FPC
Florida Pain Care

Patient Registration Form

Last Name:	**First Name:** **M.I.:**		**Preferred Name:**
Mailing Address:			
City/State/Zip:			
Preferred phone:	❑ home ❑ mobile		**Please circle:** Male or Female
Date of Birth:	**Age:**	**Social Security #:**	
Marital Status:	**Email address:**		
Emergency Contact Name:		**Emergency Contact Phone #:**	
Relationship:			
Primary Care Doctor:		**Preferred pharmacy name:**	
Referring Physician (if different from primary):		**Pharmacy Location**	
		Pharmacy phone number:	

Race (please circle one):

White Black or African American American Indian Hispanic
Asian Hawaiian or Pacific Islander Other Decline

Ethnicity (please circle one):

Hispanic or Latino Not Hispanic or Latino Other

Primary Ins. Co. Name	**Policy Holder ID#**
Secondary Ins. Co. Name	**Policy Holder ID#**

I certify that I have read and agree to Florida Pain Care's (FPC) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to FPC all money to which I am entitled for medical expenses related to the services performed from time to time by FPC, but not to exceed my indebtedness to FPC. I authorize FPC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to received communications from FPC by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to FPC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. **I have read and agree to Florida Pain Care's Payment Policy _____ (initials)**

Printed Name or Responsible Party _____ Date _____

Signature _____ Date _____

Main Reason for Visit: ❑ **Back Pain** ❑ **Neck Pain** ❑ **Knee Pain** ❑ **Shoulder Pain**

❑ **Other _____**

Have you had: ❑ Back Surgery ❑ Neck Surgery ❑ Knee Surgery Date of surgery?_____

When did your symptoms start? (Date) _____

What caused your symptoms? ❑ Unknown ❑ Fall ❑ Lifting ❑ Other_____

How did symptoms occur? ❑ Gradually ❑ Suddenly

Describe your level of pain? ❑ Mild ❑ Moderate ❑ Severe

Pain Score (0-10): 0 1 2 3 4 5 6 7 8 9 10

How does your pain feel? ❑ Dull ❑ Sharp ❑ Burn ❑ Achy ❑ Throb ❑ Stabbing ❑ Other _____

Does your pain refer to other areas? ❑ Yes ❑ No if "YES", then where _____

Associated symptoms:

Do you have *Numbness*? ❑ Yes ❑ No *Please explain* _____

Do you have *Tingling*? ❑ Yes ❑ No *Please explain* _____

Do you have *Weakness*? ❑ Yes ❑ No *Please explain* _____

Do you have *symptoms at night*? ❑ Yes ❑ No *Please explain* _____

Do you have problems *Urinating*? ❑ Yes ❑ No *Please explain* _____

Do you have problems with *Bowel Function*? ❑ Yes ❑ No *Please explain* _____

Do you have *Sexual Dysfunction*? ❑ Yes ❑ No *Please explain* _____

What makes your symptoms worse?

❑ Sitting ❑ Standing ❑ Walking ❑ Lying Down ❑ Lifting ❑ Bending

❑ Twisting ❑ Coughing ❑ Driving ❑ Other _____

What improves your symptoms?

❑ Rest ❑ Massage ❑ Acupuncture ❑ Chiropractic ❑ Ice ❑ Heat

❑ Injections ❑ Supplement ❑ Brace/Cane ❑ Medication; which medication? _____

❑ Other _____

Do you have problems with? ❑ Walking ❑ Toileting ❑ Dressing ❑ Getting Up

What tests have you had for this problem? ❑ MRI ❑ CAT Scan ❑ X-Ray

❑ EMG/Nerve Conduction ❑ Bone Scan ❑ Other _____

Your Past Medical History: please circle any of the problems you have experienced.

Diabetes	Chrohns/Ulcerative Colitis	Hemoglobin HC	Pace Maker
Acid Reflux	COPD	High Blood Pressure	Rheumatoid Arthritis/Lupus
Anxiety	Depression	HIV/AIDS	Seizures
Asthma	Gastric Band/Bypass	Hypothyroid/Hyperthyroid	Stroke
Atrial Fibrillation	Glaucoma	Kidney Disease	Tuberculosis
Bipolar / Schizophrenia	Headache	Kidney Stones	Ulcers
Burning Feet	Heart Attack	Liver Disease	Vascular Disease
Cancer _____	Heart Disease	Multiple Sclerosis	

What integrative treatments interest you?

Back Brace	Tens (Muscle Stimulation)	MSM	Yoga
Inversion Table	Glucosamine	Turmeric	Acupuncture
Knee Brace	CBD	Meditation	Chiropractic
Lumbar or Cervical Traction	Magnesium	Pilates	Massage
Sleep Supplements	Medical Marijuana	Tai Chi	Weight Loss

Medication List: ***(please list all medications currently prescribed and supplements)***

Medication	Dosage	Condition

Allergies:

_____

Past Surgical History:

Surgery	Date

Social History: ***check all that apply***

❑ Single ❑ Married ❑ Living with another person ❑ Widowed ❑ Children

❑ Drinking alcohol ❑ > 3 drinks per day ❑ Smoke ❑ Smoke Marijuana ❑ Street Drugs

❑ Working ❑ Retired ❑ Unemployed ❑ Occupation: _____

Family History: ***check all that apply***

❑ Heart Disease ❑ Hypertension ❑ Stroke ❑ Diabetes ❑ Rheumatoid Arthritis ❑ Asthma

❑ Cancer _____ ❑ Alcoholism ❑ Mental Illness ❑ Bleeding Disorders ❑ Back Pain

Review of Systems: PLEASE CHECK ALL THAT APPLY

General: ❑ No problems ❑ weight loss ❑ chills ❑fever

Allergy: ❑ No problems ❑ itching ❑ rash ❑ seasonal allergy

Eye/Ophtho.: ❑ No problems ❑ blurry vision ❑ dry eyes ❑ macular degeneration ❑ glaucoma

Endocrine: ❑ No problems ❑ nipple discharge ❑ cold intolerance ❑ excessive thirst ❑heat intolerance

Respiratory: ❑ No problems ❑ shortness of breath ❑ cough ❑ wheezing

Cardiovascular: ❑ No problems ❑ chest pain ❑ chest pain w/ exercise ❑ palpitations

Gastrointestinal: ❑ No problems ❑ constipation ❑ abdominal pain ❑ blood in stool ❑ nausea ❑ vomiting

Hematology: ❑ No problems ❑ bleeding problems ❑easy bruising ❑ fever

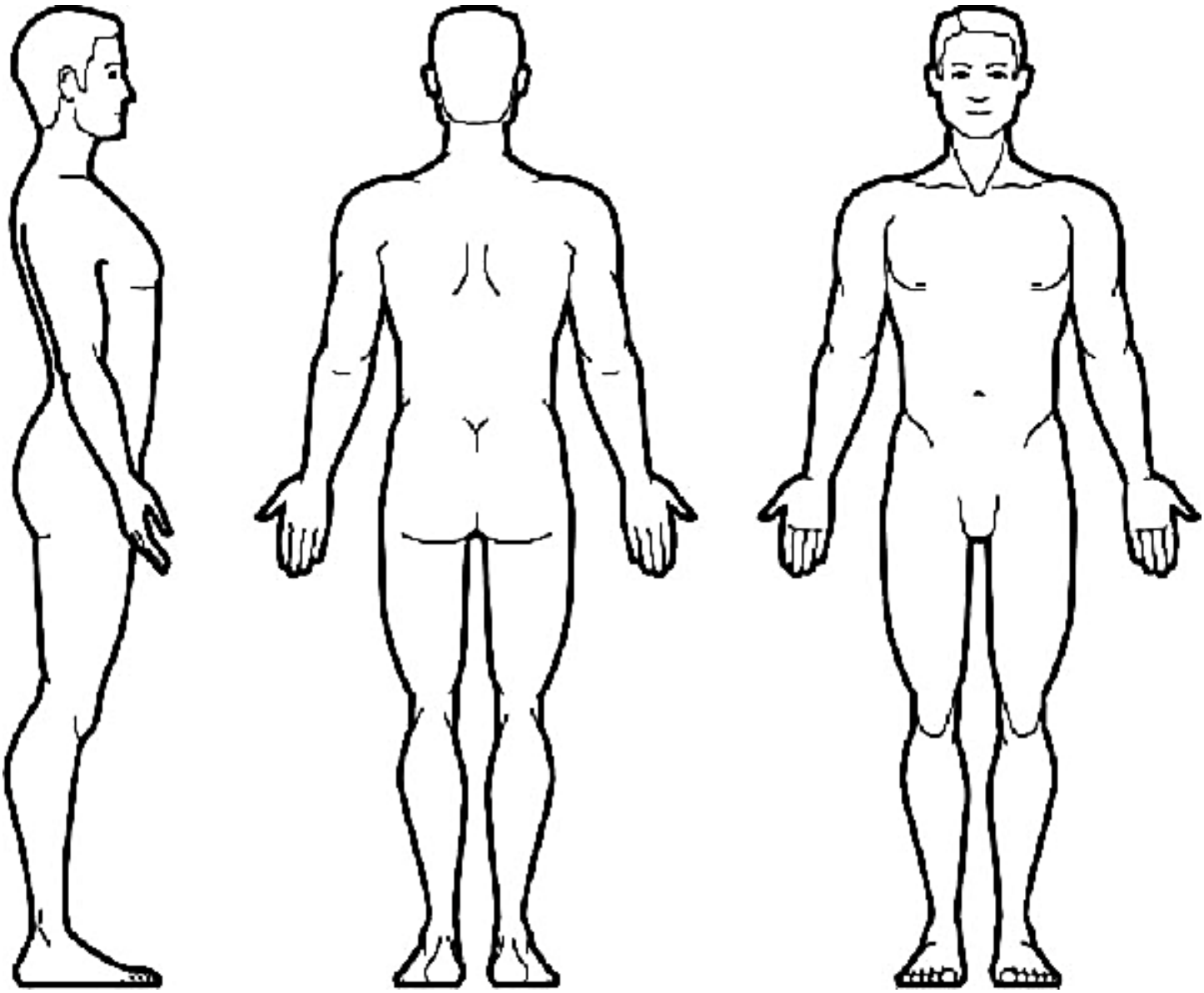
Musculoskeletal: ❑ No problems ❑ joint stiffness ❑ muscle cramps ❑ back problems ❑ painful joints

Skin: ❑ No problems ❑ dry skin ❑ itching ❑ rash ❑ skin cancer

Neurologic: ❑ No problems ❑ headache ❑ memory loss ❑seizures ❑ stroke

Psychiatric: ❑ No problems ❑ irritable ❑anxiety ❑depressed mood ❑ difficulty sleeping

Where is your pain located? Please mark on the graphic below.



IF YOU ARE UNABLE TO USE THE IMAGE ABOVE TO INDICATE WHERE YOUR PAIN IS LOCATED, PLEASE TYPE IN THE SPACE PROVIDED BELOW:

PATIENT HEALTH QUESTION QUESTIONNAIRE

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "x" to indicate your answer)

		Not at all	Several Days	More than half the days	Nearly every day
1)	Little interest or pleasure in doing things	❑ 0	❑ 1	❑ 2	❑ 3
2)	Feeling down, depressed, or hopeless	❑ 0	❑ 1	❑ 2	❑ 3
3)	Trouble falling or staying asleep, or sleeping to much	❑ 0	❑ 1	❑ 2	❑ 3
4)	Feeling tired or having little energy	❑ 0	❑ 1	❑ 2	❑ 3
5)	Poor appetite or overeating	❑ 0	❑ 1	❑ 2	❑ 3
6)	Feeling bad about yourself or that you are a failure or have let yourself or your family down	❑ 0	❑ 1	❑ 2	❑ 3
7)	Trouble concentrating on things, such as reading the newspaper or watching television	❑ 0	❑ 1	❑ 2	❑ 3
8)	Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	❑ 0	❑ 1	❑ 2	❑ 3
9)	Thoughts that you would be better off dead or of hurting yourself in some way	❑ 0	❑ 1	❑ 2	❑ 3
			____ +	____ +	____

Total Score: _____

Interpretation

- ❑ Minimal Depression [01 – 04]
- ❑ Mild Depression [05 – 09]
- ❑ Moderate Depression [10 – 14]
- ❑ Moderately Severe Depression [15 – 19]
- ❑ Severe Depression [20 – 27]

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

***

Patient's Name: _____

DOB: ___/___/___ Phone Number: _____

I authorize the release of my medical records to Florida Pain Care for review and continuation of my medical care. I authorize the following physician offices, clinics, legal offices, diagnostic centers, and medical providers to provide copies of my health records to:

FLORIDA PAIN CARE: (FAX) 352-708-3050

Persons/Organizations sending:

Physician Name	Address	Fax Number

HOSPITAL/OTHER FACILITIES: Please send the following;
❑ Procedure log ❑ last office note ❑ all radiology imaging.

_____

Restrictions: _____ there are NO restrictions to the information that can be released
_____ the following information CAN NOT be released:

_____

_____ from the date of this Authorization until ___/___/___
_____ until the provider fulfills this authorization request
_____ until the following event occurs: _____

_____
PATIENT/GUARDIAN PRINTED NAME

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

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PATIENT PERSONAL HEALTH INFORMATION CONSENT FORM

Use and disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Florida Pain Care originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Florida Pain Care *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of the *Notice of Privacy Practices* and acknowledge that I have reviewed the notice prior to signing this consent. I understand that the Florida Pain Care reserves the right to change the *Notice of Privacy Practice at any time, and I as a patient have the right to review changes at any time*. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or healthcare operations and that the Florida Pain Care is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the Florida Pain Care has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and/or disclosure of my personal health information.

_____

_____

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have reviewed Florida Pain Care Notice *of Privacy Practices*

I acknowledge that I may request a copy of Florida Pain Care Notice of Privacy Practice at any time.

_____

PRINT NAME OF PATIENT OR LEGAL REPRESENTATIVE

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

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HIPAA Compliance Patient Consent Form

***

Our Notice of Privacy provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we hall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserve the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information but the practice does not have to agree to those restrictions.
- The patient had the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on you cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

_____ _____
SIGNATURE DATE

_____ _____
WITNESS DATE

FPC
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Florida Pain Care, PLLC
Statement of Patient Rights and Responsibilities

Revised 3-1-2016 Approved by Governing Body

We have adopted the following written policies concerning the rights and responsibilities of all patients;

1. Patients have the right to be treated with dignity and respect at all times.

2. Patients have the right to be protected from discrimination or reprisals in the exercise of their rights; discrimination is against the law. In conformance with anti-discrimination laws and regulations patients may not be denied benefits, or otherwise be discriminated against on the ground of race, color, or national origin, or the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any our programs and activities in accordance with the provisions of Title VI of the Civil Rights Act of 1964. Section 504 of the Rehabilitation Act of 1972, the Age Discrimination Act of 1975, and Regulations of the US Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

3. Patients have the right to personal privacy concerning their own medical care; patients expect that all communications, health information, and records pertaining to their care will be treated as confidential. Case discussion, consultation, examination and treatment are confidential and will be conducted discreetly. Staff not directly involved in patient's care will not be present without the permission of the patient.

4. Patients have the right to be fully informed about a treatment or procedure and the expected outcome before its performed, and to actively participate in decisions regarding medical care and to refuse treatment to the extent permitted by law.

5. Patients have the right to receive information about all treatment choices and options in clear language which is understandable to the patient. Such patient information will be sufficient to allow the patient to give informed consent prior to any procedure or treatment. The patient had the right to ask family members and friends to help in decision making.

6. Patients have the right to leave the facility, even against medical advice.

7. Patients have the right to examine and receive explanation of their bill regardless of source of payment. They also have the right to know fees for specific services.

8. Patients have the right to know what rules and regulations apply to their conduct as a patient and to know provisions for after hours and emergency care.

9. Patients have the right to receive care in safe setting, free from all forms of abuse and/or harassment.

10. Patients have the right to voice grievances or suggestions regarding care that is (or fails to be) furnished verbally or in writing; a grievance form is available from any staff member or the patient may ask to speak directly to the Administrator. Grievances will be addressed in writing **within one week**.