FPC
Florida Pain Care

PATIENT REGISTRATION

(Please Print Clearly)

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Ethnicity/Race:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Home address:		City:	State		
Zip code:	Home Phone: Cell Phone:		Email:		
	Referring Dr.				

Is the reason for your visit the result of an accident? _____ Claim#_____ Claim Adjuster _____

❑Auto Accident ❑Work Comp ❑Other:_____ Date of Injury::_____

INSURANCE INFORMATION

Primary Insurance:	Policy Number:	
Secondary Insurance:	Policy Number:	
Auto/Workers Comp Insurance:	Claim Number:	

IN CASE OF EMERGENCY

Name friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

_____ _____

Patient/Guardian signature *Date*

ATTORNEY INFORMATION

Attorney Name:			
Mailing Address:	City:	Zip code:	Office Number #: ( )
Contact Person:		Fax Number:	

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Initial (New) Outpatient Information Questionnaire

Name: _____ _____ Date: _____
Date of Injury: _____ Referred By: _____
Age: _____ Date of Birth: _____ Handed: □ R □ L □ Ambidextrous □ Male □ Female

****** Mark appropriate squares ☑: (Made add comments in open lines) If you mark "YES" explain on line ******

Main Reason (Complaint) for Today's Visit: (In your own words) _____

_____

Briefly Describe Accident or Development of Present Complaint: _____

_____

_____

_____

Are Symptoms Related to an Accident or Trauma?: □ N/A □ Yes □ No Date: _____

If related to motor vehicle accident:

Were you the driver? ⊖ Yes ⊖ No Were you wearing a seat belt? ⊖ Yes ⊖ No
Were you □ Stopped □ Moving At what speed were you travelling? _____
Were you hit □ Head On □ Driver's Side □ Passenger's Side □ Rear of Vehicle At speed _____MPH
Did you have loss of consciousness? □ Yes □ No If yes, for how long? _____
Was airbag deployed? □ Yes □ No Did you go to the emergency room? □ Yes □ No Hospital: _____

Complaint's Characteristics:

When did symptoms start? (Date) _____ How did symptoms start? □ Gradual □ Sudden
Are symptoms □ Continuous □ Intermittent (Off and On)
Are symptoms □ Mild □ Moderate □ Severe Pain Scale (0-10): _____
Pain characteristic: □ Dull □ Sharp □ Burning □ Tooth-ache like □ Stabbing
□ Pressure Like □ Throbbing □ Other: _____
Does *pain refer* to other areas? □ Yes □ No Where? _____
What makes the symptoms worse? □ N/A □ Sitting □ Standing □ Walking □ Lying Down
□ Lifting □ Bending □ Twisting □ Coughing □ Driving
What makes the symptoms better? _____

Associated Symptoms:

Do you have *Numbness*? □ Yes □ No Where? _____
Do you have *Tingling*? □ Yes □ No Where? _____
Do you have *Weakness*? □ Yes □ No Where? _____
Do you have symptoms at *Night*? □ Yes □ No Where? _____
Do you have problems *Urinating*? □ Yes □ No Explain _____
Do you have *Bowel Function* problems? □ Yes □ No Explain _____
Do you have *Sexual Dysfunction*? □ Yes □ No Explain _____

Are symptoms: □ Increasing □ Decreasing □ Remain about the same
What treatments have you tried? □ Medications □ Physical Therapy □ Chiropractic Care
□ Surgery □ Injections □ Electrical Stimulation □ Braces/Cane □ Acupuncture
□ Other: _____
By whom (or where) have you been treated for this problem? _____
Primary Care Physician: _____ Attorney: _____
Pharmacies used in the last two years (name and city): _____
What tests have you had for this problem? □ Myelogram □ MRI □ CAT Scan
□ Electrodiagnostic Studies □ Bone Scan □ Arthrogram □ X-Ray □ Other: _____

Your Past Medical History: Mark appropriate squares ☑ : (May add comments in open lines)

Diabetes	□ Yes	□ No	On Blood Thinner	□ Yes	□ No
Thyroid Disease	□ Yes	□ No	Kidney Disease	□ Yes	□ No
Arthritis	□ Yes	□ No	HIV / AIDS	□ Yes	□ No
Heart Disease	□ Yes	□ No	Stroke	□ Yes	□ No
High Blood Pressure	□ Yes	□ No	Polio	□ Yes	□ No
Pace Maker	□ Yes	□ No	Lung Disease	□ Yes	□ No
Vascular Disease	□ Yes	□ No	Sleep Apnea	□ Yes	□ No
Cancer	□ Yes	□ No	Depression / Bipolar	□ Yes	□ No
Ulcers	□ Yes	□ No	Schizophrenia	□ Yes	□ No
Liver Disease	□ Yes	□ No	Prior Suicide Attempt	□ Yes	□ No
Glaucoma	□ Yes	□ No	Seizures	□ Yes	□ No
Tuberculosis	□ Yes	□ No	Gastric band/bypass	□ Yes	□ No

□ Other: _____

Do you have a history of substance abuse? □ Yes □ No □ N/A □ Quit When? _____

If history of substance abuse, please explain: When? What substance(s)? For how long? Any Treatments?

_____

Have you ever been denied care or released by any healthcare providers because of violations to their drug policies? □ Yes □ No Where & When? _____

Any history of arrests or convictions due to illegal substances or alcohol issues? ⊖ Yes ⊖ No

How much? _____

_____

List other injuries or accidents in past: _____

_____

_____

List medications tried in the past for this problem:

_____

_____

_____

Hobbies: _____

Your work history: Occupation: _____ Education level / Training: _____

Describe your job: _____

Place of work: _____ Are you still working? ⊖ Yes ⊖ No

Last Worked: (Date) _____ How many hours per week? _____ Any Restrictions? ⊖ Yes ⊖ No

Do you receive? Disability Check ⊖ Yes ⊖ No Worker's Comp Check ⊖ Yes ⊖ No

ROS: Check "☑" for active symptoms or "●" for prior inactive symptoms. Leave blank absent symptoms.

*Fever	□ / O *Short of Breath	□ / O *Weakness	□ / O *Depression	□ / O
Chills	□ / O Cough	□ / O Joint Pain	□ / O Anxiety	□ / O
Weight Loss	□ / O Sputum	□ / O Joint Swelling	□ / O Irritable	□ / O
*Blurred Vision	□ / O *Nausea	□ / O Pain in Back	□ / O Decreased Sleep	□ / O
*Headache	□ / O Vomiting	□ / O Joint Stiffness	□ / O *Night Sweats	□ / O
Hearing Loss	□ / O Blood in Stool	□ / O Muscle Cramps	□ / O Heat Intolerance	□ / O
Hard to Swallow	□ / O Diarrhea	□ / O *Rashes	□ / O Cold Intolerance	□ / O
Nasal Stuffiness	□ / O Stomach Pain	□ / O Nipple Discharge	□ / O *Bruise Easily	□ / O
*Chest Pain	□ / O *Pain when urinating	□ / O *Seizures	□ / O Allergies	□ / O
Palpitations	□ / O Discharge from genitals	□ / O Memory Loss	□ / O *Current Infection	□ / O
*Recent Fractures	□ / O *Other: _____			

Are you pregnant? ⊖ Yes ⊖ No ⊖ Estimated Due Date: _____

Do you have problems with self-care or mobility issues? □ Yes □ No (Mark that apply)

□ Eating □ Bathing □ Toileting □ Dressing □ Getting up from laying or sitting position □ Walking

Patient's Signature: _____ **MD Initials:** _____

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MEDICATIONS: PLEASE LIST ALL MEDICATION CURRENTLY PRESCRIBED OR OVER THE COUNTER			
Medication	**Dosage**	**Prescribing Physician**	**For Which Condition**

PAST SURGICAL HISTORY: Please list any major Surgical Procedures and Dates

_____
_____
_____
_____
_____
_____
_____

ALLERGIES: Drug/Food/Environmental

_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY: Circle All that Apply

Family History of Alcoholism Family History of Drug Addiction Heart Disease Hypertension

Stroke Diabetes Bleeding Disorder Rheumatoid Arthritis Back/Neck Osteoarthritis Asthma
Other: _____

SOCIAL HISTORY: Please answer the following about yourself

Do you Drink Alcohol: If yes #____ drinks per day/week/month
Do you have a history of heavy alcohol use or Alcoholism?

Do you have a history of drug addiction?
Do you use any street drugs? IF yes, what? Marijuana, cocaine, other:_____

Do you Smoke: If yes what? Cigar, Pipes, Cigarettes, e-Cigarettes #_____packs per day

FOR FEMALES OF CHILDBEARING AGE ONLY Many pain medication, X Rays and injections are potentially dangerous to an unborn baby. Is there any chance you may be pregnant? YES NO

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" 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 too 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 hurting yourself	0	1	2	3
	Add columns		+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	Total			

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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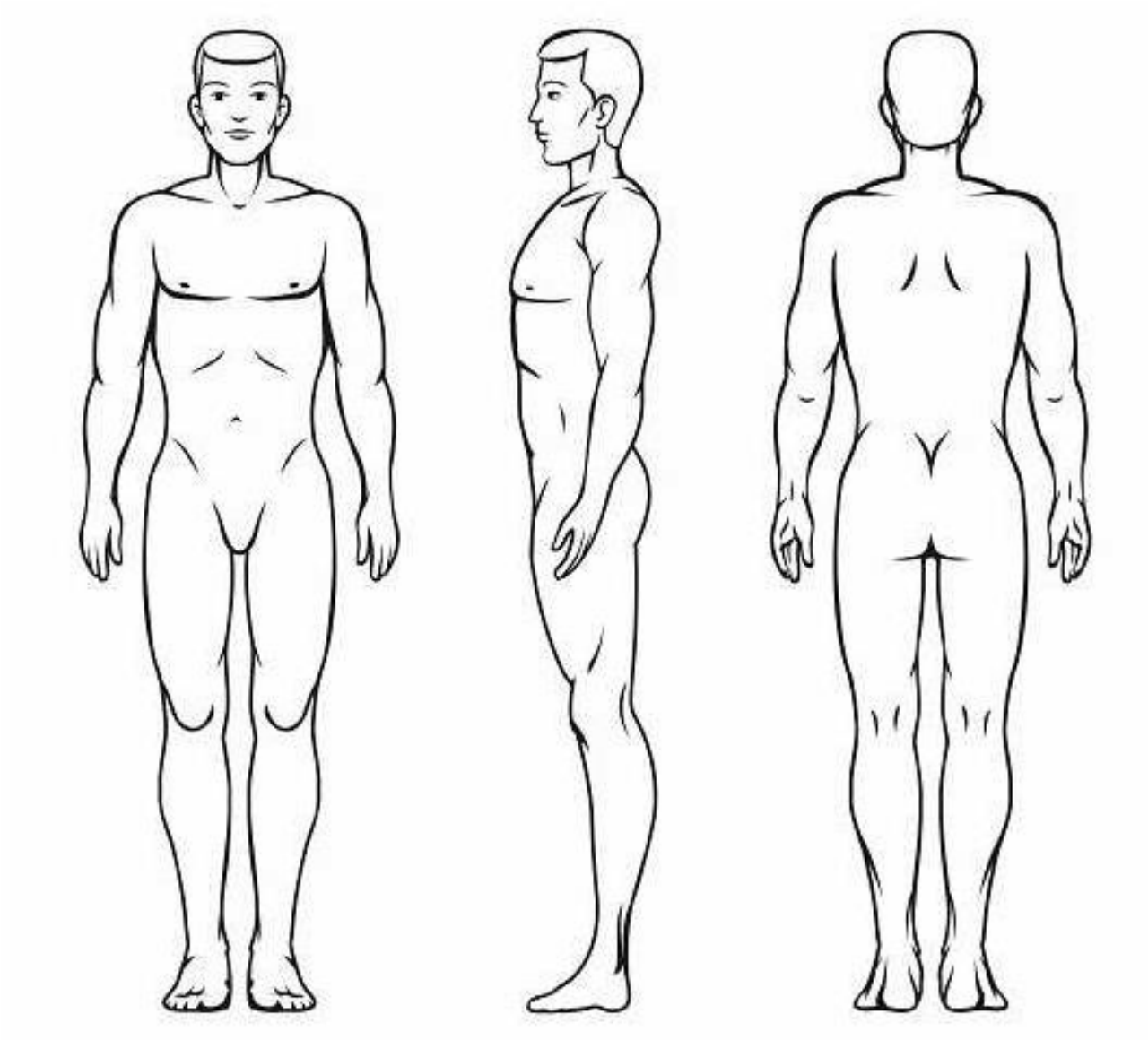
TELL US ABOUT YOUR MOST SIGNIFICANT PROBLEM

How did you hear about us? ☐**Friend** ☐**Internet** ☐**Insurance** ☐**Advertisement** ☐**Other:**_____

Where is your pain located? Please list all that apply

Where is your pain located? Please mark on graphic below



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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#352-835-0673

Persons/Organizations sending:

Physician Name	Address	Fax Number

HOSPITAL/OTHER FACILITIES: Please send the following;
Procedure log, last 3 office notes, 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 fulfill this Authorization request
_____ until the following event occurs: _____

Date:_____/_____/_____Patient/Guardian Signature _____

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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.

Signature of Patient or Legal Representative,_____Date_____

Print Name of Patient or Legal Representative _____

Patient Initials:_____ **Date: / /**

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices 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 shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare 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 reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has 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 your 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: _____

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 1973, 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 has 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 a 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**.

Patient Rights will be extended to a person appointed under State law to act on the patient's behalf.

While we at FPC respect patient rights regarding advance directives, the philosophy of our organization is to provide comprehensive resuscitative care to every patient. We will file a copy of a patient's existing advance directive, upon request, and document such action in a prominent and uniform location in our patient record. We will also provide information to our patients regarding advance directives, if requested to do so.

We credential all providers in this organization and we strive to provide the best possible care. However, the care a patient receives also depends on the patient; therefore, in addition to these rights we have granted above, each patient has certain responsibilities. These responsibilities are outlined below in the spirit of mutual trust and respect.

1. The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, allergies and sensitivities, past medical history, and other matters relation to his/her health, including the use of any medication, over the counter products, dietary supplements, and other chemical substances.

2. The patient is responsible for making it known whether he or she clearly comprehends the course of his or her medical treatment and what is expected of him or her.

3. The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals, as they carry out the physician's order.

4. The patient is responsible to provide a responsible adult to provide transport and to act as a caregiver for 24 hours, if required by the physician.

5. The patient is responsible for keeping appointments and for notifying this organization when unable to do so.

6. The patient is responsible for his or her actions should he or she refuse treatment or not follow medical advice.

7. The patient is responsible for assuring that the financial obligations of his or her care are fulfilled as promptly as possible.

8. The patient is responsible for following facility policies and procedures and for notifying the facility regarding any living wills or advance directives which may affect his or her care.

9. The patient is responsible for being considerate of the rights of other patients and our personnel.

10. The patient is responsible for being respectful of his or her personal property and that of other persons in the facility.

Patient rights and responsibilities apply also to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

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