Referring Provider

_____
(Doctor or Patient)

_____
(Phone number)

Pain & Spine Centers of Florida

Leesburg | The Villages

NEW PATIENT REGISTRATION

*= REQUIRED

***Patient's Name**: _____ **Suffix**: _____
First Ml Last

***Gender:** ☐ Male ☐Female; ☐ Transgender **SS#** _____ ***Date of Birth**: _____

***Marital Status:** ☐ S ☐ M ☐ W ☐ D ☐ Separated ***Preferred Language**: _____

***Race:** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐Hispanic ☐ Native Hawaiian

☐ Other Pacific Islander ☐ Other: _____ ☐ White ☐ Refused to report

***Ethnic Group:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Refused to report

***Physical Address**: _____ **City/State/Zip:** _____
(NO PO BOXES)

☐ Mailing Address same as Physical Address ***E-mail Address**: _____

Mailing Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Cell Phone**: _____

***Primary Care Physician:** _____ **Office Phone**: _____

***Primary Pharmacy**: _____ Crossroads: _____
(PHARMACY NAME AND PHONE NUMBER)

***Are you employed?** ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Disabled ☐ Not Working ☐ Housewife

***Employer:** _____ **Employer Phone**: _____ ***Occupation**: _____

As a result of pain, are there any compensation benefits being received or legal issues pending?
☐ Worker's compensation ☐ Social Security disability ☐ Private disability policy benefits ☐ Personal injury suit

WORKERS COMPENSATION INFORMATION

Insurance Co. Name: _____ **Phone:** _____ **DOI**: _____ **Claim #**: _____

Patient Guarantor: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Guarantor Name: _____ **Suffix**: _____
First Ml Last

Gender: ☐ Male ☐Female **SS#** _____ **Date of Birth**: _____

Mailing Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Cell Phone**: _____ **E-mail Address**: _____

Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Disabled ☐ Not Working ☐ Housewife

Employer: _____ **Employer Phone**: _____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD & PHOTO ID FOR COPYING):

Primary Insurance: _____ **Address**: _____ **Phone Number:** _____
Policy #: _____ **Grp #:** _____ **Relation to policy holder**: _____
Policy holder: _____ **DOB:** _____ **Phone**: _____
Secondary Insurance: _____ **Address**: _____ **Phone Number:** _____
Policy #: _____ **Grp #:** _____ **Relation to policy holder**: _____
Policy holder: _____ **DOB:** _____ **Phone**: _____

EMERGENCY CONTACT *(NOT* LIVING WITH YOU)

Name: _____

Relationship: _____ **Phone Number:** _____

☐ I hereby authorize the payment of medical benefits to Pain and Spine Centers of Florida for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.

☐ I further agree to pay all collections costs, attorney fees, and other collection costs that may be incurred to enforce the collection of any amounts outstanding.

☐ I hereby authorize Pain and Spine Centers of Florida to release any medical information necessary to complete and process my insurance claims.

☐ I authorize Pain and Spine Centers of Florida to treat me and use my personal information for healthcare operations.

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____ **DATE:** _____

Pain & Spine Centers of Florida

Leesburg | The Villages

NEW PATIENT REGISTRATION

*= REQUIRED

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize Pain and Spine Centers of Florida to obtain the health information of the individual named below:

Patient Name:_____ **DOB:** _____**SS#**:_____
Address: _____ **Phone:** _____

I authorize the information to be disclosed to and used by the following individual or organization:

Pain and Spine Centers of Florida
8136 Centralia Court, Suite 103
Leesburg, FL 34788
Phone: (352) 343-7246 Fax#: (352) 343-7159

For the purpose of: Continuity of care with medical evaluation and treatment

The type and amount of information to be disclosed is as follows: {specify date where appropriate)

☐ Copy of Complete Medical ☐ X-ray Films
☐ X-ray/CT Scan/ MRI Reports ☐ MRI/CT Scan Films
☐ Laboratory Reports ☐ Psychological or Psychiatric Conditions

RECORDS TO BE RELEASED FROM: (list doctor or facility to request from)

_____
_____
_____
_____

PHONE: _____ **FAX**: _____

PURPOSE OF DISCLOSURE: *We may use and disclose your medical records only for each of the following purposes: (]) Treatment, (2) Payment, and (3) Health care operations.*
We may also create and distribute de-identified health information by removing all references to individually identifiable information.

REVOCATION RIGHTS: *I certify that 1hi1, request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that J may revoke this authorization m any time by sending a written Notice of revocation to Releaser. I understand that the revocation will become effective upon receipt by Releaser. Any health information disclosed by Releaser pursuant to this Authorization, before the effective date of the revocations is not subject to revocation.*

Patient's Signature: _____ Date: _____

BILLING POLICY

The following sets forth the general billing policy of Pain & Spine Centers of Florida. Please review this information and sign where indicated.

- I understand that it is my responsibility to provide to Pain & Spine Centers of Florida the accurate billing information at the time of check- in and to notify this office of any changes to this information.

- I understand that it is my responsibility to know any specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services bring rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they a.re required to report lo the carrier any enrollees failing to pay the co-pay.

- I understand that if I present an insufficient funds check (NSF check) for payment on my account that l will be charged a $25 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check or credit card.

- I understand that the office will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any elective procedure that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective procedure. I further understand that THE FEE I AM QUOTED JS AN ESTIMATE based on: I) anticipated procedure to be performed and 2) current information provided to clinic by my insurance carrier.

- I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/deductibles) and J have a financial responsibility to pay these amounts. I understand that I will be provided with three (3) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if l do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest, or legal expenses associated with the collection efforts.

- I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. J further understand that prior authorization is not guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

- I understand that the clinic may also take a verbal request to use my listed credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent, or to cover an NSF check.

Notice for cancellation of office visits and procedures, must be given 24 hours in advance

My signature below confirms that I have read these billing policies and my financial obligation as pertaining to this office.

Legal Signature: _____

Printed Name: _____

Date: _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION .PLEASE REVIEW IT CAREFULLY.

My office is required by federal regulation, known as the HIPPA Privacy Rule; to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. My office will not disclose your health information except as described in this Notice.

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. The health information about you is documented in a medical record and on a computer. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment, and applying for future care of treatment. It also includes billing documents for those services.

OUR COMMITMENT TO YOUR PRIVACY:
My office is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realized that these laws are complicated, but we must provide you with the information.

WHO HAS ACCESS TO THIS INFORMATION?
Any person or persons who designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for my services has access to your Protected Health Information.

Entities such as Governmental Oversight agencies, Judicial and Administrative Proceeding, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by Law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:
We release your information on to those who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities that need this information for claims processing have access to your Protected Health Information.

YOUR RIGHTS:
You have the right to inspect your Protected Health Information. You also have the right to amend any errors you may find in your records.

DISCLOSURE AND CONSENT:
I have been given the opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risk of non-treatment, the procedures used, and the risks and hazards involved, and 1believe that I have sufficient information to give this informed consent.

Please name all person(s) we can contact and/or discuss your medical information:

Name: _____ **Relationship**: _____ **Phone:** _____

Name: _____ **Relationship**: _____ **Phone:** _____

Name: _____ **Relationship**: _____ **Phone:** _____

I hereby understand and accept the above criteria:

Legal Signature: _____

Printed Name: _____

Date: _____

OPIOID AND CONTROLLED SUBSTANCES CONTRACT

☐ I understand that the treatment I receive from Pain & Spine Centers of Florida includes opioid and/or other sedative medications. I understand and agree to the following while receiving these drugs:

☐ I understand that the goals of prescribing these medications are to increase my activities at borne and/or work and decrease pain symptoms and behavior within the time specified in my treatment plan.

☐ I understand that opioid medications are not the only part of my treatment plan, but agree lo follow other parts of my treatment program including physical therapy, behavioral pain management, injections etc; as necessary.

☐ I will not attempt to obtain any opioid or sedative medications from any source other than this clinic. If I require emergency treatments requiring controlled substance use, I will notify Pain & Spine Centers of Florida, the next working day.

☐ I understand that I must schedule monthly appointments for medication renewals. Renewals are contingent on keeping scheduled appointments. No opioid medications will be refilled over the phone.

☐ I understand that am only to take the medications as prescribed and, all medication changes have to be discussed during office visits, not via phone.

☐ I understand that lost or stolen medications and/or prescriptions will not be replaced. I am responsible for my own medications and it is my responsibility to verify that prescriptions are filled correctly and that the medication supply will last until my next scheduled appointment.

☐ I understand in the event of medication changes we do not accept any unused medications.

☐ I agree to use a single pharmacy for dispensing controlled substances, and provide Pain & Spine Centers of Florida with the name and phone number of that pharmacy. I will inform this office of, any changes to my overall pharmacy/health condition.

☐ I agree to random urine drug screens to monitor drug usage, and monthly pill counts during follow-up office visits.

☐ I understand that failure to follow these guidelines may require discontinuation of opioid therapy, referral to a substance abuse specialist, and termination of provider-patient relationship.

☐ I UNDERSTAND THAT THE USE OF ANY RECREATIONAL DRUG USE IS A SEVERE VIOLATION OF THE OPIOID AGREEMENT AND WILL STOP ANY FURTHER OPIOID TREATMENT.

CAUTION: OPIOID MEDICATIONS MAY CAUSE DROWSINESS . ALCOHOL SHOULD BE AVOIDED WHILE TAKING THESE MEDICATIONS. USE CARE WHEN OPERATING A CAR OR MACHINERY. FEDERAL LAW PROHIBITS ALTERATIONS OF PRESCRIPTIONS OR DIVERSION OF THESE DRUGS TO ANY OTHER PERSON!!!!

My signature below confirms that I understand and agree to all of the above requirements to obtain opioid and/or sedative medications from Pain and Spine Centers of Florida.

Patient Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

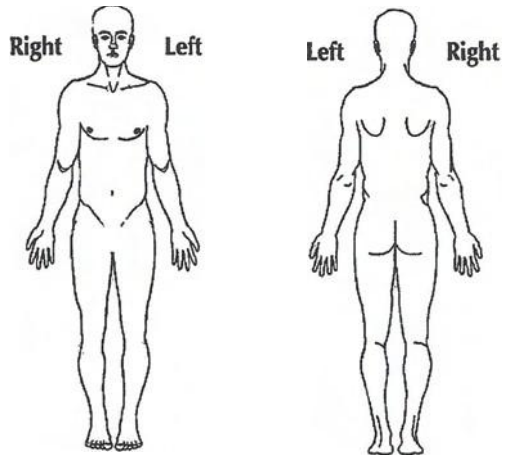
When did the pain begin? _____ **How long have you had this pain**? _____

What/where is your pain?
_____
_____

Does it radiate anywhere else?
☐ NO ☐ YES- Where to: _____
_____
_____

How did the pain begin?
☐ gradual onset
☐ sudden onset
☐ after accident at work
☐ after accident at home
☐ after other accident/injury
☐ after surgery
☐ after an illness

Please shade below the areas where you have pain



How often do you have pain?
☐ Rarely
☐ Frequently
☐ Sometimes
☐ Often

How long do pain episodes last?
☐ seconds
☐ minutes
☐ 1-4 hours
☐ more than 4 hours

Please rate your pain:→→→

|-----|-----|-----|-----|-----|-----|-----|-----|-----|----|
0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse?

☐ sitting	☐ standing	☐ lifting
☐ coughing	☐ bending	☐ turning
☐ sneezing	☐ walking	☐ lying down
☐ stretching	☐ exercise	☐ immobilization

Have you experienced any of the following?

☐ weakness	☐ numbness	☐ swelling
☐ fever/warmth	☐ tingling	☐ AM joint stiffness
☐ sweating	☐ cold	☐ visual changes

What makes your pain better?

☐ sitting	☐ standing	☐ immobilization
☐ walking	☐ lying down	☐ brace
☐ heat	☐ cold	☐ stretching
☐ exercise	☐ medication	
☐ other:_____		

What does the pain feel like?

☐ Intermittent	☐ cramping	☐ splitting
☐ Constant	☐ burning	☐ tiring
☐ Throbbing	☐ aching	☐ exhausting
☐ Shooting	☐ numb	☐ sickening
☐ Sharp	☐ heavy	☐ fearful
☐ Tingling	☐ tender	☐ punishing/cruel

What treatments have you tried?

☐ physical therapy	☐ chiropractic manipulation	☐ trigger point injections	☐ relaxation
☐ occupational therapy	☐ TENS unit	☐ nerve blocks	☐ surgery
☐ exercise	☐ acupuncture	☐ IM cortisone injection	☐ traction
☐ hot/cold packs	☐ massage	☐ psychological counseling	☐ other
☐ heating pad	☐ brace	☐ imagery/hypnosis	
☐ medication	☐ epidural steroid	☐ biofeedback	

What tests have you had since your pain began?

☐ X-rays	☐ Myelogram	☐ Sleep study
☐ CAT scans	☐ Nerve Conduction	☐ EEG
☐ MRI scans	☐ Bone scan	☐ Bone density (DEXA)

How much does your pain interfere with you sleep? 0 (no at all) to 10 (unable to sleep): _____
FILL IN BLANKS: On the average, it takes me _____minutes/hours to fall asleep. I sleep _____ hours a night. I awaken _____ times a night **DUE TO PAIN**. It takes me _____ minutes/hours to get back to sleep.

CURRENT MEDICATION LIST (Write NAME AND DOSAGE below or ATTACH A LIST)

_____ _____

_____ _____

_____ _____

_____ _____

HAVE YOU EVER TAKEN ANY OF THESE MEDICATIONS:

NEUROPATH ☐ Neurontin (gabapentin) ☐ Topamax (topiramate) ☐ Lyrica ☐ Cymbalata (duloxetine)
☐ Elavil (amitriptyline) ☐ nortriptyline

ALLERGIES ***LIST ALLERGIES BELOW OR ATTACH LIST*** ☐ NO KNOWN DRUG ALLERGIES

Do you have any allergies to medications, local anesthesia, steroids, IV contrast dye or foods? If so please list with the reaction

ALLERGY	REACTION	ALLERGY	REACTION
1._____	_____	2._____	_____
3._____	_____	4._____	_____

PAST MEDICAL HISTORY

☐ High blood pressure (401.9)
☐ High cholesterol (272.4)
☐ Diabetes (250.01)
☐ Diabetes Type II (250.00)
☐ Coronary artery disease (414.01)
☐ Colon polyps (V18.51)
☐ Inflammatory bowel disease (564.1)
☐ Breast cancer (174.9)
☐ Asthma (493)
☐ HIV (V08) or AIDS (042)

Are you receiving:
☐ Radiation therapy
☐ Chemotherapy
☐ Oral steroid therapy

Pregnancy Status:
☐ Pregnant
☐ Not pregnant
☐ Possibly pregnant

PAST SURGICAL HISTORY AND/OR MAJOR HOSPITALIZATIONS

Surgery or Hospitalization	Date	Surgery or Hospitalization	Date
☐ Cervical/Thoracic/Lumbar laminectomy	_____	_____	_____
☐ Cervical/Thoracic/Lumbar fusion	_____	_____	_____
☐ Discectomy	_____	_____	_____
☐ _____	_____	_____	_____
☐ _____	_____	_____	_____

FAMILY HISTORY **Children: _____Sons_____Daughters**

	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer
Father	☐_____	☐_____	☐_____	☐_____	☐_____	☐_____
Mother	☐_____	☐_____	☐_____	☐_____	☐_____	☐_____
Pat. GF	☐_____	☐_____	☐_____	☐_____	☐_____	☐_____
Pat. GM	☐_____	☐_____	☐_____	☐_____	☐_____	☐_____
Mat. GF	☐_____	☐_____	☐_____	☐_____	☐_____	☐_____
Mat. GM	☐_____	☐_____	☐_____	☐_____	☐_____	☐_____
Siblings	☐_____	☐_____	☐_____	☐_____	☐_____	☐_____

SOCIAL HISTORY

ALCOHOL SCREENING (3016F)

In the past 12 months, have you drank alcohol? ☐ Yes- Continue to #1-3 ☐ **NO ALCOHOL USE**

1. How often did you have 6 or more drinks on any occasions? ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily
2. How many drinks do you have on a typical day? ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more
3. How often? ☐ Never ☐ Monthly of less ☐ 2 to 4 times a month ☐ 2 to 3 times per week ☐ 4 or more times a week

TOBACCO USE ASSESSMENT (PLEASE BE SPECIFIC)

☐ Non-Smoker
☐ Never Smoker
☐ Former Smoker
☐ Tobacco Smoker
☐ Current Everyday Smoker (Cigarette/Cigar: #____/day)
☐ Current Someday Smoker (Cigarette/Cigar: #____/week)
☐ Smokeless Tobacco User (Can/Pouch:# ___/day)

ADVANCED DIRECTIVES- (1158F, S0257)

I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my care givers to the extent permitted by law. Please check one of the following statements:

☐ I HAVE executed an Advance Directive. ☐ I HAVE NOT executed an Advance Directive.
(Living Will, Durable Power of Attorney, Designation of Health Care Surrogate)

PLEASE PROVIDE COPIES OF ADVANCE DIRECTIVE/LIVING WILL TO THE RECEPTIONIST TO BE INCLUDED IN YOUR MEDICAL RECORD

MANAGEMENT OF URINARY INCONTINENCE- IN WOMEN

In the past 6 months, have you accidently leaked urine?(1090F) ☐ **Yes- Add Dx 788.30** ☐No

SCREENING FOR FUTURE FALLS
(Check all that apply)

☐ No falls in past year (1101F)
☐ One fall in past year but WITHOUT injury (1100F)
☐ Any fall in the past year WITH an injury (1100F)
☐ Two or more falls in the past year (1100F)

DEPRESSION SCREENING (PHQ-2)

1. Over the last two weeks have you felt little interest or pleasure in doing things? ☐ Yes ☐ No
2. Over the last two weeks have you felt hopeless, down or depressed? ☐ Yes ☐ No

FUNCTIONAL STATUS ASSESSMENT (1170F)

Cognitive: Oriented ☐x1 person ☐x2 person/place ☐x3 person/place/time
Ambulatory: ☐ Independent ☐ Immobile or < 50 yards ☐ walks w/help of 1 person ☐ wheelchair bound

ADL's: Grooming	☐ Independent	☐ Needs help	☐ Unable to perform
Dressing	☐ Independent	☐ Needs help	☐ Unable to perform
Toilet Use	☐ Independent	☐ Needs help	☐ Unable to perform
Housekeeping	☐ Independent	☐ Needs help	☐ Unable to perform
Food Prep	☐ Independent	☐ Needs help	☐ Unable to perform
Eating	☐ Independent	☐ Needs help	☐ Unable to perform
Transfers	☐ Independent	☐ Needs help	☐ Unable to perform
Bathing	☐ Independent	☐ Needs help	☐ Unable to perform
Medication	☐ Independent	☐ Needs help	☐ Unable to perform
Finances	☐ Independent	☐ Needs help	☐ Unable to perform

REVIEW OF SYSTEMS (check all that apply)

CONSTITUTIONAL
☐ chills
☐ fever
☐ sweats

ALLERGY
☐ runny nose
☐ scratchy throat
☐ sinus congestion

UROLOGY
☐ frequent urination
☐ blood in urine
☐ incontinence

HEMATOLOGY
☐ abnormal bleeding
☐ easy brusing

RESPIRATORY
☐ runny nose
☐ SOB w/exertion
☐ cough w/sputum or blood
☐ wheezing

GASTROINTESTINAL
☐ loss of appetite
☐ nausea
☐ diarrhea
☐ constipation

DERMATOLOGY
☐ rash
☐ itching
☐ hives

ENDOCRINOLOGY
☐ heat/cold intolerance
☐ excess thirst
☐ excess sweating

NEUROLOGY
☐ numbness/tingling
☐ burning hands/feet
☐ weakness
☐ headache

OPTHAMOLOGY
☐ wear glasses
☐ blurred vision

ENT
☐ hearing loss
☐ ringing in ears
☐ swollen glands
☐ nose bleeds

CARDIOLOGY
☐ chest pain
☐ palpitations
☐ short of breath

MUSKULOSKELATAL
☐ back pain
☐ muscle pain
☐ joint pain

PSYCHIATRIC
☐ insomnia
☐ depression
☐ anxiety

Alcohol/ Substance Abuse Structural Assessment- SOAPP- 14Q (G0396)

The questionnaire has been structured for all patients who are on or being considered for opioid therapy for their pain at Pain and Spine Centers of Florida. This information is for our records and will be kept confidential.

Your answers will not determine your treatment. Your honest opinion will be appreciated.

Please answer the questions below using the following scale:
0 = Never I = Seldom 2 = Sometimes 3 = Often 4 = Very Often

1. How often do you have mood swings?	**0**	**1**	**2**	**3**	**4**
2. How often do you smoke a cigarette within an hour after you wake up?	**0**	**1**	**2**	**3**	**4**
3. How often have any of your family members had a problem with alcohol or drugs?	**0**	**1**	**2**	**3**	**4**
4. How often have any of your close friends had a problem with alcohol or drugs?	**0**	**1**	**2**	**3**	**4**
5. How often have others suggested that you have a drug or alcohol problem?	**0**	**1**	**2**	**3**	**4**
6. How often have you attended an AA or NA meeting?	**0**	**1**	**2**	**3**	**4**
7. How often have you taken medication other than the way that it was prescribed?	**0**	**1**	**2**	**3**	**4**
8. How often have you been treated for an alcohol or drug problem?	**0**	**1**	**2**	**3**	**4**
9. How often have your medications been lost or stolen?	**0**	**1**	**2**	**3**	**4**
10. How often have others expressed concern over your use of medication?	**0**	**1**	**2**	**3**	**4**
11. How often have you felt a craving for medication?	**0**	**1**	**2**	**3**	**4**
12. How often have you been asked to give a urine screen for substance abuse?	**0**	**1**	**2**	**3**	**4**
13. How often have you used illegal/recreational drugs in the past five years?	**0**	**1**	**2**	**3**	**4**
14. How often, in your lifetime, have you had legal problems or been arrested?	**0**	**1**	**2**	**3**	**4**