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☐ :

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)

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.