE MOST unbearable pain ever. What is your pain score?

PAIN INTENSITY SCALE



0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Pain Worst Pain

Does your pain increase with activity: Yes / No

How often do you have pain? Constantly Intermittently

What makes your pain better? Heat, cold, standing, sitting, lying down, walking, bending, coughing, sneezing, medications

What makes your pain worse? Heat, cold, standing, sitting, lying down, walking, bending, coughing, sneezing, medications

What activities are more difficult because of the pain? Exercise, sleep, sitting, standing, walking, driving, bending, lifting, pulling, pushing, recreational activities.

Others activities not listed: _____

Previous Treatments

TREATMENT	YES	NO	HELPFUL	NOT HELPFUL	COMMENTS
Traction					
TENS unit					
Physical Therapy					
Biofeedback					
Hypnosis					
Psychotherapy					
Chiropractic					
Acupuncture					
Osteopathic Treatment					
Bed Rest					
Nerve Blocks					
Other					

What non-pain medications are you currently taking? (Please include any non-prescription medicines)

Name:	How many per day?	Effect (0= no help, 10= very helpful):

TAMPA PAIN RELIEF CENTERS

Patient Name: _____ Date: _____

What pain medications have you used to treat your pain?

Name:	How many per day?	Effect (0= no help, 10= very helpful):

Please list all of your ALLERGIES: _____

Past Medical History:
What illnesses do you have? (Diabetes, heart disease, liver disease, seizures…)

_____

_____

_____

What surgical / medical procedures have you had? (Please provide date)

_____

_____

_____

Social History:

How much do you smoke / have you smoked? _____ Packs / Day _____ How Many Years? _____

How much do you drink? _____ Every Day _____ Every Week _____How long? _____

Do you drink caffeinated beverages? No / Yes coffee_____ tea____ soft drinks _____Energy Drinks _____

Have you ever abused alcohol? Yes / No _____

Are you currently using or have you ever in the past used or obtained any illegal drugs or substances?
(Failure to answer truthfully would result in automatic discharge from the center)

Name of substance:	Date:	How much?

Who lives with you at home? _____

Are you involved in litigation or a law suit currently? _____

Are you currently working? Yes No Part-time _____ Full time _____ Hours per week _____

Number of Children: _____Ages: _____

Profession/work history: _____

_____

TAMPA PAIN RELIEF CENTERS

Patient Name: _____ Date: _____

Review of Systems: (Please circle as many as needed and provide explanations if needed. Mark if negative)

Negative

( ) **General:** Change in weight, Appetite, Sleep, Taste or Smell, Fatigue, Fever
( ) **Skin:** Rash, Itching, psoriasis, eczema, skin rash
( ) **Head & Neck:** Hearing impairment, Dizziness, Balance problems, Vision & eye problems, Nose bleed, Hoarseness, Mouth sores, Difficulty Swallowing, ringing in ears, bleeding gums, nose bleeds, glaucoma, cataracts
( ) **Breasts:** Any abnormal enlargement or tenderness, masses, pain
( ) **Lungs:** Chronic cough, Emphysema, Tuberculosis, Bronchitis, asthma, infections, pneumonia
( ) **Cardiovascular:** High blood pressure, Chest pain, Heart attack, Shortness of breath, Murmurs, Congestive heart failure, Deep vein thrombosis (DVT), irregular heart rate
( ) **Gastrointestinal:** Stomach ulcers, Stomach bleed, Heartburn, Rectal bleed, Hiatal hernia, Pancreatitis, Diarrhea, Constipation
( ) **Urinary Tract:** Kidney stone, Kidney infections, Painful urination, Incontinence, Bleeding
( ) **Reproductive System:** Sexually transmitted diseases, Bleeding, Impotency
( ) **Endocrine System:** Thyroid Disease, Diabetes, Pituitary or other gland or hormonal diseases_____
( ) **Blood & Lymphatic:** HIV or AIDS, Lymphoma, Bleeding problems, Sickle cell disease_____
( ) **Musculoskeletal System:** Osteoarthritis, Rheumatoid arthritis, Back pain, Joint pain, Muscle disorder_____
( ) **Nervous System:** Fainting, Headache, Seizure, Memory loss, Dizziness, Numbness_____
( ) **with Psychiatric History:** Depression, Anxiety, Psychosis _____

Sleep Questionnaire: (please circle "Y" for yes or "N" for no, if yes, often, occasionally)

Do you have sleep problems daily? Yes No

Sleep surface: firm, medium, soft Is sleep refreshing/restful? Yes no

Sleep on back, side, stomach, both, on recliner on couch Is sleep problem secondary to pain? Yes No

When did your sleep problem begin? _____

Do you have trouble falling asleep? ..... **Y ____ N**

How long does it take to fall asleep? _____ Hours

How many hours do you sleep each night? _____

Do you wake up during sleep? ..... **Y ____ N**

Do you wake up too early in the morning? ..... **Y ____ N**

Cannot stop thinking when trying to fall asleep? ..... **Y ____ N**

Do you sleep during the day? ..... **Y ____ N**

Do you gasp for air while sleeping? ..... **Y ____ N**

Do you have morning fatigue? ..... **Y ____ N**

Do your legs jerk while sleeping? ..... **Y ____ N**

Do you have bad dreams? ..... **Y ____ N**

Family Medical History: (please check or fill in as needed)

Relation	Age	Deceased	Alive	General Health	Medical Problems
Father					
Mother					
Brothers					
Sisters					
Grandparents					

What illnesses are found in your family: Please circle those that apply!

Arthritis, Gout, Asthma, Hay Fever, Cancer, Diabetes, Heart Disease, Stroke, High Blood Pressure, Kidney Disease

TAMPA PAIN RELIEF CENTERS

Patient Name: _____ Date: _____

Is there any history of substance abuse in your family, what substance was abused? [ ] yes [ ] no	[ ] Alcohol [ ] Illegal drugs [ ] Other
Do you have any personal history of substance abuse? [ ] yes [ ] no	[ ] Alcohol [ ] Illegal drugs [ ] Prescription drugs
History of preadolescent sexual abuse	[ ] yes [ ] no
Any history of psychological disease? [ ] yes [ ] no	Attention deficit disorder Bipolar disorder depression Obsessive compulsive disorder schizophrenia

MAST Questionnaire

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)

CAGE Questionnaire

Do you drink alcohol? Yes no

Have you experimented with drugs? Yes no

When thinking about drug use, include illegal drug use, and the use of prescription drugs other than as prescribed.

1. In the last three months, have you felt you should cut down or stop drinking or *using drugs?*
   Yes No
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or *using drugs?*
   Yes No
3. In the last three months, have you felt guilty or bad about how much you drink *or use drugs*?
   Yes No
4. In the last three months, have you been waking up wanting to have an alcoholic drink or *use drugs*?
   Yes No

SOAP Questionnaire V1.0 SF

How often do you have mood swings?	Never	Seldom	Sometimes	Often	Very Often
How often do you smoke a cigarette within an hour after you wake up?	Never	Seldom	Sometimes	Often	Very Often
How often heavy taken medication other than the way it was prescribed?	Never	Seldom	Sometimes	Often	Very Often
How often, have you used illegal drugs in the past five years?	Never	Seldom	Sometimes	Often	Very Often
How often, have you had legal problems or been arrested?	Never	Seldom	Sometimes	Often	Very Often

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

Patient Name: _____ Date of Birth: _____

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.

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.

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.

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: _____

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing **TAMPA PAIN RELIEF CENTERS** 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 **TAMPA PAIN RELIEF CENTERS**. 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 **TAMPA PAIN RELIEF CENTERS** and the physicians, staff, and hospitals associated with **TAMPA PAIN RELIEF CENTERS** 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 **TAMPA PAIN RELIEF CENTERS** 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 **TAMPA PAIN RELIEF CENTERS** personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.

TAMPA
PAIN RELIEF CENTERS

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 payers to ***TAMPA 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: *TAMPA PAIN RELIEF CENTER* 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/ResponsibleParty*_____*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 ***TAMPA PAIN RELIEF CENTER***.

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

TAMPA PAIN RELIEF CENTERS

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

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_____

TAMPA PAIN RELIEF CENTERS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ DOB: _____/_____/_____

I authorize the release of my health information records to **Tampa Pain Relief Centers** to enable a comprehensive review of my medical care. I authorize the following physician offices, clinics, hospitals, other health care providers, pharmacies and legal offices to provide copies of my health information to:

TAMPA PAIN RELIEF CENTERS, INC.
3000 Medical Park Drive Suite 510
Tampa, FL 33613
OFFICE: 813-872-4492 FAX: 813-830-9400

(List of all facilities, clinics, and offices from which information will be requested)
PHYSICIAN OFFICES (please list all physicians you have seen in the past two years)

Physician's Name	Address	Phone Number	Fax Number
1.			
2.			
3.			
4.			

PHARMACY (please provide an updated list of all pharmacies that you have used in the past two years)

Pharmacy Name	Address	Phone Number	Fax Number
1.			
2.			
3.			
4.			

HOSPITAL AND OTHER FACILITIES (for surgeries/procedures, MRI/CT SCANS and any LAB and X-RAY reports)

Facility Name	Address	Phone Number	Fax Number
1.			
2.			
3.			
4.			

Restrictions:
_____ There are NO restrictions on the information that can be released.
_____ The following information CAN NOT be released:
_____

DURATION:
This authorization shall be effective immediately. I understand this authorization to release medical records will become invalid when I am no longer a patient of Tampa Pain Relief Center. I understand I have the right to revoke this authorization, at any time by sending written notification to the privacy/compliance office at the above listed address.

_____ _____
Signature of Patient Date

(PLEASE PRINT) Name of patient or personal representative: _____

(PLEASE PRINT) If personal representative, describe authority: _____

*****THIS RELEASE FORM MUST BE FILLED OUT IN ITS ENTIRETY TO BE VALID*****