



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					
Race: <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 _____		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Other		Smoker: <input type="checkbox"/> Current Every day <input type="checkbox"/> Current Some days <input type="checkbox"/> Former Smoker <input type="checkbox"/> Never Smoked		Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other
Work Status: 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						
How did you hear about us? 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		
**We do not accept MEDICAID and its products as Primary or Secondary Insurance **						
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 pending litigation , related to any type of injury / treatment by another provider?			YES / NO	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 Painalgie 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 Painalgie 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

PAIN HISTORY:		
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"/> Other: _____	<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"/> Other: _____
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"/> Other: _____
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 _____		

MEDICAL HISTORY / REVIEW OF SYSTEMS: Check (✓) symptom you currently have or have had in the past year:			
GENERAL <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	CARDIOVASCULAR <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	EYE, EAR, NOSE, THROAT <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	GASTROINTESTINAL <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)
PSYCHIATRIC <input type="checkbox"/> Anxiety <input type="checkbox"/> Bi-polar <input type="checkbox"/> Depression <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Other _____	GENITO-URINARY <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Loss of Bladder Control (Incontinence) <input type="checkbox"/> Painful Urination	MUSCULOSKELETAL <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Joint Popping <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Arthritis Type ____	NEUROLOGICAL <input type="checkbox"/> Epilepsy <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Tremors
RESPIRATORY <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	SKIN <input type="checkbox"/> Dermatological Conditions <input type="checkbox"/> Itching <input type="checkbox"/> Rashes <input type="checkbox"/> Scars	Are you pregnant Yes / No / Not Sure No of Children: _____	

SURGICAL HISTORY:	
Type of Surgery	Date
Do you have needlephobia ? Yes / No	

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?

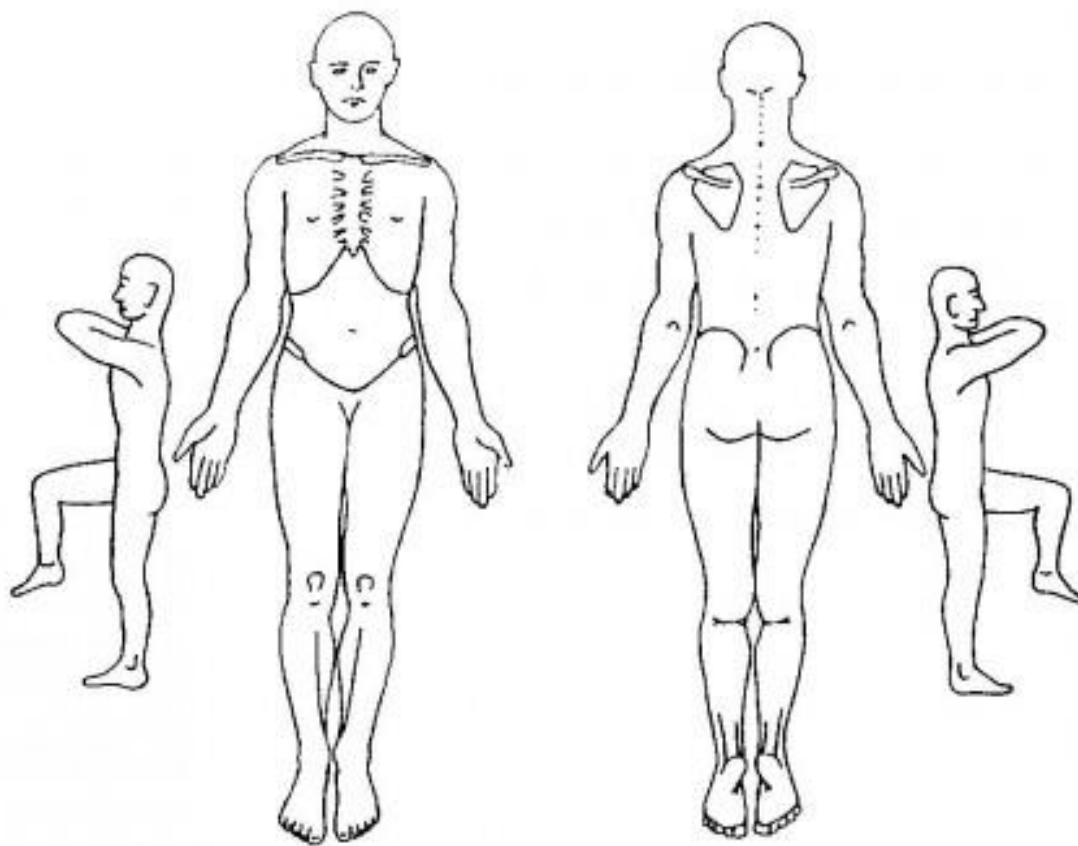
FAMILY HISTORY:				
	Age	Health Condition	If applicable,	
			age at time of death	cause of death
Father				
Mother				
Brother				
Sister				

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 narcotics from any other physicians? Yes / No				
Name of the doctors / medications :				
Have you taken any Pain Medications in the past? Yes / No , If yes, please explain				
Are you currently taking antibiotics ?			Yes / No	
Are you currently taking Blood thinners like Aspirin, Coumadin, or Plavix ?			Yes / No	
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: _____				

CURRENT / PREVIOUS TREATMENT:				
<input type="checkbox"/> Yes (please complete below)		<input type="checkbox"/> No Current Treatment		
Type	Being Treated	For How Long?	Helped?	If not treated, would you need information from your Doctor?
Back Brace	Yes / No		Yes / No	Yes / No
Knee/Wrist or Other Brace	Yes / No		Yes / No	Yes / No
Joint Injections (Shoulder/Knee/Ankle)	Yes / No		Yes / No	Yes / No
Nerve Blocks	Yes / No		Yes / No	Yes / No
Spinal Injections	Yes / No		Yes / No	Yes / No
Trigger Point Injections	Yes / No		Yes / No	Yes / No
Acupuncture	Yes / No		Yes / No	Yes / No
Iontophoresis Patch	Yes / No		Yes / No	Yes / No
				Comments
Active Exercise	Yes / No		Yes / No	
Biofeedback	Yes / No		Yes / No	
Chiropractor	Yes / No		Yes / No	
Ice / Heat	Yes/No		Yes/No	
Massage Therapy	Yes/No		Yes/No	
Physical Therapy	Yes / No		Yes / No	
Occupational Therapy	Yes / No		Yes / No	
Holistic or Alternative Treatments	Yes / No		Yes / No	
Hypnosis	Yes / No		Yes / No	
Osteopathic	Yes / No		Yes / No	
Traction	Yes / No		Yes / No	
TENS / Electrical Simulation	Yes / No		Yes / No	
Counseling	Yes / No		Yes / No	

INVESTIGATIONS:				
Test	Done	If yes Name of Facility	Date	Body Part(s) / Results
X-ray	Yes / No			
CTscan	Yes / No			
MRI	Yes / No			
Other Tests	Yes / No			
NCV / EMG	Yes			
	No	If no, do you have radiating pain, Tingling, Numbness, Muscle weakness in legs/arms/joints Yes / No		

Demographics and H & P Forms Scanned by:	
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PAIN MANAGEMENT AGREEMENT

Patient Name: _____

I understand, accept, and agree to the following terms and conditions in order to receive care for the treatment of pain at **PAINALGIA RELIEF CENTER LLC** (place your initials next to each statement):

_____ I understand that my provider and I will work together to find the most appropriate treatment for my chronic pain. I understand the goals of treatment are not to eliminate pain, but to partially relieve my pain in order to improve my ability to function. **Chronic opioid therapy is only one part of my overall pain management plan.**

_____ I understand that my provider and I will continually evaluate the effect of opioids on achieving the treatment goals and make changes as needed. **I agree to take the medication at the dose and frequency prescribed by my provider.** I agree not to increase the dose of opioids on my own and understand that doing so may lead to the treatment with opioids being stopped.

_____ I understand that the common adverse effects of opioid therapy include constipation, nausea, sweating, itchiness of the skin, confusion or other changes in mental state or thinking ability, and problems with coordination or balance. Drowsiness may occur when starting opioid therapy or when increasing the dosage. **I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.**

_____ **I will not seek opioid medications from another physician for the treatment of my pain.** Regular follow-up care is required and only my provider will prescribe these medications for my chronic pain for me at scheduled appointments.

_____ I will attend all appointments, treatments and consultations as requested by my providers. **I will attend all appointments and follow pain management recommendations.**

_____ **I will not give or sell my medication to anyone else**, including family members, nor will I accept any opioid medication from anyone else. I agree to be responsible for the secure storage of my medication at all times. **If my medications are stolen, I will report this to police and my provider and will produce a police report of this event if requested to do so.**

_____ **I understand that if my prescription runs out early for any reason** (for example, if I lose the medication or I take more than prescribed), **my provider may not prescribe extra medication for me.** I may have to wait until the next prescription is due and that my provider will not be available to prescribe medication during evenings and weekends. **I understand that my provider will not provide me with refills by phone or at night or on weekends, and that it is my responsibility to call my doctor at least five business days in advance of running out of medications.**

_____ **I understand that using or attempting to use a forged or falsified prescription will result in the immediate discharge from the practice, and notification of the appropriate law enforcement agencies**

_____ I understand that the use of other medications can cause adverse effects or interfere with opioid therapy. Therefore, **I agree to notify my provider of the use of all substances, including marijuana, alcohol, medications not prescribed for me (tranquilizers), and all illicit drugs.**



PRESCRIPTION PROGRAM AT PAINALGIA RELIEF CENTER

Painalgia Relief Center offers Electronic Prescription Prescribing (EPP). EPP allows us to send your medication refills electronically to your Pharmacy. This means no more waiting for your prescriptions to be filled.

Please fill in the blanks below with your Pharmacy information and return the form to our front office.

Pharmacy Name: _____

Pharmacy Location: _____

Pharmacy Phone Number: _____

Patient Name: _____
(Please print)

Patient Signature: _____ Date: _____

OFFICE USE ONLY

Pharmacy Name: _____

Phone Number: _____

Address: _____

Crossroads: _____



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

I, _____ hereby authorize **Painalgia 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 **Painalgia Relief Center**, except to the extent that action by **Painalgia 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 Painalgia 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 Painalgia Relief Center. I further understand that while I am being assessed and/or treated at Painalgia 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)

CONSENT TO OBTAIN MEDICATION HISTORY

Painalgie Relief Center has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your medication history. A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. You benefit from this information sharing by enabling us to reconcile your medications more easily thereby preventing any undesired drug interactions. To provide this service, Painalgie Relief Center securely connects to a patient's medication history data stored in the databases of community pharmacies and pharmacy benefit managers. Painalgie Relief Center then presents that data to prescribers through software from a certified vendor. The prescriber is required to obtain all necessary patient consents prior to electronically accessing a patient's medication history. Please rest assured that we will treat this shared information, like all other Protected Health Information, with the utmost due care, as HIPAA requires. Please carefully read the information carefully before making your decision.

I GIVE CONSENT to access my electronic medication history in connection with providing me any health care services, including emergency care.

I DENY CONSENT to access my electronic medication history for any purpose, even in a medical emergency.

Print Name of Patient

Signature of Patient or Patient's Legal Representative

Date

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.

Date

Patient Name

Patient Signature in full

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



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.

Date Patient Name Patient Signature in full

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.

Please print your name here

Signature

Date

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)
-
-

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.



PATIENT CANCELLATION/NO-SHOW POLICY ACKNOWLEDGEMENT

I understand that Painalgia Relief Center has a cancellation/no-show policy, and that I will be charged for any appointment I cancel or miss with less than 24 hours notice. Cancellations are reserved for emergencies only, and require a minimum of a 24 hour notice. All cancellations are to be rescheduled to ensure continuity of care. Any arrival 15 minutes or more after the scheduled start time of your appointment will be considered a cancellation/no-show.

I understand that the Painalgia Relief Center does not overbook patients, my appointment time is set aside specifically for me. Thus the Painalgia Relief Center reserves the right to charge a fee of \$50.00 for each scheduled appointment that is cancelled with less than 24 hours notice, as well as for no-shows. I also understand that I may be discharged from the care of Painalgia Relief Center if I cancel with less than 24 hours notice, or no-show, more than 3 times within any 6 month period.

I also understand that I will not be seen until any outstanding cancellation/no-show fees have been paid in full and that any self-pay fees are non-refundable.

By signing below, I understand and agree to the above policy.

Patient Name (Print): _____

Patient Signature: _____

Provider Signature: _____

Date: _____