Patient Information Form

Patient Name:_____ Age:_____ Birthdate:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____ Social Security :_____

Driver's License #: _____Driver's License State: _____ Sex: M F Marital Status: S M D W

Primary Care Physician: _____ Phone:_____ Fax:_____

Referring Physician: _____ Phone:_____ Fax:_____

Occupation:_____ Employer:_____ Phone:_____

Email address: _____ Race: _____ Ethnicity:_____

Someone to contact locally in case of emergency:

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Workers Compensation / Auto Accident

Insurance Company: _____ Date of Incident: _____

Adjuster/Case Manager: _____ Phone: _____

If an attorney is on the case… Name: _____ Phone: _____

If patient is a minor, please complete the following:

Father's Name:_____ Father's Name:_____

Employed By:_____ Employed By:_____

Position: _____ Position: _____

Phone: _____DOB:_____ Phone: _____DOB:_____

Primary Insurance Information:

Insurance Company:_____ ID #:_____

Group Name or #:_____ Address:_____

Phone #:_____ Insured's Full Name:_____ Insured's DOB:_____

Insured's Social Security: _____ Employer Name: _____

Insured's Relationship to Patient:_____

Secondary Insurance Information:

Insurance Company:_____ ID #:_____

Group Name or #:_____ Address:_____

Phone #:_____ Insured's Full Name:_____ Insured's DOB:_____

Insured's Social Security: _____ Employer Name: _____

Insured's Relationship to Patient:_____

GUARANTEE OF PAYMENT:

I fully understand that I am directly responsible for payments to the physician's in this office for all medical services rendered to me. I also understand that all bills are payable and before due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

AUTHORIZATION TO RELEASE INFORMAITON:

I hereby authorize the Physicians in this office to release any information acquired in the course of my examination of treatment to my insurance company for the purpose of processing any insurance claims.

ASSIGNMENT OF INSURANCE BENEFITS

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to the Physicians in this office for medical or surgical treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of the authorization to be used in place original.

SIGNATURE: _____ **DATE:** _____

Authorization to Discuss Protected Health Information

Release of Health Information: I _____, authorize **Blue Water Pain Solutions dba/ Florida Pain Center** to release or discuss information related to my medical condition (including information related to my treatment plan, medication information, and /or billing information) to the following named persons**.

1. _____ 2. _____
1. _____ 4. _____

*Please be advised that any person not referred to on this list will not be given any information related to your care, including billing information. You may change, restrict, or expand this list at any time.

**You are not required to list any name if you do not so choose.

Patients' Signature: _____ Date:_____

Advance Directive: Do you have an advance directive/living will? YES NO

If yes, please provide us with a copy for our records. If no, please let us know if you require information.

Acknowledgement of Receipt of Notice of Privacy Practices:

By signing below, I acknowledge that I have received the Notice of Privacy Practices for the company and its subsidiaries and affiliates. The Notice of Privacy Practices is required to be provided to be under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including as it has been amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 and any implementing regulations. **Effective Date of Notice: September 23, 2013**

Patients' Signature: _____ Date:_____

Patient Representative Signature: _____ Date:_____

Financial Policy

The purpose of this form allows Blue Water Pain Solutions (DBA Florida Pain Center) to treat you, and bill any insurance's you provide us, share information with other health care offices/facilities, and collect on your account.

Co-payments, Co-insurances, Deductibles, and Non-covered services are the responsibility of the patient/guarantor and expected at the time of service.

I authorize treatment by the providers of Blue Water Pain Solutions (DBA Florida Pain Center. I authorize the release of any information requested by insurance companies or liable third parties and I assign all benefits or injury benefits to Blue Water Pain Solutions (DBA Florida Pain Center). If the correct insurance is not provided or the proper referral is not obtained, then the patient acknowledges full responsibility for the bill.

I acknowledge that I received or read a copy of the Notice of Privacy Practices, which was provided to me with the initial new patient forms which will remain present in my chart.

I hereby understand the financial policy of this office. I guarantee payment of all charges incurred for the account of the below patient. I further agree to pay all reasonable Attorney's Fee, Collection Agencies Fee, court costs and any other collection related fees incurred on my account. I also understand that my employer may be contacted to verify employment status.

Special Needs: There are times when making a payment can be a financial hardship. If this is the case, proof of hardship will be required, and will have to be provided for special payment arrangements to be made PRIOR TO RECEIVEING TREAMENT. Co-Payments are exempt as required by law and your insurance company.

You are required to notify us if this is a worker's comp or accident to avoid additional financial costs. If you are not covered by any insurance, let us know you are a self-pay.

Note our Fees for the following:

- Returned check fees vary depending on payment amount.
- Any forms such as FMLA, Disability, etc. $35.00 each **CASH EXACT CHANGE ONLY!**

Co-pays, Co-insurance, Deductibles, and Non-Covered services, or unpaid balances not paid at time of service, will result in our inability to treat you.

If a referral is required and not obtained, you will be responsible for payment for those services. Incorrect insurance information provided or changes in policies will be patient responsibility.

Patients' Signature: _____ Date:_____

Patient Representative Signature: _____ Date:_____

Attorney Cases- Authorization to release records to patient attorney - I do hereby authorize Blue Water Pain Solutions, PA to furnish my attorney with a full report of my examination, diagnosis, treatment, prognosis, billing charges, etc., regarding the accident in which I was involved.

Attorney Name:_____ Attorney Phone:_____

Patients' Signature: _____ Date:_____

Medical History

Name: _____ Date: _____ DOB: _____

Occupation: _____ Problem began when: _____

Type of Injury: □ at work/work related □ at home □ slip/fall □ MVA □ sports injury □ arthritis

Have you been unable to work due to your injury? □ Yes □ No How long? _____

Have you been seen in an Emergency Room? □ Yes □ No Name of Hospital? _____

Have you had an MRI of the injured area? □ Yes □ No Name of Facility? _____

Present Pain History

Back Pain	Neck Pain	Pain Level at worst
□ Back pain only; no leg pain	□ Neck pain only; no arm pain	0-1-2-3-4-5-6-7-8-9-10
□ Back pain worse than leg pain	□ Neck pain worse than arm pain	0-1-2-3-4-5-6-7-8-9-10
□ Back and leg pain are equal	□ Neck and arm pain is equal	0-1-2-3-4-5-6-7-8-9-10
□ Leg pain worse than back pain	□ Arm pain worse than Neck pain	0-1-2-3-4-5-6-7-8-9-10
□ Leg pain only; no back pain	□ Arm pain only; no neck pain	0-1-2-3-4-5-6-7-8-9-10

Do you have any of the following symptoms? □ Numbness □ Tingling □ Pins and Needles
Treatments for your current pain include: □ Medication □ Physical Therapy □ Chiropractor
□ Injections □ acupuncture □ Massage □ Cold/Hot Packs □ Exercise/Stretching □ TENS Unit

Medical History

Disease	When Diagnosed	Treatments	Disease	When Diagnosed	Treatments
High Blood Pressure			Bleeding Disorder		
Heart Problems			Incontinence (Bowl/Bladder)		
Seizures			Nerve Disease		
Diabetes			Kidney Problems		
Asthma			Liver Problems		
Cancer			Stroke		
Chemo/Radiation			High Cholesterol		
Emphysema			Hepatitis		
Thyroid Problems			Osteoporosis		
Ulcers			Arthritis		
Migraines			Lung Disease		
HIV/AIDS			Nausea/Vomiting		
GI Problems			Other:		

Are you allergic to any medications? □NO □YES If yes, please list:

_____

Are you taking any anticoagulants (blood thinners)? □NO □YES If yes, please list:

_____

In the past 6 months to a year, what tests have you had to evaluate your pain? _____

_____

Medical History Continued…

Do you drink caffeinated drinks? □NO □YES Cups per day _____ (Coffee, Teas, Cola, etc.)

Do you drink Alcoholic beverages? □NO □YES Drinks per day? _____

Do you smoke cigarettes or cigars? (yes if within 1 year) □NO □YES

If yes, please specify: Packs per day: _____ Cigars per day: _____

Did you ever use street drugs? (yes if within 1 year) □NO □YES If yes, please specify:

Marijuana Cocaine Amphetamines Other: _____

Please list ALL current medications that you are taking:

Medications:	Reason:	Dose:	How long used?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What medications have you taken in the past for pain?

□ Avinza	□ Darvocet	□ Darvon	□ Duragesic	□ Hydrocodone	□ Kadian	□ Lorcet
□ Lortab	□ Methadone	□ Morphine	□ MS Contin	□ Norco	□ Oromorph	□ Oxycodone
□ Oxycontin	□ Percocet	□ Percodan	□ Talwin	□ Tylenol#3	□ Tylenol#4	□ Tylox
□ Ultracet	□ Ultram	□ Advil	□ Aleve	□ Arthrotec	□ Bextra	□ Celebrex
□ Mobic	□ Motrin	□ Naprosyn	□ Naproxen	□ Flovicet	□ Florinal	□ Gabapentin
□ Gabitrel	□ Lamictal	□ Neurontin	□ Topamax	□ Baclofen	□ Fexeril	□ Methcarbamol
□ Norflex	□ Paraton Forte		□ Robaxin	□ Skelaxin	□ Soma	□ Zanaflex

Other: _____

I certify that I have answered truthfully all the questions, and have not knowingly withheld any information concerning any of the above problems, either past or present.

_____ _____

Patient's Signature Date

_____ _____

Physician's Signature Date

Review of Systems

Have you experienced any of the following in the past 6 months:

(Please answer ALL questions)

Constitutional

Fever	YES	NO
Chills	YES	NO
Sweats	YES	NO
Anorexia	YES	NO
Recent Weight Changes	YES	NO

Eyes

Blurred Vision	YES	NO
Double Vision	YES	NO
Eye Irritation	YES	NO
Vision Loss	YES	NO
Eye Pain	YES	NO
Photosensitivity	YES	NO

ENT

Ear Pain	YES	NO
Ringing in the Ears	YES	NO
Decreased Hearing	YES	NO
Nosebleeds	YES	NO
Sore Throat	YES	NO
Hoarseness	YES	NO
Voice Change	YES	NO

Cardiovascular

Chest Pain	YES	NO
Heart Beat Changes	YES	NO
Fainting Episodes	YES	NO
Shortness of Breath	YES	NO

Respiratory

Cough	YES	NO
Spitting up Blood	YES	NO
Asthma/Wheezing	YES	NO

Gastrointestinal

Nausea/Vomiting	YES	NO
Frequent Diarrhea	YES	NO
Constipation	YES	NO

Genitourinary

Painful Urination	YES	NO
Frequent Urination	YES	NO
Blood in Urine	YES	NO

Musculoskeletal

Difficulty in Walking	YES	NO
Joint Pain	YES	NO
Joint Stiffness or Swelling	YES	NO
Weakness of Muscle	YES	NO
Weakness of Joint	YES	NO
Numbness or Tingling	YES	NO
Cold Extremities	YES	NO

Neurologic

Paralysis	YES	NO
Seizures	YES	NO
Dizziness	YES	NO
Tremors	YES	NO
Balance Problems	YES	NO
Headaches	YES	NO

Psychiatric

Depression	YES	NO
Anxiety	YES	NO
Memory Loss	YES	NO
Mental Disturbances	YES	NO
Suicidal Ideations	YES	NO

Endocrinologic

Heat Intolerance	YES	NO
Cold Intolerance	YES	NO
Excessive Thirst	YES	NO
Excessive Hunger	YES	NO
Excessive Urination	YES	NO

Hematologic

Easily Bruise/Bleed	YES	NO
Hives	YES	NO
Enlarged Lymph nodes	YES	NO
Hives	YES	NO
Hay Fever	YES	NO
Persistent Infections	YES	NO

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Our goal in the field of Pain Management Medicine is to assist patients with the treatment of their chronic pain. We achieve this goal through various modalities, including injections or nerve blocks, physical therapy, exercise programs, psychological counseling when needed, and referrals to surgeons or other specialists as required. We strive to manage pain through means other than the medications to allow patients to live a relatively pain free life. We seek to treat the cause of pain and not the symptoms. **However, we also understand that strong narcotic analgesic and other prescription medications may be indicated for the treatment of certain chronic pain conditions.**

The purpose of this agreement is to clarify the conditions under which the pain management doctor will prescribe medication stop you. The agreement will help you and your doctor comply with the laws regarding controlled pharmaceutical and prevent misunderstandings about the medicines you may take for your pain condition. **Please read each item in this agreement very carefully.**

I UNDERSTAND AND AGREE TO THE FOLLOWING TERMS OF ANY AND ALL PRESCRIPTIONS:

1. I WILL USE MY MEDICATIONS AT A RATE NO GREATER THAN THAT PRESCRIBED BY MY PAIN MANAGEMENT PHYSICIAN. IF I DO OVER-USE MY MEDICATION, THAT MEDICATIN WILL NOT BE REFILLED EARLY, AND I MAY BE WITHOUT PAIN MEDICATION FOR SOME PERIOD OF TIME.

2. I WILL NOT SHARE, SELL, OR TRADE MY MEDICATION WITH ANYONE. I WILL NOT ATTEMPT TO OBTAIN ANY CONTROLLED MEDICINES, INCLUDING OPIOID PAIN MEDICINES, CONTROLLED STIMULANTS, OR ANTI-ANXIETY MEDICINES FROM ANY OTHER DOCTORE. I WILL SAFEGUARD MY WRITTEN PRESCRIPTIONS AND PAIN MEDICINE FROM LOSS OR THEFT. I UNDERSTAND THAT LOST OR STOLEN WRITTEN PRESCRIPTIONS OR MEDICINES WILL NOT BE REPLACED.

3. SUDDEN DISCONTINUATION OF A NARCOTIC PAIN MEICATION MAY LEAD TO UNPLEASANT OR DANGEROUS WITHDRAWAL SYMPTOMS.

4. IN THE EVENT THAT MY PHYSICIAN FEELS THAT MY DOES OF PAIN MEDICATION IS EXCESSIVE OR MAKES THE DIAGNOSIS OF ADDICTION, HE/SHE WILL REDUCE THE MEDICINE OVER A PERIOD OF TIME (DAYS, WEEKS, MONTHS) AS NECESSARY TO AVOID WITHDRAWAL SYMPTONS. ALSO, A DRUG-DEPENDENCE TREATMENT OR DETOXIFICATION PROGRAM MAY BE RECOMMENDED.

5. I UNDERSTAND AND AGREE THAT I AM NOT TO RECEIVE ANY TOPE OF PRESCRIPTION PAIN MEDICATION OR SEDATIVE MEDICATION FROM ANY PHYSICIAN OTHER THAN MY PAIN MANAGEMENT PHYSICIAN <u>UNLESS</u> THERE IS A SPECIFIC MEDICAL NECESSITY. SHOULD MY CAREGIVER OR I RECEIVE ANY PAIN OR SEDATIVE MEDICATIONS FROM ANY OTHER PHYSICIAN, MY CAREGIVER OR I MUST INFORM THE PAIN CENTER EITHER BY TELEPHONE OR IN WRITING WITHIN 72 HOURSOF HAVING FILED THE PRESCRIPTIONS.

6. REFILLS OF MY PRESCRIPTIONS WILL BE ISSUED <u>ONLY</u> DURING REGULAR OFFICE HOURS.

7. REFILLS <u>WILL NOT</u> BE AVAILABLE DURING EVENINGS, ON WEEKEND, OR HOLIDAYS, AND WITHOUT <u>AT LEAST 72 HOURS NOTICE</u> TO MY PHYSICIAN OR HIS OFFICE STAFF.

8. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KEEP TRACK OF MY SUPPLY OF MEDICATION.

9. MY DOCTOR MAY, AT HIS/HER DISCRETION, ISSUE A REFILL OF MY MEDICATIONS BASED ON A TELEPHONE CONVERSTAION THAT WE HAVE REGARDING MY PAIN CONDITION AND THE EFFECTS THAT PRESCRIBED MEDIATIONS HAVE ON THIS CONDITION.

10. I WILL COMMUNICATE FULL AND THRUTHFULLY WITH MY DOCTORE ABOUT THE CHARACTER AND INTESNITY OF MY PAIN, THE EFFECT OF THE PAIN ON MY DAILY LIFE, AND HOW WELL THE MEDICINE IS HELPING TO RELIEVE THE PAIN. I UNDERSTAND THAT I, OR MY CAREGIVER IS RESPONSIBLE FOR INFORMATION THE PHYSICIAN EITH I PERSON, AT FOLLOW-UP, OR BY TELEPHONE AT THE PAIN CENTER TELEPHONE NUMBER (954-447-5206) DURING REGULAR BUSINESS HOURS REGARDING ANY PROBLEMS OR SIDE EFFECTS ENCOUNTERED WITH THE MEDICATION.

11. I HAVE BEEN ADVISED TO ABSTAIN FROM OR SIGNIFICANTLY MODERATE MY USE OF **ALCOHOLIC BEVERAGES** WHILE TAKING MEDICATION FOR MY PAIN CONDITION. I WILL NOT USE ANY ILLEGAL OR CONTROLLED SUBSTANCES, INCLUDING BUT NOT LIMITED TO MARIJUANA, COCAINE, HEROIN, ECSTASY, GHB, ETC. IF I AM A **CIGARETTE SMOKER,** I UNDERSTAND THAT I WILL BE ASKED TO QUIT. CIGARETTE SMOKERS TYPICALLY HAVE DECREASED RESPONSE TO PAIN TREATMENT BECAUSE OF THE EFFECTS OF SMOKING ON OXYGEN DELIVERY TO PERIPHERAL TISSUES. ADDITIONALLY, **OBESITY** IS ONE OF THE MOST IMPORTANT CAUSES FOR FAILED TERATMENT FOR CHRONIC PAIN. EVERY TEN POUNDS OF EXCESS WEIGHT THAT ONE CARRIES ON THE SPINE, VERTEBRAL DISCS, AND SPINAL NERVES. EXCESSIVE WEIGHT WILL THEREFORE RESULT IN AN INCREASE IN PAIN. IF YOU ARE OVERWEIGHT YOU WILL NEED TO ENROLL IN A WEIGHT LOSS PROGRAM. PHYSICAL THERAPY WILL ALSO BE DIRECTED TO THIS AREA AS WELL.

12. IF PHYSICAL THERAPY IS PRESCRIBED, I AGREE TO ATTEND AND PARTICIPATE TO THE FULLEST EXTENT POSSIBLE. IF THERE ARE ANY PROBRLEMS WITH MY PHYSICAL THERAPY, I AGREE TO COMMUNICATE THIS TO MY PHYSICIAN SO THAT HE OR SHE CAN MAKE THE APPROPRIATE CHANGES IN MY THERAPY PROGRAM.

13. I AGREE THAT I WILL SUBMIT TO A BLOOD OR URINE TEST IF REQUIRED BY MY DOCTOR TO DETERMEN MY COMPLIANCE WITH MY REGIMEN OF PAIN MEDICATION.

14. IF REQUESTED, I WILL BRING ALL UNUSED PAIN MEDICINE TO AN OFFICE VISIT FOR A “PILL COUNT”. MY PHYSICIAN MAY REQUEST ADDITIONAL “PILL COUNTS” AT ANY TIME, AND I AGREE TO COMPLY WITH THESE REQUESTS. I AGREE THAT I WILL BRING THE MOST RECENT PRESCRIPTION CONTAINER FOR EACH MEDICATION TO EACH VISIT WITH MY PHYSICIAN. THESE CONTAINERS MUST CORRESPOND TO THE LAST PRESCRIPTION RECORDED IN THE MEDICAL RECORD WITH THE PRESCRIPTION LABELS INTACT AND LEGIBLE SO THAT THE PHYSICIAN IN THE MEDICAL RECORD MAY DOCUMENNT APPROPRIATE CONTROL INFORMATION, SPECIFICALLY, THE PRESCRIPTION REGISTRATION NUMBER AND PHARMACY TELEPHONE NUMBER WILL BE NOTED AND VERIFIED.

15. I FURTHER UNDERSTAND THAT THIS AGREEMENT IS ESSENTIAL TO THE TRUST AND CONFIDENCE NECESSARY IN A DOCTOR-PATIENT RELATIONSHIP AND THAT MY DOCTOR UNDERTAKES TO TREAT ME BASED ON THIS AGREEMENT. I UNDERSTAND THAT IF I BREAK THIS AGREEMENT OR PROVIDE ANY FALSE INFORMATION, MY DOCTOR WILL STOP PRESCRIBING THESE PAIN-CONTROL MEDICINES AND I MAY BE IMMEDIATELY REMOVED FROM THE DOCTORS CARE.

I have reviewed all the items contained in this 2-page agreement. I agree to follow all the guidelines that are described above. All my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given to me upon request. I voluntarily consent to the participation in the pain medication program described in this agreement.

Patients’ Signature: _____ Date:_____

Patient Representative Name: _____ Patient Representative Signature: _____

Witness:_____