PAINALGIA RELIEF CENTER
FIGHT YOUR PAIN

PATIENT INFORMATION - DEMOGRAPHICS

PATIENT INFORMATION						
Today's Date ____/_____/_____	Name (Last)		First		M.I.	Gender M○ F○
SSN	Date of Birth __/___/_____ MM/DD/YYYY	Age ___years	Marital Status: S○ M○ W○ Divorced○ Separated○ Partnered○		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: ☐ American Indian or Alaska Native ☐ African American or Black ☐ Asian ☐ Caucasian or White ☐ Native Hawaiian / Other Pacific Islander ☐ Other Race _____		**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic ☐ Other	**Smoker:** ☐ Current Every day ☐ Current Some days ☐ Former Smoker ☐ Never Smoked		**Preferred Language:** ☐ English ☐ Spanish ☐ Other	
Work Status: If employed, Employer's Name, required: Job Title: Duties:			☐ Unemployed ☐ Student ☐ Retired		☐ Worker's Comp ☐ Disability	

REFERRAL INFORMATION / TREATING PHYSICIAN INFORMATION	
How did you hear about us? friend/family ☐ previous patient ☐ yellow pages ☐ lawyer ☐ other	
Primary **C**are **P**hysician:	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		
Indicate 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: _____

PAINALGIA RELIEF CENTER
FIGHT YOUR PAIN

PATIENT INFORMATION – HISTORY & PHYSICAL

PAIN HISTORY:

What is your chief complaint?

- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Lower Back Pain
- ☐ **Other**:_____
- ☐ Right Leg Pain
- ☐ Left Leg Pain
- ☐ Pain in Both Legs
- ☐ Right Arm Pain
- ☐ Left Arm Pain
- ☐ Pain in Both Arms

What aggravates the pain?

- ☐ Walking
- ☐ Standing
- ☐ Lying Down
- ☐ Activity in general
- ☐ Nothing in particular
- ☐ **Other**: _____

What decreases the pain?

- ☐ Walking
- ☐ Standing
- ☐ Lying Down
- ☐ Activity in general
- ☐ Nothing in particular
- ☐ **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

- ☐ AIDS/HIV
- ☐ Cancer, Type_____
- ☐ Chills
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non- Insulin
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Headaches
- ☐ Hepatitis
- ☐ Loss of Sleep
- ☐ Kidney Disease, Type_____
- ☐ Thyroid Disease, Type____
- ☐ Ulcers, Type_____
- ☐ Weight Gain
- ☐ Weight Loss

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Heart Murmur
- ☐ Heart Attack

EYE, EAR, NOSE, THROAT

- ☐ Blurred Vision
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Ringing in Ear
- ☐ Visual Loss
- ☐ Glaucoma
- ☐ Cataracts

GASTROINTESTINAL

- ☐ Acid Reflux
- ☐ Bowel Changes Type_____
- ☐ Heart Burn
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Loss of Bowel Control (Incontinence)

GENITO-URINARY

- ☐ Frequent Urination
- ☐ Loss of Bladder Control (Incontinence)
- ☐ Painful Urination

MUSCULOSKELETAL

- ☐ Joint Swelling
- ☐ Joint Popping
- ☐ Joint Stiffness
- ☐ Arthritis Type ___

NEUROLOGICAL

- ☐ Epilepsy
- ☐ Nervousness
- ☐ Numbness
- ☐ Seizures
- ☐ Stroke
- ☐ Tremors

PSYCHIATRIC

- ☐ Anxiety
- ☐ Bi-polar
- ☐ Depression
- ☐ Suicide Attempt
- ☐ Other_____

RESPIRATORY

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chest Pain
- ☐ Emphysema
- ☐ Lung Disease
- ☐ Shortness of Breath
- ☐ Wheezing

SKIN

- ☐ Dermatological Conditions
- ☐ Itching
- ☐ Rashes
- ☐ 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?

FAMILYHISTORY:				
	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:

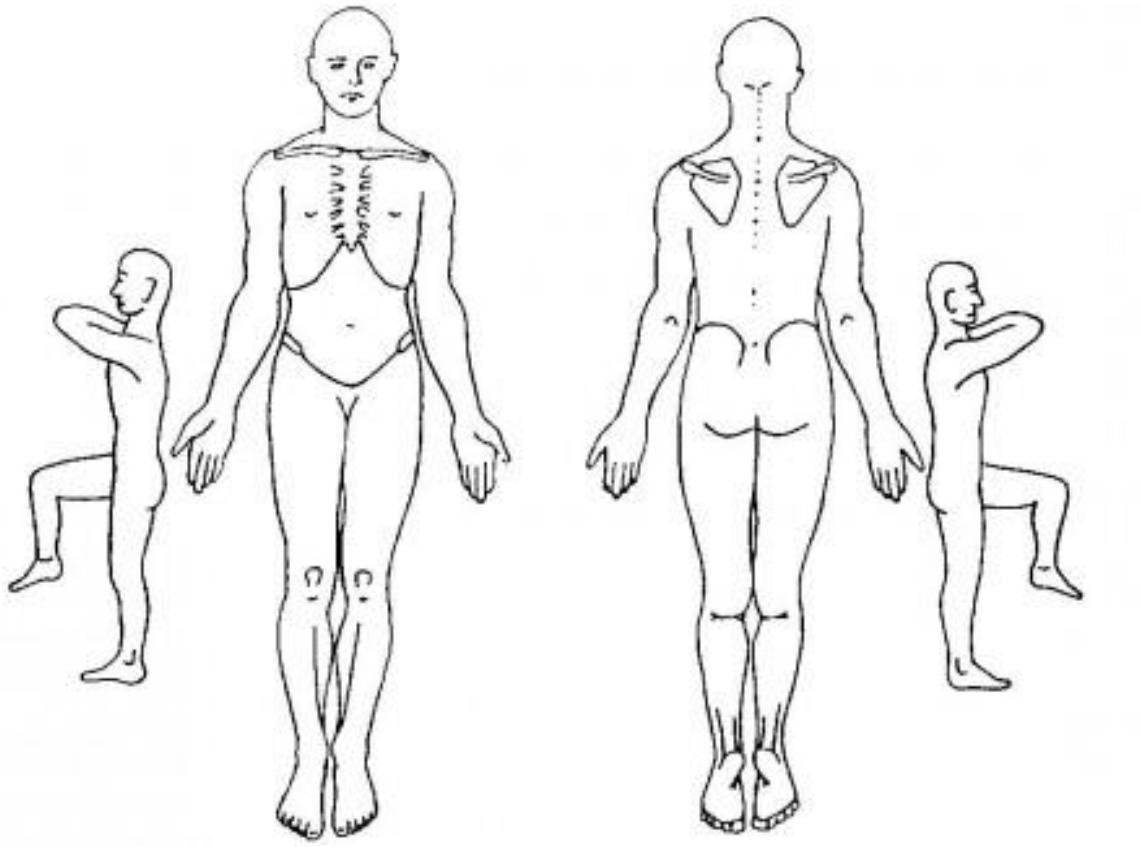
Any Known Allergies in Medications: Yes◯ No◯ , If Yes, Indicate below

Iodine☐ , Latex☐ , Cortisones☐ , IV Contrast☐ , Lidocaine☐ , or any other☐ :

CURRENT / PREVIOUS TREATMENT:				
☐ Yes (please complete below)		☐ 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○			
OtherTests	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:	



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.**

_____ I agree to periodic unscheduled drug screens.

_____ I understand that I may become physically dependent on opioid medications, which in certain patients may lead to addiction. **I agree that if necessary, I will permit referral to addiction specialists as a condition of my treatment plan.**

_____ **I understand that my failure to meet any of the requirements of this agreement may result in my provider choosing to stop writing prescriptions for me.** In this case, my doctor may choose to taper my medications over a period of several days, as necessary, to avoid withdrawal symptoms. If this is not deemed to be viable option, I understand that I may be discharged and may be provided with a 30 day supply of medication for use while I find a new physician to provide me with medical care. I understand that withdrawal from medications will be coordinated by my provider and may require specialist referrals.

_____ I hereby agree that my provider has the authority to discuss my pain management with other health care professionals and my family members when it is deemed medically necessary in the provider's judgment.

_____ **My providers may obtain information from State controlled substances databases and other prescription monitoring programs.** I authorize my providers and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my provider to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ To the best of my knowledge, I am not pregnant at this time and I agree to notify my pain management provider as soon as I am aware that I am or may be pregnant. I understand that opioids are considered dangerous to a fetus. I will do everything possible to avoid getting pregnant while taking these medications unless otherwise approved by my provider.

_____-- _____

Patient Signature Date

_____ _____

Physician Signature Date

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

☐ 1405 S Orange Ave Ste 306 Orlando FL 32806
☐ Tel: 407-531-8069, Fax: 407-386-3212
☐ Email: contact@painalgia.com

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

Painalgia 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, Painalgia Relief Center securely connects to a patient's medication history data stored in the databases of community pharmacies and pharmacy benefit managers. Painalgia 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: _____