New Patient Intake Paperwork

Your completed intake paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call (321) 784-8211 if you have any questions or are unsure how to complete any section of this form.

Today's Date _____

Patient Information

Your Name: _____ Social Security Number: _____

Street Address: _____ Date of Birth: _____ Age: _____

Address 2: _____ Height: _____ Weight: _____ lbs

City/State/Zip: _____ Gender: ❑ Male ❑ Female

Physical Address Same as Mailing? ❑ Yes ❑ No If not, _____

Preferred Phone: _____ ❑ Home ❑ Mobile ❑ Work

Secondary Phone: _____ ❑ Home ❑ Mobile ❑ Work

Email: _____ Driver's License # / State: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other _____

Race: ❑ Caucasian ❑ African American ❑ American Indian or Alaskan Native ❑ Asian or Pacific Islander ❑ Refuse to Report

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Refuse to Report Primary Language: ❑ English ❑ Spanish ❑ Other

Is your pain the result of: ❑ an injury on the job? ❑ an automobile accident? ❑ other accident?

Referral

How were you referred to our clinic? ❑ Another Physician ❑ www.FloridaPain.net ❑ TV ❑ Radio ❑ Insurance Company ❑ Family ❑ Friend ❑ Facebook ❑ Twitter ❑ YouTube ❑ Other _____

Referring Physician: _____ Primary Care Physician: _____

Phone: _____ City: _____ Phone: _____ City: _____

Primary Insurance Plan

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Complete this box if you are *not* the policy holder for your primary insurance

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Complete this box if you are *not* the policy holder for your secondary insurance

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim.

Workers Comp Company: _____ Agent Name: _____

Phone number: _____ Fax number: _____

Claim Number: _____ Date of initial injury: _____

Preferred Pharmacy

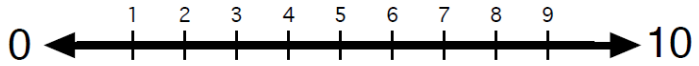
Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City/State/Zip: _____

Pain Description

Use the pain scale described below to rate your pain for the questions below:

0 – Pain-free
1 – Very minor annoyance, occasional minor twinges
2 – Minor annoyance, occasional strong twinges
3 – Annoying enough to be distracting
4 – Can be ignored if you are really involved in your work/task, but still distracting
5 – Cannot be ignored for more than 30 minutes
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9 – Unable to speak, crying out or moaning uncontrollably, near delirium
10 – Unconscious, pain makes you pass out



_____ What number on the pain scale (0-10) best describes your pain **right now**?

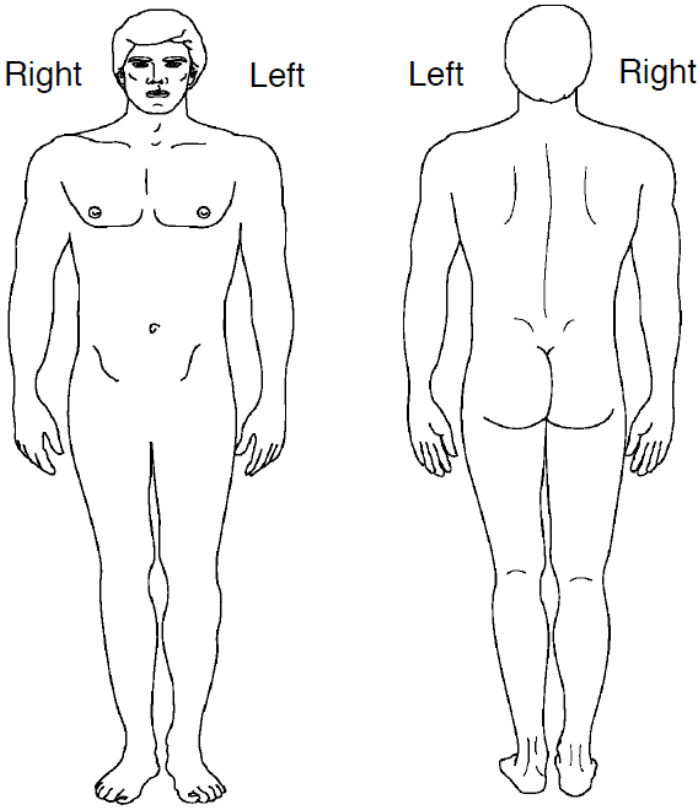
_____ What number on the pain scale (0-10) best describes your **worst pain**?

_____ What number on the pain scale (0-10) best describes your **least pain**?

_____ What number on the pain scale (0-10) best describes your **average pain over the last month**?

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

"N" = numbness
"S" = stabbing
"B" = burning
"P" = pins and needles
"A" = aching



Where is your worst area of pain located? _____

Does the pain refer somewhere else? If so, where? _____

Please list any additional areas of pain: _____

Onset and Mechanism of Injury

Approximately when did this pain begin? ❑ In the past few days ❑ In the last 30 days ❑ In the last year ❑ In the last 2 years ❑ In the last 5 years ❑ More than 5 years ago ❑ Date: _____

What caused your current pain episode? ❑ Nothing ❑ Assault ❑ Exercise ❑ Heavy weight lifting ❑ Injury ❑ Injury at work ❑ Motor vehicle accident ❑ Multiple health / medical problems ❑ Surgery ❑ Trauma ❑ Other: _____

How did your injury occur? ❑ Not applicable ❑ Altercation ❑ Assault ❑ Struck by a falling object ❑ Bending ❑ Exercise ❑ Falling ❑ Falling from height ❑ Lifting ❑ Repetitive movements ❑ Rotating ❑ Sports ❑ Stretching ❑ Other: _____

How did your current pain episode begin? ❑ Gradually ❑ Suddenly

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

Since your pain began, how has it changed? ❑ Decreased ❑ Increased ❑ Stayed the same

When is your pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ Middle of the night

Pain Description

Check all of the following that describe of your pain:

❑ Aching ❑ Band-like ❑ Burning / Hot ❑ Cramping
❑ Deep ❑ Dull ❑ Numb ❑ Piercing
❑ Pressure ❑ Shooting ❑ Stabbing / Sharp ❑ Spasming
❑ Throbbing ❑ Shock-like ❑ Squeezing ❑ Tiring / Exhausting
❑ Tingling / Pins and Needles

Pain Interference

Check all of the following activities that your pain interferes with:

❑ **Nothing** ❑ Driving ❑ Intercourse ❑ Leisure Activities
❑ Personal Grooming ❑ Relationships ❑ Sleep ❑ Sports Activities
❑ Walking ❑ Work duties: minimally / mildly / severely ❑ Other: _____

Prior Pain Treatments

Mark all of the following treatments you have had prior to today's visit for your current pain complaints:

❑ Acupuncture- Where _____How many Treatments_____
❑ Chiropractic- Where _____How many treatments _____
❑ Pain Medications ❑ Physical Therapy- Where _____ How many treatments_____ ❑ Psychological Therapy

❑ Epidural Steroid Injection(s) ❑ Trigger Point Injections ❑ Joint Injection(s) ❑ Nerve Blocks

❑ Radiofrequency Ablation ❑ Spinal Cord Stimulator – (circle one) Trial Only / Permanent Implant

❑ Vertebroplasty / Kyphoplasty – Level(s) _____

❑ Pain Pump – What Type?_____ Date Implanted? _____

❑ Spine Surgery – What type? _____ When? _____

❑ Other: _____

❑ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS.

In the past three months have you developed any new:

❑ Balance Problems ❑ Bladder incontinence ❑ Bowel incontinence ❑ Chills
❑ Difficulty Walking ❑ Fevers ❑ Nausea ❑ Vomiting
❑ Numbness/Tingling – Where?_____ ❑ Weakness – Where? _____
❑ I HAVE NOT RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIONS.

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

❑ MRI of the _____ Date: _____ Facility: _____

❑ X-ray of the _____ Date: _____ Facility: _____

❑ CT scan of the _____ Date: _____ Facility: _____

❑ EMG/NCV study of the _____ Date: _____ Facility: _____

❑ Other diagnostic testing: _____

❑ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

Allergies

Do you have any known drug allergies? ❑Yes ❑No

If so, please list all medications you are allergic to.

Medication Name	**Allergic Reaction Type**

Topical Allergies: ❑ Iodine ❑ Latex ❑ Tape Are you allergic to shellfish? ❑ Yes ❑ No

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical
- ❑ Cancer – Type _____
- ❑ Diabetes – Type _____
- ❑ HIV / AIDS
- ❑ Hyperthyroidism
- ❑ Hypothyroidism

Head/Eyes/Ears/Nose/Throat
- ❑ Headaches
- ❑ Migraines
- ❑ Head Injury
- ❑ Glaucoma

Cardiovascular / Hematologic
- ❑ Anemia
- ❑ Atrial Fibrillation
- ❑ Bleeding Disorders
- ❑ Blood Clots
- ❑ Coronary Artery Disease
- ❑ Cong. Heart Failure
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Mitral Valve Prolapse
- ❑ Murmur
- ❑ Pacemaker
- ❑ Phlebitis
- ❑ Poor Circulation
- ❑ Stroke
- ❑ Tachycardia
- ❑ TIA

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema / COPD
- ❑ Pneumonia
- ❑ Tuberculosis

Gastrointestinal
- ❑ Bowel Incontinence
- ❑ Cirrhosis
- ❑ Constipation
- ❑ GERD (Acid Reflux)
- ❑ Gastrointestinal Bleeding
- ❑ Hepatitis A / B / C
- ❑ Hernia
- ❑ Irritable Bowel Syndrome
- ❑ Ulcers

Musculoskeletal
- ❑ Amputation
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Chronic Low Back Pain
- ❑ Chronic Neck Pain
- ❑ Chronic Joint Pain
- ❑ Degenerative Disc Disease
- ❑ Fibromyalgia
- ❑ Joint Injury
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Rheumatoid arthritis
- ❑ Spinal Stenosis
- ❑ Tennis Elbow
- ❑ Vertebral Compression Fracture

Genitourinary/Nephrology
- ❑ Bladder Infection(s)
- ❑ Dialysis
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Urinary Incontinence

Neuropsychological
- ❑ Alcohol Abuse
- ❑ Alzheimer Disease
- ❑ Anxiety
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Prescription Drug Abuse
- ❑ PTSD
- ❑ Multiple Sclerosis
- ❑ Peripheral Neuropathy
- ❑ Schizophrenia
- ❑ Seizures
- ❑ Sleep Disorders

❑ Reflex Sympathetic Dystrophy/CRPS

❑ Other Diagnosed Conditions _____

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery

❑ Gallbladder removal _____

❑ Appendectomy _____

❑ Other _____

Female Surgeries

❑ Cesarean section _____

❑ Hysterectomy _____

❑ Laparoscopy _____

❑ Ovarian _____

❑ Other _____

Heart Surgery

❑ Valve replacement _____

❑ Aneurysm repair _____

❑ Angioplasty _____

❑ Other _____

Joint Surgery

❑ Shoulder _____

❑ Hip replacement _____

❑ Knee replacement _____

Spine / Back Surgery

❑ Discectomy (levels)_____

❑ Laminectomy _____

❑ Spinal fusion (levels) _____

Other Common Surgeries

❑ Hemorrhoid surgery _____

❑ Hernia repair _____

❑ Thyroidectomy _____

❑ Tonsillectomy _____

❑ Vascular stent _____

Please list any other surgeries and dates (attach an additional sheet if necessary)

❑ I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE.

Current Medications

Please indicate which (if any) of the following blood-thinners you are taking:
❑Aggrenox ❑ Coumadin / Warfarin ❑ Effient ❑Lovenox ❑ Plavix ❑ Pletal ❑ Pradaxa ❑ Prasugrel ❑ Ticlid ❑ Other _____

Please list *all* medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Social History

Work Status: ❑ Full Time ❑ Part Time ❑ Retired ❑ Off work since: _____ ❑ Disabled since: _____

❑ Light Duty, restrictions: _____ Restricting Physician: _____

Living Situation: ❑ Alone ❑ With Spouse ❑ With Significant Other ❑ Other: _____

Number of people living in your household: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7+

Are you capable of becoming pregnant? ❑ Yes ❑No *If so*, are you currently pregnant? ❑ Yes ❑No

Highest level of education obtained: ❑ Grammar school ❑ High School ❑ College ❑ Post-graduate

Alcohol Use: ❑ Daily Limited Use ❑ History of Alcoholism ❑ Current Alcoholism
❑ Never Drinks Alcohol ❑ Drinks Alcohol Socially

Tobacco Use: ❑ Current Tobacco User ❑ Former Tobacco User ❑ Has Never Used Tobacco

Illegal Drug Use: ❑ Denies Any Illegal Drug Use ❑ Currently Using Illegal Drugs (Which: _____)
❑ Currently Uses Marijuana ❑ Currently Using Someone Else's Prescription Medications
❑ Formerly Used Illegal Drugs (not currently using) (Which: _____)

Have you ever abused narcotic or prescription medications? ❑ Yes ❑No (Which: _____)
Are there any substance abuse issues in your household? ❑ Yes ❑No

Family History

Mark all appropriate diagnoses as they pertain to your biological *MOTHER AND FATHER* only.

	Mother	Father		Mother	Father
Arthritis	☐	☐	Kidney Problems	☐	☐
Cancer	☐	☐	Liver Problems	☐	☐
Diabetes	☐	☐	Osteoporosis	☐	☐
Heart Disease	☐	☐	Rheumatoid Arthritis	☐	☐
High Blood Pressure	☐	☐	Seizures	☐	☐
High Cholesterol	☐	☐	Stroke	☐	☐

Other medical problems: _____

❑ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY ❑ I AM ADOPTED (No Medical History Available)

Review of Systems

Mark the following symptoms that you currently suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History.*

Constitutional:
❑ Abnormal Bleeding ❑ Chills ❑ Difficulty Sleeping
❑ Easy Bruising ❑ Excessive Sweating ❑ Excessive Thirst ❑ Fatigue
❑ Fevers ❑ Insomnia ❑ Low Sex Drive ❑ Night Sweats
❑ Swollen / Tender Lymph Nodes ❑ Tremors
❑ Unexplained Weight Gain ❑ Unexplained Weight Loss ❑ Weakness

Skin:
❑ Rashes ❑ Sores ❑ Blisters
❑ Changes in Moles ❑ Discoloration

Head / Eyes / Ears / Nose / Throat:
❑ Recent Visual Changes ❑ Dental Problems ❑ Earaches ❑ Hearing Problems
❑ Nosebleeds ❑ Recurrent Sore Throats ❑ Ringing in the Ears ❑ Sinus Problems

Respiratory:
❑ Cough ❑ Wheezing ❑ Pulmonary Embolism
❑ Shortness of Breath on Exertion/Effort ❑ Shortness of Breath at Rest

Cardiovascular:
❑ Bleeding Disorder ❑ Chest Pain ❑ Deep Vein Thrombosis
❑ Fainting ❑ High Blood Pressure ❑ Irregular Heartbeat ❑ Lightheadedness
❑ Shortness of Breath During Sleep ❑ Swelling in the Feet

Gastrointestinal:
❑ Abdominal Cramps ❑ Acid Reflux ❑ Constipation
❑ Coffee Ground Appearance in Vomit ❑ Dark and Tarry Stools ❑ Diarrhea
❑ Hernia ❑ Vomiting

Genitourinary:
❑ Blood in Urine ❑ Decreased Urine Flow/Frequency/Volume
❑ Increased Urination Frequency ❑ Flank Pain ❑ Painful Urination

Musculoskeletal:
❑ Back Pain ❑ Joint Pain ❑ Joint Stiffness
❑ Joint Swelling ❑ Muscle Spasms ❑ Neck Pain

Neurological:
❑ Dizziness ❑ Headaches ❑ Numbness/Tingling
❑ Numbness/Pain in Hand(s) ❑ Instability When Walking ❑ Tremors ❑ Seizures

Psychiatric:
❑ Depressed Mood ❑ Feeling Anxious ❑ Stress Problems
❑ Suicidal Thoughts ❑ Suicidal Planning ❑ Thoughts of Violence

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize Florida Pain and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

Signed:_____ Date: _____

321-784-8211(phone) 321-394-9425 (fax)

Primary Care Doctors Records Release Form

Patient Name: _____

So that we may keep your family physician and/ or referring physician informed of your progress while under our care, please list the name, address, and phone numbers of the physicians.

Primary Care Physician: _____
Address: _____
_____
_____
Phone: _____ Fax: _____

Referring Physician: _____
Address: _____
_____
_____
Phone: _____ Fax: _____

I understand that the information in my record may include sensitive information about behavioral or mental health services, treatment for alcohol and/or drug abuse. It may also contain information related to sexually transmitted disease, Acquired Immuno-Deficiency Syndrome (AIDS), and infection with Human Immunodeficiency Virus (HIV). I understand that any disclosure of this information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.
_____ (patient initials)

_____
Print Name of Signer

Relationship to patient: (check one)
☐ Self ☐ Legal Guardian ☐ Power of attorney

_____ _____
Signature Date

Financial Policy

You are financially responsible for the medical services you receive. Please review our policies below and sign at the end to indicate your agreement to these terms.

Appointments

1. **Copayments.** Copayments for clinic visits are due at the time of service. If you are unable to make your copayment at the time of service, Florida Pain reserves the right to reschedule your appointment until a time that you are able to make your copayment. Payment for any outstanding balance is due at your appointment.
2. **Procedure Prepayment**. Florida Pain collects your payment for a procedure at the time when the procedure is scheduled. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment you may request a refund according to our refund policy, below. We reserve the right to reschedule your procedure until prepayment has been made.
3. **Missed Appointments and Late Arrivals.** If you are more than 10 minutes late, we may reschedule your appointment. If you are more than 60 minutes late, or if you do not show up to your appointment, you will be responsible for a missed appointment fee. Missed office visit appointments are subject to a $25 charge. These charges are your responsibility and will not be billed to any insurance carrier.

Insurance Payments

4. **Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.
5. **Coverage Changes and Timely Submission.** It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which Florida Pain must submit a claim on your behalf to your insurer. If Florida Pain is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.
6. **Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by Florida Pain, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available from our front desks). Self-pay patients are expected to make payment in full at the time of service.

Benefits and Authorization

7. **Insurance Plan Participation.** We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out of network charges may have higher deductibles and copayments.

8. **Referrals.** Referral and prior authorization requirements vary widely among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by Florida Pain, it is your responsibility to be aware of this fact, and to obtain this referral.

9. **Prior Authorization and Non-Covered Services.** Florida Pain may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. Florida Pain, as a courtesy to our patients, makes a good faith effort to determine if services we order are covered by your insurance plan, and, if so, whether or not prior authorization for treatment is required. If determine that a prior authorization is required, we will attempt to obtain such authorization on your behalf.

10. **Out of Network Payments.** If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to Florida Pain, immediately.

ACCOUNT BALANCES AND PAYMENTS

11. **Reassignment of Balances.** If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.

12. **Collection of Unpaid Accounts.** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Florida Pain reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Florida Pain for any expenses we incur to collect on your account, including reasonable attorneys' fees and collection costs.

13. **Returned Checks.** Returned checks will be subject to a $38 returned check fee.

14. **Refunds.** Refunds for overpayment or prepayment on cancelled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow four to six weeks for your request to be processed. Send requests to: Florida Pain, Attn: Billing Department, 595 N Courtenay Pkwy STE 101, Merritt Island FL 32953.

15. **Statements.** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.

Agreement and Assignment of Benefits

I have read and understand the financial policy of The Pain Institute LLC d.b.a. Florida Pain, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to Florida Pain. I understand that I am financially responsible for all services I receive from Florida Pain. This financial policy is binding upon you and your estate, executors and/or administrators, if applicable.

Signed: _____ Date: _____

FLORIDA PAIN INSTITUTE

Richard Gayles, M.D - Stanley Golovac, M.D. - Ashish Udeshi, M.D – George Arcos, D.O.

MEDICATION THERAPY CONTRACT

Office hours for Merritt Island are Monday thru Thursday, 8:30 am to 5:00 pm and Friday 8 am to 12 Noon, Pineda office is Monday thru Thursday 7 am to 5:30 pm. Medications refills will not be filled after hours, on weekends, or on holidays or outside the parameters of state and federal guidelines. It is the patient's responsibility to request medication refills by making a scheduled appointment to be seen and/or examined by the physician during normal business hours. To receive narcotic medications you must be seen in the office every 30 days.

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

I am aware of the possible risks and benefits of other types of treatments that do not involve the use of Opioid/controlled medications. I will tell my physician about all other medicines and treatments that I am receiving.

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

I am aware that certain medicines such as nalbuphine (Nubain), pentazocaine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol), may reverse the action of the medicine I am using for pain control.
Taking any of these medications while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other physicians that I am taking pain medications and cannot take any of the medicines listed above.
I am aware that addiction to my pain medicine is low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has family or personal history of addiction. I agree to tell my physician my complete and honest personal drug history and that of my family to the best of my knowledge.
I understand that physical dependence is a normal, expected result of using these medicines for a long time.
I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and flu-like feeling. I am aware that Opioid withdrawal is uncomfortable but not life threatening.
I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help, and may cause unacceptable side effects. Tolerance or failure to respond well to Opioids may cause my physician to choose another form of treatment.
I understand that failure to comply with the prescribed medication plan may lead to increased urine screenings on a frequent basis and random basis for medications that are prescribed to me. I also understand that if my physician suspects I am abusing medications, diverting use of my medications or have a problem with taking opioid due to addiction, I may be referred to an additictionologist or certified addiction specialist for further counseling. Failure to follow advised therapy or treatment may be cause for discharge from the practice.

MALES ONLY: I am aware that chronic Opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my physician or family physician may check my blood to see if my testosterone level is normal.

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

Summary of Guidelines for prescribed Opiates:

1. The patient must provide copies of reports from previous and concurrent treating physicians.
2. The patient must provide The Pain Institute accurate patient address and phone number and keep us up to date of any changes in their personal information.
3. **THE PAIN INSTITUTE WILL BE THE ONLY PROVIDER TO PRESCRIBE NARCOTIC AND/OR CONTROLLED MEDICATIONS.**
4. The patient must provide us with the name and phone number of the pharmacy that the patient is using and keep us up to date with any changes.
5. The patient must be seen for regular office visits to receive a medication refill. Prescriptions will be written for a 30-day supply.
6. The patient is responsible for all prescriptions/medications given and must understand that if the prescriptions/medications are lost, misplaced or destroyed; the prescriptions/medications **cannot be replaced.**
7. We reserve the right to do a random pill count. It is your responsibility to take the medications as prescribed by your physician, **DO NOT** increase at your own discretion.
8. **NO REFILLS WILL BE MADE AFTER HOURS, ON WEEKENDS OR HOLIDAYS.**
9. Other therapies may be ordered to assist the pain management such as nerve blocks, TENS, physical or occupational therapy, psychological counseling as appropriate to the diagnosis.
10. "Street Drugs" such as marijuana, cocaine, amphetamines, etc. are in themselves dangerous and illegal. Mixed with some of the medicines often used in pain management, the combination could be lethal. Evidence of altering a prescription or obtaining controlled substances from other sources will require notification of law enforcement agencies as needed.
11. We will randomly check the patient's urine for compliance with therapy. The urine will be tested for the presence of the prescribed drugs as well as several other drugs, including illegal drugs.
12. The patient understands that if their urine sample contains illegal substances, we may end the patient-doctor relationship.
13. The patient has the right to refuse such random urine testing. The Pain Institute reserves the right to end the patient-doctor relationship on a patient that refuses to comply with our urine drug testing policy.

The patient authorizes any physician office, hospital, or clinic to provide full details of medical history and treatment to The Pain Institute for the use of continuity of care by completing a medical release form up to date.

Any breach of these guidelines may result in the patient being discharged from the practice of The Pain Institute.

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

_____ _____

Patient signature Date

_____ _____

Patient Name **(PRINT**) Date

_____ _____

Witness printed name and signature Date

I acknowledge this agreement but I am signing that I am declining any medications.

_____ _____

Patient Name (PRINT) **Date**

FLORIDA PAIN INSTITUTE
Richard Gayles, M.D - Stanley Golovac, M.D. - Ashish Udeshi, M.D. - George Arcos, D.O.

Urine Toxicology Screen Policy

This notice is to inform all patients as to why you have been asked to give a urine specimen and information regarding billing of the specimen.

In an effort to provide timely service while reducing energy and cost to our patients, the physicians have assumed the responsibility of providing laboratory services for urine confirmations. The physicians have an ownership interest, but understand if you, the patient request to send your lab work to a secondary facility, we will honor that request.

In an effort to deter Pill Mill activity, in January 2010, the State of Florida changed rules and laws pertaining to all pain management practices or clinics. **Florida Rule: 64B8-9.0131** was passed by the Florida House and all "pain management "practices must be in compliance. This rule states that all patients receiving care must be tested at a minimum of twice yearly to ensure that there are no inconsistencies, and/or medications that you are taking are being metabolized in an effective manner, in order to better treat your pain. Unfortunately, **this testing is to be done whether you are being prescribed no medication or multiple medications**. If there are inconsistencies in your results, it is up to the physician/practitioner to retest randomly as needed.

Florida pain understands that this testing may come as an added expense to you, and we do apologize for any inconvenience this may cause. We will make every effort to keep your expenses down and still maintain our contracts with you insurance carrier, as to keep claims "in network", with your insurance. Therefore, it is important to confirm correct insurance information at every office visit, to ensure that your claim is filed properly. Florida Pain makes every effort to provide accurate insurance information, but sometimes your outgoing information may be incorrect or not updated. By verifying insurance information, you are able to reduce any issues and resolve questions directly with the outside laboratories.

Relationship to patient: (check one)
☐ Self ☐ Legal Guardian ☐ Power of attorney

_____
Print Name of Signer

_____ _____
Signature Date

595 N Courtenay Parkway
Suite 101
Merritt Island, FL 32953

5545 N Wickham Road
Suite 104
Melbourne, FL 32940

6100 NE Minton Road
Suite 103B
Palm Bay, Fl. 32907

FLORIDA PAIN INSTITUTE

Stanley Golovac, M.D. Richard E. Gayles, M.D. Ashish Udeshi, M.D. George Arcos, D.O.
Board Certified Anesthesiology and Pain Management
Phone (321)784-8211 Fax (321)394-9425

Print Patient's Name: _____

I. Acknowledgement of Practice's *HIPAA Privacy Notice*:

By subscribing my name below, I acknowledge that Florida Pain has provided a copy of the HIPAA Privacy Notice, and that I have read (or had the opportunity to read if I so chose) and understand my rights and ask questions regarding my rights and receive answers to my satisfaction, and agree to its terms.

☐ I agree ☐ I Do Not Agree Initials: _____

II. Designation of Caregivers as my Personal Representative:

I give permission for the following person(s) to pick up prescriptions and or any of my personal health information, to include super sensitive information on my behalf. I understand that no prescriptions will be released other than to the person(s) listed below.

***Please Note** – Person(s) listed below will be required to present driver's license or other state/federally issued photo ID when picking up prescriptions, billing information, and/or any personal health information.

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

☐ I agree ☐ I Do Not Agree Initials: _____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home / Cell Telephone Number:

_____
_____OK to leave message with detailed information
_____Leave message with call back numbers only

Written Communication Address:

_____
_____OK to mail to address listed above
_____E-mail me at: _____

Work Telephone Number:

_____
_____OK to leave message with detailed information
_____Leave message with call back numbers only

Fax Communication Number:

_____
_____OK to Fax to the number listed above

_____
Print Name of Signer

Relationship to patient: (check one)
☐ Self ☐ Legal Guardian ☐ Power of attorney

_____
Signature

_____
Date

***** If representative is a court appointed legal guardian, a copy of court documents *****
***** must be provided and kept in medical records. *****

HIPAA PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be released to other healthcare professionals within the organization for the purpose of providing you with quality healthcare.
- Your confidential healthcare information may be released to your insurance provider for the purpose of the organization receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. This provision includes but is not limited to any psychotherapy notes, for marketing purposes and any disclosures that may constitute a sale of your protected healthcare information. Any other uses or disclosures not described in this notice can only be made with your express authorization. You may revoke your permission to release confidential healthcare information at any time.
- You may restrict the disclosure of your protected health information for any services provided whereby you or somebody else pays "out of pocket", in full, for the services.
- You may be contacted by the organization to remind you of any appointments.
- You have the right to opt out of notifications regarding healthcare treatment options, marketing and fundraising, or other health services that might be of interest to you.
- You may be contacted by the organization for the purposes of raising funds to support the organization's operations. It is your express right to opt out of any fund raising communications.
- You have the right to restrict the use of your confidential healthcare information. However, the organization may chose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- The organization is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information.
- The organization will promptly contact you should there be any breach of your protected health information.
- The organization will abide by the terms of this notice. The organization reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information.
- You have the right to complain to the organization if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the organization at:

  Florida Pain
  595 N. Courtenay Pkwy. Suite 101
  Merritt Island, Florida 32953

  - All complaints will be investigated. No personal issue will be raised for filing a complaint with the organization.
- For further information about this Privacy Notice, please contact:

  Claudia by email at claudiab@floridapain.net or by calling (321)784-8211 ext. 1129
- This notice is effective as of 10/16/2013. This date must not be earlier than the date on which the notice is printed or published.