



**PATIENT INFORMATION - DEMOGRAPHICS**

PATIENT INFORMATION						
Today's Date ____/____/____		Name (Last)		First	M.I.	Gender M / F
SSN		Date of Birth ____/____/____	Age ____ years	Marital Status: S / M / W/ Divorced/Separated/Partne red	Height: Ft/In	Weight: Lb
Address City, State, ZIP			Preferred Contact: E-mail / Cell / Home / Work			
Email:		Cell Tel:	Home:	Work:		
Emergency Contact	Name				Relationship to Patient	
	Number					
<b>Race:</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> African American or Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian or White <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> Other Race _____		<b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Other	<b>Smoker:</b> <input type="checkbox"/> Current Every day <input type="checkbox"/> Current Some days <input type="checkbox"/> Former Smoker <input type="checkbox"/> Never Smoked	<b>Preferred Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other		
<b>Work Status:</b> If employed, Employer's Name, required: Job Title:                      Duties:			<input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Retired	<input type="checkbox"/> Worker's Comp <input type="checkbox"/> Disability		
REFERRAL INFORMATION / TREATING PHYSICIAN INFORMATION						
<b>How did you hear about us?</b> friend/family ___ previous patient ___ yellow pages ___ lawyer ___ other						
Primary Care Physician:				Phone		
Who Referred You?				Phone		
Current Treating Physician(s)				Phone		
Are you currently being treated by another Pain Management Doctor: Yes / No, Details:						
PHARMACY INFORMATION						
Pharmacy Name/City				Phone		
<b>**We do not accept MEDICAID and its products as Primary or Secondary Insurance **</b>						
PRIMARY HEALTH INSURANCE INFORMATION (Please Provide this, even if your visit is injury related)						
Insurance Name		Policy Number		Group Number		
Claims Address City, State, ZIP		Phone Number				
Primary Subscriber, if different		Date of Birth		Relation to patient		
SECONDARY HEALTH INSURANCE INFORMATION (Please Provide this, even if your visit is injury related)						
Insurance Name:		Policy Number		Group Number		
Claims Address City, State, ZIP		Phone Number				
Primary Subscriber, if different		Date of Birth		Relation to patient		
Are you involved in any <b>pending litigation</b> , related to any type of <b>injury</b> / treatment by <b>another provider</b> ?			<b>YES / NO</b>	Explain		
AUTO, WORKER'S COMP PATIENTS, SLIP AND FALL						
Circle where you were injured Auto / Work / Slip and Fall/ Others		Date of Injury	Details:			
Represented by Attorney? Attorney's Name and Phone #		Adjuster Name and Phone # Case Manager's Name and Phone #				



I do hereby consent to any medical care which is deemed advisable or necessary by my physician and grant authority to Painalgia Relief Center, to administer and perform all examinations, treatments and diagnostic procedures needed now or in the future. I guarantee payment for all services rendered. All medical benefits including major medical benefits, private insurance and any other health plan, are assigned to Painalgia Relief Center. The signature below confirms all of the information provided herein is true and accurate. Photocopy of this consent is to be considered as valid as the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT INFORMATION – HISTORY & PHYSICAL**

<b>PAIN HISTORY:</b>		
What is your chief complaint?		
<input type="checkbox"/> Neck Pain <input type="checkbox"/> Upper Back Pain <input type="checkbox"/> Lower Back Pain <input type="checkbox"/> <b>Other:</b> _____	<input type="checkbox"/> Right Leg Pain <input type="checkbox"/> Left Leg Pain <input type="checkbox"/> Pain in Both Legs	<input type="checkbox"/> Right Arm Pain <input type="checkbox"/> Left Arm Pain <input type="checkbox"/> Pain in Both Arms
What aggravates the pain?		
<input type="checkbox"/> Walking <input type="checkbox"/> Standing	<input type="checkbox"/> Lying Down <input type="checkbox"/> Activity in general	<input type="checkbox"/> Nothing in particular <input type="checkbox"/> <b>Other:</b> _____
What decreases the pain?		
<input type="checkbox"/> Walking <input type="checkbox"/> Standing	<input type="checkbox"/> Lying Down <input type="checkbox"/> Activity in general	<input type="checkbox"/> Nothing in particular <input type="checkbox"/> <b>Other:</b> _____
What time of day is the pain worst? _____		
Rate your worst pain 1-10 _____		
What time of day is the pain least severe? _____		
Rate your least pain 1-10 _____		

<b>MEDICAL HISTORY / REVIEW OF SYSTEMS: Check ( ✓ ) symptom you currently have or have had in the past year:</b>			
<b>GENERAL</b> <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Cancer, Type _____ <input type="checkbox"/> Chills <input type="checkbox"/> Diabetes, Insulin Dependent <input type="checkbox"/> Diabetes, Non- Insulin <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Headaches <input type="checkbox"/> Hepatitis <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Kidney Disease, Type _____ <input type="checkbox"/> Thyroid Disease, Type _____ <input type="checkbox"/> Ulcers, Type _____ <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss	<b>CARDIOVASCULAR</b> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Attack  <b>GENITO-URINARY</b> <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Loss of Bladder Control (Incontinence) <input type="checkbox"/> Painful Urination	<b>EYE, EAR, NOSE, THROAT</b> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Double Vision <input type="checkbox"/> Earache <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Ringing in Ear <input type="checkbox"/> Visual Loss <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts	<b>GASTROINTESTINAL</b> <input type="checkbox"/> Acid Reflux <input type="checkbox"/> Bowel Changes Type _____ <input type="checkbox"/> Heart Burn <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Stomach Pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Loss of Bowel Control (Incontinence)
<b>PSYCHIATRIC</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Bi-polar <input type="checkbox"/> Depression <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Other _____	<b>RESPIRATORY</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Chest Pain <input type="checkbox"/> Emphysema <input type="checkbox"/> Lung Disease <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing	<b>MUSCULOSKELETAL</b> <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Joint Popping <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Arthritis Type ____	<b>NEUROLOGICAL</b> <input type="checkbox"/> Epilepsy <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Tremors  Are you pregnant Yes / No / Not Sure  No of Children: _____

<b>SURGICAL HISTORY:</b>	
Type of Surgery	Date
Do you have <b>needlephobia</b> ? <span style="float: right;"><b>Yes / No</b></span>	

SOCIAL HISTORY:				
Do you consume any of the following :				
Cigarettes	Yes	No	How much per day/week?	# of years?
Alcohol	Yes	No	How much per day/week?	# of years?
Caffeine	Yes	No	How much per day/week?	# of years?
Illegal Drugs	Yes	No	How much per day/week?	# of years?
Narcotics	Yes	No	How much per day/week?	# of years?

FAMILY HISTORY:				
	Age	Health Condition	If applicable,	
			age at time of death	cause of death
Father				
Mother				
Brother				
Sister				

CURRENT MEDICATIONS:				
Medication Name	Strength	Times a day	Status	Comments
			Current / Discontinued	
			Current / Discontinued	
			Current / Discontinued	
			Current / Discontinued	
			Current / Discontinued	
			Current / Discontinued	
			Current / Discontinued	
			Current / Discontinued	
Are you currently receiving <b>narcotics</b> from any other physicians? Yes / No				
Name of the <b>doctors / medications</b> :				
Have you taken any <b>Pain Medications</b> in the past? <b>Yes / No</b> , If yes, please explain				
Are you currently taking <b>antibiotics</b> ?			<b>Yes / No</b>	
Are you currently taking <b>Blood thinners</b> like <b>Aspirin, Coumadin, or Plavix</b> ?			<b>Yes / No</b>	
ALLERGIES:				
Any Known Allergies in Food:		Yes /No, If Yes, Type of reaction:		
Any Known Allergies in Medications:		Yes /No, If Yes, Circle below		
Iodine, Latex, Cortisones, IV Contrast, Lidocaine, or any other: _____				



**FROM PAINALGIA RELIEF CENTER  
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_ hereby authorize **Painalgie Relief Center, LLC** to release medical, psychiatric, drug and/or alcohol abuse or HIV testing and AIDS information in my medical records to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

For the purpose of medical care.

I understand that the specific reports shall include \_\_\_\_\_

I understand that this consent is revocable upon written notice to **Painalgie Relief Center**, except to the extent that action by **Painalgie Relief Center** has been taken in reliance of this authorization and that this authorization shall remain in force for a reasonable time order to effect the purpose which it is given.

Alcohol abuse information, if present has been disclosed from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibit making any further of it without the specific written consent of the undersigned, or as otherwise permitted by such regulations. HIV testing and/or AIDS related diagnosis is prohibited from further disclosure by State Regulations without consent from the patient.

\_\_\_\_\_  
Date                      Patient Name                      Patient Signature in full

\_\_\_\_\_  
Date of Birth                      Parent, Legal Guardian or Authorized Representative

\_\_\_\_\_  
Social Security Number                      Witness

**\*\*\*Patient may delete any of the categories above by marking through**

Office Use Only

\_\_\_\_\_  
Specific records Released

\_\_\_\_\_  
Date of Release                      Released by



**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION  
TO PAINALGIA RELIEF CENTER**

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_  
to release medical, diagnostic, psychiatric, drug and/or alcohol abuse or HIV testing and AIDS  
information in my medical records, for the purpose of medical care to:

**Painalgia Relief Center**

- 4700 Millennia Blvd Ste 175 Orlando FL 32839  
Tel: 407-708-3540, Fax: 407-386-3212

I understand that this consent is revocable upon written notice to \_\_\_\_\_, except  
to the extent that action by \_\_\_\_\_ has been taken in reliance of this  
authorization and that this authorization shall remain in force for a reasonable time order to  
effect the purpose which it is given.

Alcohol abuse information, if present has been disclosed from records whose confidentiality is  
protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibit making any further of it  
without the specific written consent of the undersigned, or as otherwise permitted by such  
regulations. HIV testing and/or AIDS related diagnosis is prohibited from further disclosure by  
State Regulations without consent from the patient.

\_\_\_\_\_  
Date Patient Name Patient Signature in full  
\_\_\_\_\_  
Date of Birth Parent, Legal Guardian or Authorized Representative  
\_\_\_\_\_  
Social Security Number Witness

**\*\*\*Patient may delete any of the categories above by marking through**

Office Use Only

\_\_\_\_\_  
Specific records Released

\_\_\_\_\_  
Date of Release Released by



## CONSENT FOR TREATMENT

I do hereby consent to treatment of my condition by the staff of the Painalgie Relief Center. I also certify that no guarantees or assurances have been made to me as to the results that may be obtained as a result of procedures, treatment and/or techniques used by the Painalgie Relief Center. I further understand that while I am being assessed and/or treated at Painalgie Relief Center will not be held responsible for any injury sustained outside of its immediate physical premises.

\_\_\_\_\_ Date: \_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_ Date: \_\_\_\_\_  
**Alternate Signature** (if patient cannot sign)

## ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits to which I am entitled, including major medical benefits, private insurance and any other health plan, are assigned to Painalgia Relief Center. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment checks(s) directly to Painalgia Relief Center for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I fully understand that I am ultimately responsible for any amount not covered or denied by my insurance.

I, the undersigned Patient, have and do assign all rights and benefits of insurance of any and all applicable personal injury protection, medical payments and/or insurance to the Painalgia Relief Center for services and/or supplies to the undersigned Patient and covered by Personal Injury Protection (P.I.P) Coverage, Worker's Compensation or other insurance coverage under my policy, in accordance with Florida State Statute §627.736. I have read the information herein and it is true to the best of my knowledge and belief

This Assignment includes, but is not limited to, all rights to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company obligated to provide benefits, including legal suit. If for any reason the insurance company fails to make payments of benefits to which I am due. Specifically, this assignment includes the right to collect payment for the reasonable costs incurred in accordance with Florida State Statute §627.736.

**Effective date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

My signature below certifies that I have read (or the form has been read to me) and I understand the contents on this form and confirms all of the information provided herein is true and accurate.

Photocopy of this consent is to be considered as valid as the original.

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Date

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Patient Name

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Patient Signature in full

**Responsible party (if not the patient), Name/Signature:**

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## FINANCIAL POLICY

This is an agreement between Painalgia Relief Center, LLC as creditor, and the Patient/Debtor named on this form.

By executing this agreement, you are agreeing to pay for all services that are received. Payment is expected at the time services are rendered. We accept cash, personal check, money orders cashier's check, Visa and Master Card. We collect copay, coinsurance and any deductible at the time services are rendered.

### Insurance:

Insurance is a contract between you and your insurance company. We will file insurance claims **only** for plans with whom we have a contract with. We are or will be participating in some managed care plans. In order to file your claims, we require a legible copy of the front & back of the insurance card, photo ID, social security number and verification of benefits by your insurance company prior to visits. It is the responsibility of the insured/patient to supply current and accurate information for claims submissions. All copay, coinsurance and deductibles are due at the time services are rendered.

If you are covered by a plan that we are not participating providers for, payment is expected when services are rendered. We will provide you with an itemized receipt for you to file your insurance. Your insurance company will be responsible for reimbursing you for any coverage you may have.

**Collection fee:** A fee totaling 30% of the balance due will be added to your account if we have to send your account to a collection agency. You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account to any credit reporting agency such as a credit bureau.

**Waiver of confidentiality:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

**Returned checks:** There is a fee currently of \$25.00 for any checks returned by the bank. Payment made on a returned check must be made in cash or by a money order.

**Copying of records:** You will need to request in writing, and pay a reasonable copying fee (\$1/page for the first 25 pages and 25 cents for every page thereafter) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

**Effective date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

My signature below certifies that I have read (or the form has been read to me) and I understand the contents on this form.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Responsible party (if not the patient), Name/Signature:** \_\_\_\_\_

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

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Please print your name here

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Signature

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Date

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FOR OFFICE USE ONLY We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- The patient refused to sign
  - Due to an emergency situation it was not possible to obtain an acknowledgment
  - We were not able to communicate with the patient. (Please provide specific details)
  - Other (Please provide specific details)
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- 

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Employee's signature

Date

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices This form does not constitute legal advice and covers only federal, not state law.