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 .

ASSIST screening tool

Patient name: _____

Date of birth: _____

The ASSIST is designed to be administered by a health professional as part of a verbal interview with an adult patient. Alternatively, it can be self-administered electronically, using automatic skip patterns based on patient answers.

The ASSIST can be modified based on which substances are screened for and what language is used to describe these substances. This version screens for non-medical drug use only, and uses language that defines misuse of three types of prescription drugs.

Sample introductory text to read to patient: "Thank you for agreeing to take part in this brief interview about recreational drug use. I am going to ask some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills."

Question 1

In your life, which of the following substances have you ever used?	No	Yes
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
b. Cocaine (coke, crack, etc.)	0	3
c. Prescription stimulants just for the feeling, more than prescribed, or that were not prescribed for you? (Ritalin, Adderall, diet pills, etc.)	0	3
d. Methamphetamine (meth, crystal, speed, ecstasy, molly, etc.)	0	3
e. Inhalants (nitrous, glue, paint thinner, poppers, whippets, etc.)	0	3
f. Sedatives just for the feeling, more than prescribed, or that were not prescribed for you? (sleeping pills, Valium, Xanax, tranquilizers, benzos, etc.)	0	3
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3
h. Street opioids (heroin, opium, etc.)	0	3
i. Prescription opioids just for the feeling, more than prescribed, or that were not prescribed for you? (Fentanyl, Oxycodone, OxyContin, Percocet, Vicodin, methadone, Buprenorphine, etc.)	0	3
j. Any other drugs to get high? Specify:	0	3

Patients who answer "no" to all questions, or who do not provide any answers, are done. Patients who answer "yes" to any question should proceed to Question 2.

Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

☐ methamphetamines (speed, crystal)
☐ cannabis (marijuana, pot)
☐ inhalants (paint thinner, aerosol, glue)
☐ tranquilizers (valium)
☐ cocaine
☐ narcotics (heroin, oxycodone, methadone, etc.)
☐ hallucinogens (LSD, mushrooms)
☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

I	II	III	IV
0	1-2	3-5	6+

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(Please Print)

Date _____ Referred by_____

Patient's Name_____

Address _____

City _____ State _____ Zip _____

Phone # _____ Cell#_____

Birthdate _____ Sex_____ SS#_____

Email: _____

o Married o Single o Divorced o Separated o 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.

- o ASPIRIN THERAPY
- o PLAVIX / CLOPIDOGREL BISULFATE
- o AGGRENOX/ASPIRIN - DIPYRIDAMOLE
- o COUMADIN / WARFARIN
- o LOVENOX / ENOXAPARIN
- o 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 ($0.25) 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 your 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 form 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, ma 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 ma 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 your to provide appointment reminders of information about treatment alternatives r other health0related benefits and services that may be of interest to you. You have the right to opt0out 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 singing 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 responsive to pay the amount of all charges incurred for the services and procedures rendered **at North Florida Pain Center.** I am responsible for nay 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.

RESPONSIBLIITY 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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ADDITONAL 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

Patient Name:
DOB:

Musculoskeletal		
Joint pain	O Yes	O No
Joint swelling	O Yes	O No
Muscle cramps	O Yes	O No
Psychology		
Serious depression	O Yes	O No
Sleep disturbances	O Yes	O No
Suicidal ideation	O Yes	O No
Constitutional		
Weight gain	O Yes	O No
Loss of appetite	O Yes	O No
Weakness	O Yes	O No
Insomnia	O Yes	O No
ENT		
Cold	O Yes	O No
Cough	O Yes	O No
Cardiology		
Chest pain (angina)	O Yes	O No
Irregular heartbeats (palpitations)	O Yes	O No
Shortness of breath	O Yes	O No
Gastroenterology		
Diarrhea	O Yes	O No
Vomiting	O Yes	O No
Constipation	O Yes	O No
Nausea	O Yes	O No
Heartburn	O Yes	O No

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Patient Name:
DOB:

Endocrinology		
Fatigue	O Yes	O No
Cold Intolerance	O Yes	O No
Heat Intolerance	O Yes	O No
Neurology		
Headache	O Yes	O No
Seizures	O Yes	O No
Memory Loss	O Yes	O No
Weakness in Arms	O Yes	O No
Weakness in Legs	O Yes	O No
Respiratory		
Shortness of Breath	O Yes	O No
Excessive Sputum	O Yes	O No
Cough	O Yes	O No
HEENT		
Change in vision	O Yes	O No
Social History		
Occupation	O Yes	O No
Alcohol	O Yes	O No
Smoking	O Yes	O No
Recreational drug use	O Yes	O No
Exercise	O Yes	O No
Children	O Yes	O No

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Patient Name:
DOB:

Past Medical History

Depression	O Yes	O No
Migraine headache	O Yes	O No
Knee pain	O Yes	O No
Low back pain	O Yes	O No
Insomnia	O Yes	O No
Carpal tunnel	O Yes	O No
Obesity	O Yes	O No
Trigeminal neuralgia	O Yes	O No
Hormone replacement therapy	O Yes	O No
Hepatitis C	O Yes	O No
Hepatitis B	O Yes	O No
Tennis elbow	O Yes	O No
Irritable bowel syndrome	O Yes	O No
Pain	O Yes	O No
Lumbar Degenerative Disc Disease	O Yes	O No
Lumbar Radiculopathy	O Yes	O No
Cervical Spine Fusion	O Yes	O No
Osteoarthritis	O Yes	O No
Drug abuse	O Yes	O 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.

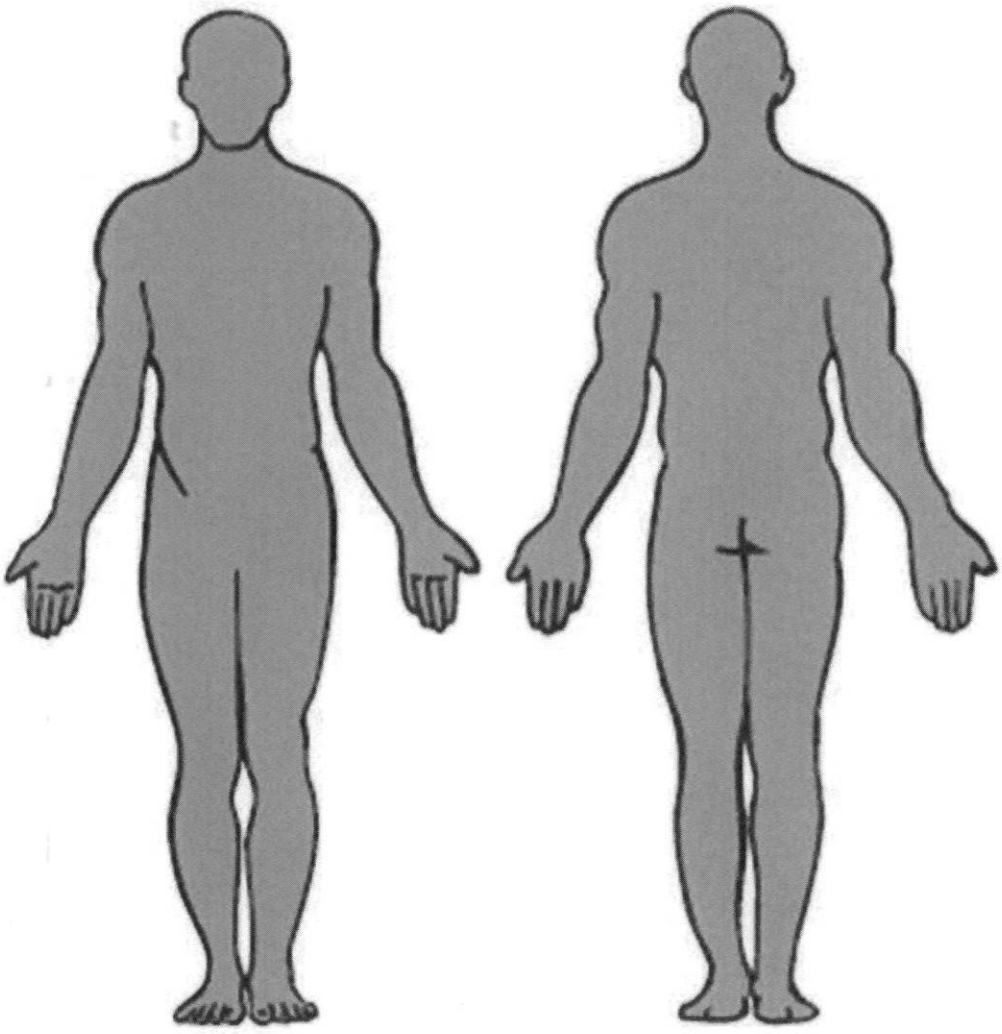
Please print and bring with you to your appointment.

☐ 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