



Patient Information

Patient Name: _____
Last First Middle
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 Middle
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 fee may be accrued.

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 **TAMPA 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 _____

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 Primary Care Provider? _____

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 (Doctor's Name): _____

_____ Retired - Since: (MM)_____ (DD)_____ (YYYY)_____

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

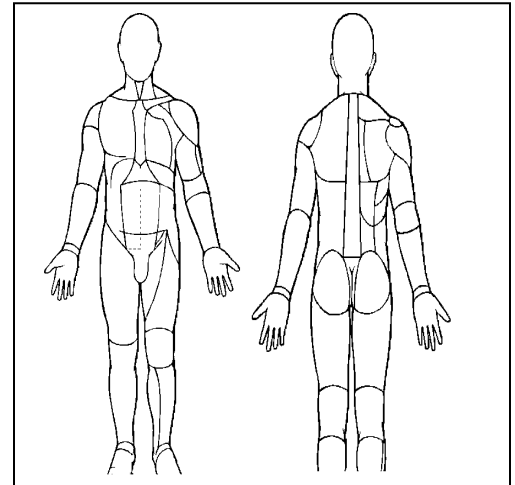
Type of Nerve Block _____

___ Back or Neck Surgery Type _____ When _____

___ Spinal Cord Stimulator Type _____ Date implanted _____

___ Morphine Pump Type _____ Date implanted _____

___ Other: _____



Allergies: _____

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		___ Other: _____	
	___ Other: _____			
Genitourinary:		Respiratory:		
___ Urinary Incontinence		___ Asthma		
___ Kidney Disease		___ COPD		
___ Other: _____		___ 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.

<u>Medications</u>	<u>Dose</u>	<u>Frequency</u> (use back of paper if needed)
_____	_____	_____
_____	_____	_____

All Others (including Over-the-Counter)

Medications

SURGERIES

DATE (month/year)

FAMILY HISTORY

<u>Relation</u>	<u>Current State of Health & History of Problems</u>
Mother _____	_____
Father _____	_____
Siblings _____	_____



**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

Addiction 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.



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/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 **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 RESPONSIBILITY 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 _____

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 _____



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.
2333 W Hillsborough Ave, #100
Tampa, FL 33603

OFFICE: 813-872-4492 FAX: 813-870-1502

(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*****

Permission to Verbally Discuss Health Information

In limited cases, we may provide health information to family members, or close friends who are directly involved in your care or the payment for your health care, **unless you tell us not to**. For example, we may tell a friend who asks for you by name where you are in our facility, and we may allow a friend or family member to pick up a prescription for you. We may also contact a family member if you have a serious injury or in other emergency circumstances. We may discuss medical information in the presence of a family member or friend **if you are also present and indicate that it is okay to do so**.

You can give us permission to discuss information about you with family, friends and others you designate who are involved in your care or concerned about your health status and may ask about your condition or need information **when you are not present**. You can tell us who we may talk with about your medical care, including your appointment and scheduling information, lab and test results, treatment information and billing information. This does not mean that the person will have access to your medical records. Permission to disclose or release medical records is handled completely separate.

Complete this form to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. You may also send us a letter with this information. Here are some examples of when it might be useful to you to release information:

- If you want a relative or friend to help understand medical treatment instructions
- If a relative or friend is helping with billing questions
- If a friend or relative calls to verify an appointment time
- If a relative or friend comes in and asks if you are here and in or out of surgery or the procedure room.

If you change your mind when you have another appointment with us, you can complete a new permission form. You must notify us **IN WRITING of the changes you want**.

I give permission to Tampa Pain Relief Center, Inc. to discuss the following information about me (check all boxes that apply) with the following person(s):

Name: _____

Address: _____

Phone numbers: Work _____ Mobile _____ Home _____

- Appointment information
- Medical information, including my symptoms, diagnosis, medications, and treatment plan
- Lab/test results
- Billing and payment information
- My location in the facility, whether I have been released and discharged.

I understand that I have the right to revoke my permission at any time except where Tampa Pain Relief Center, Inc. has already made disclosures relying upon this permission request. **I understand I must notify Tampa Pain Relief Center, Inc. in writing if I want to revoke my permission.**

_____/_____/_____
Print Patient Name Date of Birth

Signature of Patient/Authorized Representative Date

PLACE RECORD ID STICKER HERE