

****WE ARE LOCATED IN
CREEKSIDE OFFICE PARK SUITE 401****



NORTH FLORIDA PAIN CENTER

5851 TIMUQUANA RD STE: 401
JACKSONVILLE, FLORIDA 32210
PHONE: (904) 317-5069
FAX: (904) 778-6440

Welcome and thank you for choosing North Florida Pain Center!

On behalf of the entire medical staff at NFPC, welcome to our practice! We understand that you have probably seen a number of other physicians and specialists before coming to us. With that in mind, we want to make your initial consultation with us as beneficial as possible.

The more information you are able to provide us for your first appointment, the more we are able to help you. Please have the following documents/records with you:

- *Picture ID/Insurance card*
- *New Patient Forms: In order to reduce wait time at your first appointment, we have included these forms and ask that you have them completed prior to your appointment.*
- *Bring any imaging results from an XRAY/MRI/CT and/or relevant records from other providers that you might have.*
- *A current medication list and/or the original bottles of current prescriptions.*

Should you complete the documents quickly, we encourage you to bring them to the office so the staff can get them into your chart and any pertinent records or information can be requested in enough time that they are available to our providers at your first appointment. If you have any questions or we can assist you in any way, please do not hesitate to call us at (904)317-5069.

PAGE 1: DEMOGRAPHICS – FILL OUT & SIGN

PAGE 2: MED & ALLERGY LIST - SECTION 1 LIST ALL MEDS – SECTION 2 LIST ANY ALLERGIES – SECTION 3 DOCUMENT BLOOD THINNERS.

PAGE 3 & 4: RELEASE – ONLY YOUR SIGNATURE IS REQUIRED ON THE 2 SIGNATURE LINES ON PAGE 4 – NO NEED TO FILL IT OUT OR DATE IT

PAGES 5/6/7: HIPPA PRIVACY PRACTICES – READ, THEN SIGN & DATE PAGE 7 – IF YOU HAVE ANYONE YOU WOULD LIKE US TO BE ABLE TO SPEAK TO OR SPEAK FOR YOU, LIST THEM AT THE BOTTOM OF PAGE 7.

PAGES 8 & 9: FINANCIAL AGREEMENT – READ, THEN SIGN & DATE ON PAGE 9.

PAGES 10 & 11: EMAIL CONSENT – FILL OUT/SIGN THE HIGHLIGHTED SECTIONS ON BOTH PAGES.

PAGES 12/13/14/15: MEDICAL HISTORY/PAIN LEVEL – ANSWER YES OR NO TO EACH QUESTION ON PAGES 12-14 AND FOLLOW INSTRUCTIONS TO MAP YOUR PAIN ON PAGE 15/ANSWER YES OR NO TO EACH QUESTION ON PAGES 12-14 AND FOLLOW INSTRUCTIONS TO MAP YOUR PAIN ON PAGE 15/PUT YOUR NAME & DOB ON EACH PAGE .



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(Please Print)

Date _____ Referred by _____

Patient's Name _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Cell# _____

Birthdate _____ Sex _____ SS# _____

Email: _____

Married Single Divorced Separated Widowed

Employer _____ Phone # _____

FIRST INSURANCE: _____

Policyholder _____

Policy # _____ Group # _____

Policyholder's Social Security _____

Policyholder's Birthdate _____

SECOND INSURANCE _____

Policyholder _____

Policy # _____ Group # _____

Policyholder's Social Security # _____

Policyholder's Birthdate _____

SIGNATURE

DATE

Responsible Person if Patient is a Minor



**NORTH FLORIDA
PAIN CENTER**

MEDICATION, ALLERGY, AND BLOODTHINNER INFORMATION

NAME: _____

DOB: _____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING PLEASE INCLUDE DOSE AND HOW OFTEN:

*	_____	*	_____
*	_____	*	_____
*	_____	*	_____
*	_____	*	_____
*	_____	*	_____
*	_____	*	_____

PLEASE LIST ALL ALLERGIES: _____

DO YOU CURRENTLY TAKE ANYONE OF THESE? PLEASE MARK ANY YOU ARE TAKING.

WE NEED TO KNOW **BEFORE** YOU ARE SCHEDULED FOR A PROCEDURE.

- ASPIRIN THERAPY
- PLAVIX / CLOPIDOGREL BISULFATE
- AGGRENOX/ASPIRIN - DIPYRIDAMOLE
- COUMADIN / WARFARIN
- LOVENOX / ENOXAPARIN
- HEPERIN

IF YOU ARE CURRENTLY TAKING A BLOODTHINNER THAT IS LISTED: _____



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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORD

PATIENT INFORMATION

This authorization is for the release of medical information.

PATIENT'S NAME _____
Last First M.I.

ADDRESS _____

BIRTHDATE ____/____/____ DAYTIME TELEPHONE NUMBER _____

SOCIAL SECURITY NO. _____

AUTHORIZATION:

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization except as provided by law.

RELEASE FROM LIABILITY:

I FURTHER UNDERSTAND THAT IF THE ORGANIZATION AUTHORIZED TO RECEIVE THE INFORMATION IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION COULD POTENTIALLY BE RE-DISCLOSED AND MA NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS. THEREFORE, I RELEASE North Florida Pain Center FORM ANY AND ALL LEGAL LIABILITY THAT MAY ARISE FROM WHAT THE PARTY NAMED BELOW DOES WITHIN THE PHI.

ORGANIZATION RELEASING INFORMATION:

PH: _____
(NAME OF PERSON OR ORGINAZATION RECEIVING INFORMATION)

FAX: _____
STREET ADDRESS

CITY STATE ZIP CODE

ORGANIZATION RECEIVING INFORMATION:

PH: _____
(NAME OF PERSON OR ORGINAZATION RECEIVING INFORMATION)

FAX: _____
STREET ADDRESS

CITY STATE ZIP CODE

INFORMATION TO BE DISCLOSED:

- All records **OR**
- Demographic Information Lab Reports Diagnostic Tests Reports
- Consultant Reports Other(*please specify*): _____

PURPOSE OF DISCLOSURE:

- Second Opinion Continuing Medical Treatment Patient Request
- Marketing Promotion: I have been informed that North Florida Pain Center ___is___ not receiving direct or indirect Compensation from a third party as a result of disclosing information for this purpose.
- Other (please specify): _____



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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORD

SPECIAL AUTHORIZATION TO DISCLOSE SUPER-CONFIDENTIAL INFORMATION:

ALCHOL/DRUG/INFECTIOUS DISEASE/MENTALHEALTH RECORDS are protected by Federal Regulations. Release of such records requires specific consent. I hereby grant such specific consent as initialed below. **I UNDERSTAND** that the following records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection.

IN ADDITION TO ANY RECORDS CHECKED ABOVE, THE FOLLOWING INITIALED RECORDS MAY BE RELEASED:

- HIV/AIDS related information and/or records
- Sexually transmitted diseases

- Mental Health information and/or records
- Drug/alcohol diagnosis, treatment or referral information

SIGNATURE: _____

DATE: _____
(Patient or legal representative)

(I understand that this authorization will expire one (1) year from the date of signature below.)

RIGHT TO REVOKE AUTHORIZATION:

I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING TO THE PRACTICE, BEFORE THE INFORMATIN HAS BEEN RELEASED, I FUTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST.

Authorization Copy Received: Yes No

SIGNATURE:

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Date: _____

Patient Signature: _____

Parent, Guardian or Legal Representative Signature: _____

Printed Name of Parent, Guardian or Legal Representative: _____

Relationship to Patient: _____

Legal Representative's Authority to Act for Patient (Power of Attorney, Healthcare Surrogate, etc): _____

Witness Signature: _____

(I understand that this authorization will expire one (1) year from the date of signature below.)

COPYING COSTS:

THE CHARGE FOR COPYING COSTS FOR THE MEDICAL RECORDS IS ONE DOLLAR (\$1.00) PER PAGE UP TO TWENTY-FIVE (25) PAGES AND TWENTY-FIVE CENTS (\$.25) FOR EACH PAGE THEREAFTER. PLEASE ALLOW SEVEN (7) TO TEN (10) BUSINESS DAYS FOR RECORDS TO BE COPIED.



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Notice of Privacy Practices

At North Florida Pain Center, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective October 1, 2013, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information: A record of your visit is made each time you visit North Florida Pain Center. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others. You have a right to receive notification of breaches of unsecured protected health information.

Your Health Information Rights: Although your health record is the physical property of North Florida Pain Center, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528, request communications of your health information by alternative means or at alternative locations, request a restriction of PHI regarding care and services you pay for out-of-pocket. Requests must be in writing and the provider will adhere to your request.
- Request a copy of your health record in an electronic format if applicable,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities: North Florida Pain Center is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you following a breach of unsecured PHI,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Required Authorization: A written authorization is required from you for:

- Disclosure of psychotherapy notes
- Use of Protected Health information (PHI) in marketing
- Sales of PHI

For More Information or to Report a Problem: If you have any questions and would like additional information, you may contact the Practice's Compliance/Privacy Officer, Laura Stuckey, at (904) 317-5069

If you believe your privacy rights have been violated, you can file a complaint with the Practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

The address for the OCR is: *Office for Civil Rights*, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201.

Examples of Disclosures for Treatment, Payment and Health Operations:

We will use your health information for treatment. For example, information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his other expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this healthcare facility.

We will use your health information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations. For example, members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication from Offices: We may call your home or other designated location and leave a message on voice mail or in person in reference to any items that assist the Practice in carrying our TPO, such as appointment reminders, insurance items and any call pertaining to my clinical car. We may mail to your home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. We may e-mail to your home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Open Treatment Areas: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, some patient information may be overheard by others while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our privacy officer.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy for your health information.

Coroners, Medical Examiners, and Funeral directors: We may disclose health information to funeral director consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You have the right to opt out by notifying us in writing.

Fundraising: We may contact you as part of fundraising effort. You have the right to opt out of such communications.

Sale of your PHI: We may not "sell" your PHI to a third party without your written authorization that acknowledges the remuneration unless such an exchange meets a regulatory exception.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Health Oversight Activities: Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Deceased Individuals: In the unfortunate event of your death, we are permitted to disclose your PHI to your personal representative and your family members and others who were involved in the care or payment for your care prior to your death, unless inconsistent with any prior expressed preference that you provided to us.



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By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of North Florida Pain Center. Our Notice provides information about how we may use and disclose the medical information that we maintain about you.

If you have any questions about our *Notice of Privacy Practices* that our registration staff cannot answer, please contact our Privacy Office at (904) 317-5069.

ACKNOWLEDGEMENT OF RECEIPT: I acknowledge receipt of the *Notice of Privacy Practices* of North Florida Pain Center.

Signature: _____
Patient, Parent or Personal Representative

Date: _____

For Office Use Only

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient but it could not be obtained for the following reason:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (provide specific details): _____

Employee Signature

Date

Name(s) of others authorized to discuss or request medical information:

_____	_____
_____	_____
_____	_____



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Terms and Conditions

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for the services and procedures rendered **at North Florida Pain Center**. I am responsible for any applicable deductive or co-payments prior to the provision of services. For surgery and pregnancy, **North Florida Pain Center** will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, procedure or pregnancy, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment.

North Florida Pain Center may file a claim for payment with insurance company as required by contractual agreement. If the insurance company fails to pay in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to **North Florida Pain Center**. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay for all costs of collection, including a reasonable attorney's fee.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is **my responsibility** to provide **North Florida Pain Center** with a copy of my current insurance card and **to obtain a referral** from my Primary Care Physician (if required by my insurance). **North Florida Pain Center** is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. **I will notify North Florida Pain Center immediately upon any change in my insurance.**

INSURANCE WAIVER and NON-COVERED SERVICES WAIVER

I understand that if I do not have a copy of a current insurance card and a valid referral, if required, **North Florida Pain Center** is not obligated to see me, but if I still wish to be seen, I can be seen as a "Private Pay" patient. I agree that neither **North Florida Pain Center** nor I will file a claim for the visit. I will be required to pay the total cost of the visit in advance.

In addition, there may be a service I desire, suggested or provided that is not covered under my insurance plan ("Non-Covered Services"); I understand I must pay for the "Non-Covered" services, if feasible a waiver will be completed for each "Private Pay" visit or "Non-Covered Service."

ANNUAL EXAMS (Including Medicare Annual Visits)

Annual and "well-women" exams are preventive visits and may not be paid for by all insurance carriers. Medicare pays 100% of a "wellness visit" once every 12 months. I understand I am responsible for payment, if the exam or portion of the exam is not covered by my insurance.

Annual exams do not typically include problems I may be having- as problem visits may require longer time. If I am experiencing problems, the office may be required to reschedule another visit to address these concerns.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patient, directly to **North Florida Pain Center**. I hereby authorize **North Florida Pain Center** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.



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ADDITIONAL INFORMATION

North Florida Pain Center accepts payments in: Cash, Check and Credit Cards.

I understand additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I may also be charged if I do not cancel my appointment, for telephone management services, for educational materials and for other administrative expenses not covered by my insurance plan.

In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to North Florida Pain Center.

MEDICARE LIFETIME BENEFITS (if applicable)

I request that payment of authorized Medicare benefits be made on my behalf for services furnished to me by North Florida Pain Center. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration (HCFA) and/or its agent's information needed to determine these benefits for related services. I request that payment of authorized insurance/Medicare benefits be made on my behalf to North Florida Pain Center for any services for me by a physician or supplier I authorize any holder of medical information about me to release to any of my insurance companies any information needed to determine these benefits payable for related services.

I hereby authorize payment directly to North Florida Pain Center of benefits otherwise payable to me. I understand and agree that any unpaid balances not covered by my medical policy will be payable by me. This includes coverage denied as a result of pre-existing conditions.

I permit a copy of this authorization to be used in place of the original.

Patient Signature: _____

Parent, Guardian or Legal Representative Signature: _____

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Date: _____

Patient Signature: _____

Parent, Guardian or Legal Representative Signature: _____

Employee's signature who reviewed intake of form: _____



NORTH FLORIDA
 PAIN CENTER
 5851 Timuquana Road Suite 401
 Jacksonville, Florida 32210
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E-mail Consent Form

Patient Name: _____

E-Mail Address: _____

Date of Birth: _____

Phone Number: _____

North Florida Pain Center offers our patients the opportunity to communicate by e-mail. This form provides information about the risks of e-mail, guidelines for e-mail communication and how we will use e-mail communication. It also will be used to document our consent for us to communicate with you by e-mail.

RISKS

Communication by e-mail has a number of risks which include, but are not limited to, the following:

- E-mail can be circulated, forwarded and stored in paper and electronic files.
- Backup copies of e-mail may exist even after the sender or recipient has deleted his/her copy.
- E-mail can be received by unintended recipients.
- E-mail can be intercepted, altered, or forwarded or used without authorization or detection.
- E-mail senders can easily type in the wrong e-mail address.
- E-mail can be used to introduce viruses into computer systems.

HOW WE WILL USE E-MAIL

1. We will limit e-mail correspondence to established patients who are adults 18 years or older. Or the legal representatives of established patients.
2. We will use e-mail to communicate with you only about non-sensitive and non-urgent issues such as:
 - Questions about prescriptions, use of glasses or contact lenses, etc.
 - Routine follow-up questions,
 - Appointment scheduling, and/or
 - Billing questions
3. All e-mails to or from you will be made a part of your medical record. You will have the same right of access to such e-mails as you do to the remainder of your medical file.

4. Your e-mail messages may be forwarded to another office staff member as necessary for appropriate handling.
5. The Notice of Privacy Practices may be provided via e-mail.
6. We will not disclose your e-mails to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted use of your health information and your rights regarding privacy matters.

IN A MEDICAL EMERGENCY, DO NOT USE E-MAIL... CALL 911. Also do not use e-mail for urgent problems. If you have an urgent problem, call our office or go to an urgent care facility.

GUIDELINES FOR E-MAIL COMMUNICATION

1. Include the general topic of the message in the "subject" line of your e-mail. For example, "advice," "prescription," "appointment" or "billing question."
2. The e-mail message should not be time-sensitive. While we try to respond to e-mail messages daily, it may take up to three (3) working days for us to respond to your message. Urgent messages or needs should be relayed to us using regular telephone communication.
3. Include your name and phone number in the body of the message.
4. Review your message to make sure it is clear and that all relevant information is included before sending.
5. Send us an e-mail confirming receipt of our message after you have received and read an e-mail message from us.
6. If your e-mail requires a response from us, and you have not heard back from us within three (3) working days, call our office to follow-up to determine if we received your e-mail.
7. Take precautions to protect the confidentiality of e-mail, such as safeguarding your computer password and using screen savers.
8. Inform us of any changes in your e-mail address.

CONSENT

I, _____
(Print name)

am:

- _____ a) an established patient of North Florida Pain Center.
- _____ b) the parent/legal guardian of an established Patient,

(Print patient's name)

I may want to communicate with North Florida Pain Center and the office staff by e-mail. I understand the risks of communicating by e-mail, in particular the privacy risks explained in this form, I understand that North Florida Pain Center cannot guarantee the security and confidentiality of e-mail communication. North Florida Pain Center will not be responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct.

I understand that I may also communicate with North Florida Pain Center by telephone or during a scheduled appointment, and that e-mail is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or any sensitive medical information.

I understand that either I or North Florida Pain Center may stop using e-mail as a means of communication upon my written request.

I understand that I may revoke this consent at any time by so North Florida Pain Center in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail communications to and from North Florida Pain Center and or

(Name of provider)

(Print name)

(Signature)

(Date)

****Keep the original or top copy in the patient's medical record and give the patient a cop for his/her reference.***



NORTH FLORIDA
PAIN CENTER
Jeffrey Caudill, MD

Patient Name:

DOB:

Musculoskeletal

Joint pain Yes No

Joint swelling Yes No

Muscle cramps Yes No

Psychology

Serious depression Yes No

Sleep disturbances Yes No

Suicidal ideation Yes No

Constitutional

Weight gain Yes No

Loss of appetite Yes No

Weakness Yes No

Insomnia Yes No

ENT

Cold Yes No

Cough Yes No

Cardiology

Chest pain (angina) Yes No

Irregular heartbeats (palpitations) Yes No

Shortness of breath Yes No

Gastroenterology

Diarrhea Yes No

Vomiting Yes No

Constipation Yes No

Nausea Yes No

Heartburn Yes No



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Jeffrey Caudill, MD

Patient Name:

DOB:

Endocrinology

Fatigue Yes No

Cold Intolerance Yes No

Heat Intolerance Yes No

Neurology

Headache Yes No

Seizures Yes No

Memory Loss Yes No

Weakness in Arms Yes No

Weakness in Legs Yes No

Respiratory

Shortness of Breath Yes No

Excessive Sputum Yes No

Cough Yes No

HEENT

Change in vision Yes No

Social History

Occupation Yes No

Alcohol Yes No

Smoking Yes No

Recreational drug use Yes No

Exercise Yes No

Children Yes No



NORTH FLORIDA
PAIN CENTER
Jeffrey Caudill, MD

Patient Name:

DOB:

Past Medical History

Depression	<input type="radio"/> Yes	<input type="radio"/> No
Migraine headache	<input type="radio"/> Yes	<input type="radio"/> No
Knee pain	<input type="radio"/> Yes	<input type="radio"/> No
Low back pain	<input type="radio"/> Yes	<input type="radio"/> No
Insomnia	<input type="radio"/> Yes	<input type="radio"/> No
Carpal tunnel	<input type="radio"/> Yes	<input type="radio"/> No
Obesity	<input type="radio"/> Yes	<input type="radio"/> No
Trigeminal neuralgia	<input type="radio"/> Yes	<input type="radio"/> No
Hormone replacement therapy	<input type="radio"/> Yes	<input type="radio"/> No
Hepatitis C	<input type="radio"/> Yes	<input type="radio"/> No
Hepatitis B	<input type="radio"/> Yes	<input type="radio"/> No
Tennis elbow	<input type="radio"/> Yes	<input type="radio"/> No
Irritable bowel syndrome	<input type="radio"/> Yes	<input type="radio"/> No
Pain	<input type="radio"/> Yes	<input type="radio"/> No
Lumbar Degenerative Disc Disease	<input type="radio"/> Yes	<input type="radio"/> No
Lumbar Radiculopathy	<input type="radio"/> Yes	<input type="radio"/> No
Cervical Spine Fusion	<input type="radio"/> Yes	<input type="radio"/> No
Osteoarthritis	<input type="radio"/> Yes	<input type="radio"/> No
Drug abuse	<input type="radio"/> Yes	<input type="radio"/> No

NAME : _____

DOB : _____



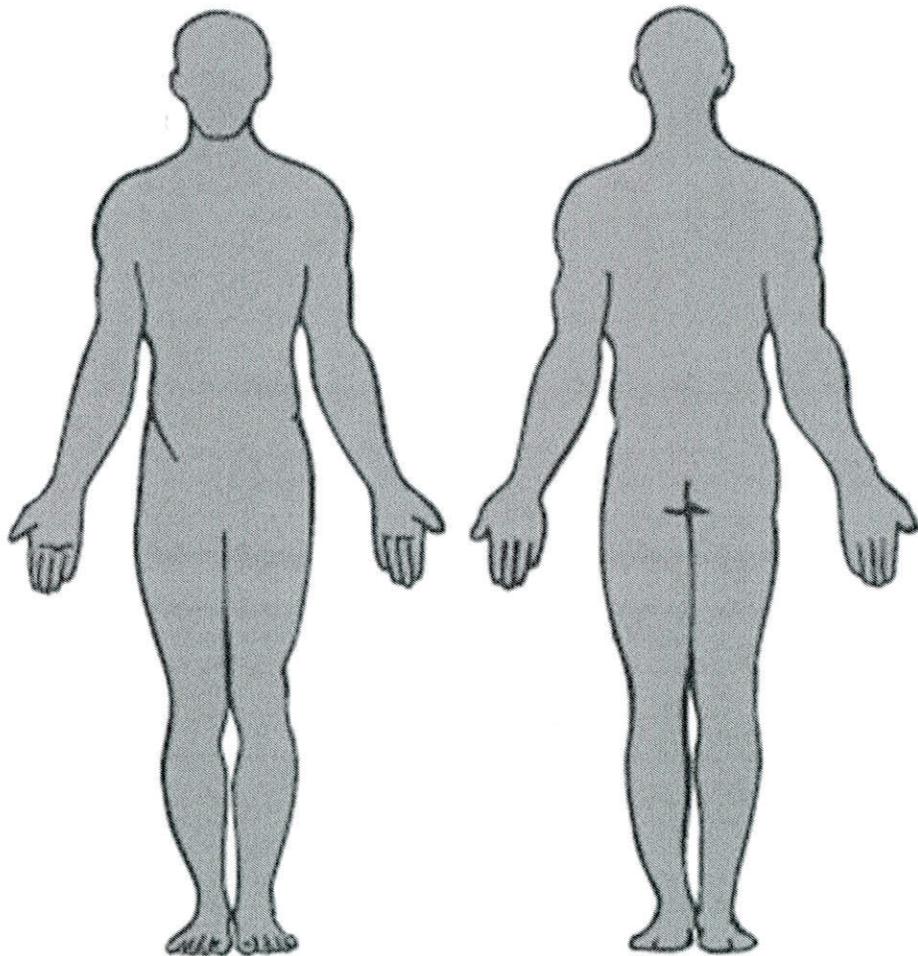
NORTH FLORIDA PAIN CENTER

Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark The drawings on the right side of the neck, etc). Please indicate which sensations you feel by referring to the key below.

Please print and bring with you to your appointment.

- Right Handed
- Left Handed

KEY	
////	Stabbing
XXXX	Burning
0000	Pins & Needles
=====	Numbness
++++	Aching
PAIN LEVEL	
0	No pain
1	Mild pain; you are aware of it but it doesn't bother you.
2	Moderate pain that you can tolerate without medication.
3	Moderate pain that requires medication to tolerate.
4	More severe pain; you begin to feel antisocial.
5	Severe Pain
6	Intensely severe pain.



CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10