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 physicians in this office for all medical services rendered to me. I also understand that all bills are payable and before they are 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 during 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 of the 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 no person not referred to on this list will 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 of your records. If not, 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 is to allow Blue Water Pain Solutions (DBA Florida Pain Center) to treat you, and bill any insurance's you provide us with, 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 self-paid.

Note our Fees for the following:

- Returned check fees vary depending on the 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: _____

New Patient: Name_____ Date: _____
DOB_____ Age: _____ Sex: _____

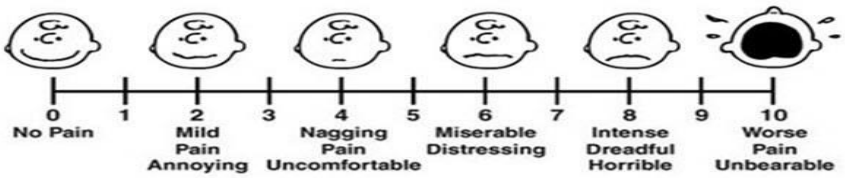
Past Medical History

Conditions: Check conditions you have or have had in the past.

☐ Aids	☐ Cancer	☐ HIV Positive	☐ Pneumonia
☐ Alcoholism	☐ Chemical Dependency	☐ Hypertension	☐ Prostate Problem
☐ Anemia	☐ Diabetes	☐ Kidney Disease	☐ Rheumatic Fever
☐ Appendicitis	☐ Emphysema	☐ Kidney Stones	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Liver Disease	☐ Stoke, Mini (TIA)
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraine Headaches	☐ Suicide Attempt
☐ Blood Cots	☐ Heart Disease	☐ Mononucleosis (Mono)	☐ Thyroid Problems
☐ Bronchitis	☐ Hepatitis	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bulimia	☐ High Cholesterol	☐ Musculoskeletal	☐ Ulcers
☐ Eating Disorder	☐ Urinary Tract Infection	☐ Pacemaker	☐ Other _____

Pharmacy name:	**Phone #:**	**Address:**
Primary Care Physician Name:		

- **Allergies:** (Circle all that apply)
  No Known Allergies or Iodine / Contrast Dye / Cortisone / Lidocaine / Tape / Latex / Medication
  (List other Allergies) → _____



Please Rate your overall pain using the scale:

- **Please Circle The location of your pain Below. Also, Using the 1-10 scale, write the number next to the location.**

Head		Neck		Mid Back		Low back		Buttocks		Abdomen	
Right /Left Arm		Right/Left Leg		Right /Left Shoulder		Right/Left knee		Right/Left Hip		Other:	

- **Which area above is your #1 worst pain** (If more than one location circled)? _____
- **How Long ago did your pain Begin?** ____Days ____Weeks ____Months ____Years or Date: _____
- **Did your pain Begin**: ____Suddenly or ____ Progress Gradually

Cause of pain:

Car accident	Job Injury	Sports Injury	Slip/Fall	Other Trauma	Disease	Arthritis

- **How would you describe your pain? <u>(circle below)</u>**

Throbbing	Achy	Dull	Shooting	Stabbing	Sharp
Cramping	Squeezing	Gnawing	Electric	Deep	Superficial (Shallow)
Tender	Burning	Tight	Pins/Needles	Constant	Comes and Goes

- **Does your Neck pain Radiate into the arms**: Y / N

  _____Neck pain worse than Arm pain _____Neck and arm pain are equal ____Arm pain worse than Neck

- **Does your Back pain Radiate into the legs**: Y / N

  _____Back pain worse than Leg pain _____Back and Leg pain are equal ____Leg pain worse than Back

- **Do you have Numbness, Tingling or weakness in your arms or legs?** None / Right Arm / Left Arm / Right Leg / Left Leg

- **Do you have:** Bowel/Bladder Incontinence or Numbness in the Groin or N/A

- **Which of the below are you unable to do or worsens your pain?**

Sleep	Cook/Clean	Work	Lifting	Driving	Exercise	Bending	Standing	Rising from sitting
Driving	Recreation	Sex	Walking	Caring for Family	Weather changes	Dress self	Sitting	Other:

- **Which Activities/Positions improve your pain?**

Ice	Heat	Walking	Sitting	Acupuncture	Other:
Lying down	TENS	Massage	Exercise		

- **Have/had you recently participated in:** (please circle) **Physical therapy / Chiropractic Care / Home exercise / Gym**

  When_____ How long_____ Helpful? _____

- **Do you use it?** Cane Walker Wheelchair Other: _____

Please list Previous Physicians seen FOR PAIN…	Specialty (Ex. Surgeon, Pain management, Primary care)	When did you stop seeing them?	Why did you stop seeing them?
1)			
2)			
3)			

- **Have you had any Injections for pain**? **(Please circle all that apply or write in other)**

Epidurals	Facet joint injections	Trigger point injection	Joint injection	Botox
Nerve Block	Rhizotomy / RFA	Spinal cord stimulator	Stem Cells	PRP
Other:				

Please write all related Surgeries or imaging in the Sections Below.

Type of Surgery	**Date**	**Outcome (Did it help?)**
1)		
2)		
3)		
4)		

Test:	Facility Name:	Date:	Test:	Date:
Cat Scan (CT)			EMG/NCV	
MRI			Bone Scan	
X-ray			Dexa Scan	
Other:				

- **Have you used any pain medications below in the past?**

Medication	✔	Medication	✔	Medication	✔	Medication	✔
Oxycodone, Percocet		Oxymorphone, Opana		Cyclobenzaprine, Flexeril		Tepentadol, Nucynta	
Hydrocodone, Vicodin, Norco		Hydromorphone, Dilaudid		Robaxin		Tramadol, Ultram	
Morphine		Ibuprofen		Baclofen		Topamax	
Fentanyl		Naproxen		Carisoprodol Soma		Buprenorphine, Butrans, Belbuca	
Tylenol #3 or #4		Meloxicam, Mobic		Tizanidine Zanaflex		Subutex, Suboxone	
Duloxetine, Cymbalta		Prednisone		Gabapentin		Lyrica	
Celebrex		Nortriptyline Elavil		Amitriptyline			
Others:							

Please list Side effects:

- **List all medications you are currently taking....**

Name	Strength (dose)	Frequency (How often taken)	Condition being treated
1)			
2)			
3)			
4)			
5)			
If more, please attach medication list or write on the back of the last page.			

- **In the last year have you used any drugs such as:** Marijuana, Cocaine, Heroin, meth, other _____? None
- **Do you have any history of Drug abuse or addiction including prescription medications or illicit drugs?**

  Y / N
- **Do you smoke cigarettes or use any tobacco products?** Current / Previous / Never
- **Do you drink Alcohol?** Y / N **How many drinks per week?** _____

Authorization for Release of Medical Information to Florida Pain Center

Patient Name: _____ Date of Birth: _____

Address: _____

Phone #: _____ Last 4 of Social: _____

I authorize (Name and Phone of medical facility holding your medical records:

_____

_____

_____

To release all medical information relating to my treatment from _____ to _____.

This is to include all records, if any, concerning HIV or AIDS, mental or behavioral health or psychiatric care, and drug or alcohol abuse.

Purpose of this request: For provision of continuing medical care

Specific items to be released:

__Cardiovascular Reports __Emergency Room __Pathology Reports

__Consultation Reports __History & Physical __Progress Note

__Discharge Summary __Laboratory Results __Xray Reports

__EKG reports __Operative Reports __MRI Reports

__Photographs, video, or other digital images ___Records of prescription medications

Other (describe) _____

Send information via:

__Fax: 954-447-5259

__Mail to 1951 SW 172 Avenue, Suite 314, Miramar, FL 33029

__Hold for pick up by authorized representative of _____

I understand that this consent can be revoked at any time except to the extent that action has been taken prior to revocation. If not previously revoked, this consent will terminate one year after the date of my signing this consent.

Signed: _____ Date: _____

Printed Name: _____ Relation to the patient: _____

Pain Management Narcotic Agreement (Page 1 of 2):

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 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 pharmaceuticals 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 all prescriptions:
(Please initial below)

2. _____ 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 medication will not be refilled early, and I may be without pain medication for some period.

3. _____ 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 doctor. 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.

4. _____ Sudden discontinuation of narcotic pain medication may lead to unpleasant or dangerous withdrawal symptoms.

5. _____ If my physician feels that my dose of pain medication is excessive or makes the diagnosis of addiction, he/she will reduce the medicine over a period (days, weeks, months) as necessary to avoid withdrawal symptoms. Also, a drug-dependence treatment or detoxification program may be recommended.

6. _____ I understand and agree that I am not to receive any type of prescription pain medication or sedative medication from any physician other than my pain management physician unless 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 hours of having filled the prescriptions.

7. _____ Refills of my prescriptions will be issued only during regular office hours.

8. _____ Refills will not be available during evenings, on weekends, or holidays, and without at least 72 hours' notice to the physician or their office staff.

9. _____ I understand that it is my responsibility to keep track of my supply of medication.

10. _____ I will communicate fully and truthfully with my doctor about the character and intensity 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 the information given to the physician.

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 treatment 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 fully participate as possible. If there are any problems 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, urine, or saliva test if required by my doctor to determine my compliance with my regimen of pain medication. These tests confirm that I am following the treatment exactly how my provider has ordered. I understand I may be required to come to the office on short notice to complete these required tests if necessary. I understand that not following these requirements may result in my provider not sending my prescription.

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 document 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 doctor's 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 participation in the pain medication program described in this agreement.

Patients' Signature: _____ **Date:** _____

Patient Representative Name: _____ **Patient Representative Signature:** _____

Witness: _____

FLORIDA SPINE & PAIN CENTER
partnercare practice

Patient Financial Policy:

We are committed to providing you with high-quality healthcare services and ensuring transparency in all financial matters. To facilitate a clear understanding of our payment procedures and your responsibilities, we have outlined the following Patient Financial Policy. Please review this policy before your appointment.

Payment at the Time of Visit:

Payment for all services, including copayments, coinsurance, deductibles, and payments for non-covered services, is *required at the time of your visit.* We accept Cash, Checks, Mastercard, VISA, Discover, and American Express for your convenience.

Insurance and Referrals:

- Insurance Information: It is your responsibility to provide accurate and current insurance information to our staff at the time of your appointment, and this includes providing us with any updates that may have been retroactive and may impact your claims from being adjudicated. *This includes notifying our staff if you are enrolled with a Medicare Advantage Plan.*
- Copays/Coinsurance/ Deductibles: Your policy with your insurance company represents a contract between you and the insurer. Copayments, coinsurances, and deductibles are your responsibility and will not be waived. You are required to arrange payment for these costs before scheduling an appointment, and this includes knowing the applicable copayment for office visits and procedures at the Surgery Center. *You must also verify that we are in-network with your insurance before your appointment. This includes both the office and the Surgery Center if you are scheduled for a procedure.* We encourage you to alert us immediately if you see that our doctors or the facility are not listed under your plan so we can investigate this further.
- Specialist Referrals: If your insurance policy mandates a referral to see our specialists, it is your obligation to obtain and provide this referral before your appointment. Failure to do so may result in appointment rescheduling, subject to the rescheduling fee. Primary Care Doctors will not "back-date" referrals.
- Claim Submission: If you are covered by an insurance policy with which we have a contract, we will submit a claim to your insurance company for reimbursement.
- Out of Network: **If you have a procedure done at one of our surgery centers, and they are out of network with your insurance, as a courtesy, we will apply your in-network benefits to your out-of-network patient responsibility. If you have questions about this, please discuss it with one of our financial advisors in the business office before your appointment.**
- **Non-Covered Services:** You are responsible for any services not covered by your insurance.
- **Payments made to the patient directly:** In the event your insurance company erroneously pays you directly, you are obligated to endorse the payment to **Florida Spine & Pain Center - 1951 SW 172 Avenue, Suite 314, Miramar, FL 33029,** along with an Explanation of Benefits (EOB) from your insurance provider. Using insurance proceeds for personal use constitutes insurance fraud, which is strictly prohibited.

Appointment Policy:

- Payment Timing/ Reschedule Fee: Copayments must be paid before services are provided. Suppose you are unable to pay your copayment before being seen. In that case, this may result in rescheduling your appointment, which will be subject to a rescheduling fee of $50 for office visits or a rescheduling fee of $100 for appointments at the Surgery Center.
- Cancellations and "No-Show" Fees: To provide the best services for our patients, we require a minimum of 48 hr. notice for cancellations or rescheduling of your appointments. Failure to provide timely notification will result in a fee of $50 for office visits and $100 for Surgery Center appointments. If you have an emergency or are sick, please notify us immediately. We will evaluate our fee on a case-by-case basis.

We understand that from time to time, extenuating circumstances are out of your control, but please understand that 3 No-shows may result in you being discharged from the practice.

Miscellaneous Fees:

- Check Bouncing Fee: A fee of $35 will be charged for checks that are returned due to insufficient funds.
- Collections Fees: If your account is referred to a collection agency, you will be responsible for any additional interest, collection, and attorney fees associated with collecting the outstanding balance. Additionally, this may affect your credit and potentially result in your discharge from the practice.

- Failure to Maintain Payment Plans: If you sign up for a payment plan using your credit card, you will be expected to pay your balance in full within 6 months. Furthermore, you are responsible for updating us if any information related to your credit card changes. This includes the expiration date, the CVV, CVC, or CID number. If your credit card is rejected for any reason, the payment plan will be considered null and void, and payment in full will be required before being seen again.

I acknowledge and agree to the terms outlined in this Patient Financial Policy by seeking care at **Florida Spine & Pain Center**. I recognize the importance of complying with these policies for the mutual benefit of all parties involved. Misusing insurance proceeds constitutes insurance fraud, and I am committed to upholding all relevant regulations and ethical standards.

- I understand that I am responsible for all charges incurred. This includes non-covered services, exclusions, coverage lapses, coverage termination, or services denied when policy maximums have been reached.
- I authorize the release of any information concerning my or my dependent's medical record and treatment for the purpose of evaluating and adjudicating payment for claims incurred.
- I authorize that payments can be made directly to my provider.

Patient Name: _____ **Date:** _____

Signature: _____

Guardian/Representative (If applicable): _____

Please retain a copy of this policy for your records.