



## Patient Registration Form

<b>Last Name:</b>	<b>First Name:</b>	<b>M.I.:</b>	<b>Preferred Name:</b>
<b>Mailing Address:</b>			
<b>City/State/Zip:</b>			
<b>Preferred phone:</b>	<input type="checkbox"/> home <input type="checkbox"/> mobile	<b>Please circle:</b> Male or Female	
<b>Date of Birth:</b>	<b>Age:</b>	<b>Social Security #:</b>	
<b>Marital Status:</b>	<b>Email address:</b>		
<b>Emergency Contact Name:</b>		<b>Emergency Contact Phone #:</b>	
<b>Relationship:</b>			
<b>Primary Care Doctor:</b>		<b>Preferred pharmacy name:</b>	
<b>Referring Physician (if different from primary):</b>		<b>Pharmacy Location</b>	
		<b>Pharmacy phone number:</b>	
<b>Race (please circle one):</b>			
White	Black or African American	American Indian	Hispanic
Asian	Hawaiian or Pacific Islander	Other	Decline
<b>Ethnicity (please circle one):</b>			
Hispanic or Latino	Not Hispanic or Latino	Other	
<b>Primary Ins. Co. Name</b>		<b>Policy Holder ID#</b>	
<b>Secondary Ins. Co. Name</b>		<b>Policy Holder ID#</b>	
<p>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. <b>I have read and agree to Florida Pain Care's Payment Policy _____ (initials)</b></p>			

Printed Name or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Is the reason for your visit, the result of an  Auto Accident  Worker's Compensation Injury?

Claim #: \_\_\_\_\_

Claim Adjuster/Case Worker: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Attorney Information: \_\_\_\_\_

Attorney Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Were you the driver?  Yes  No

Were you wearing a seat belt?  Yes  No

Were you  stopped  moving  from behind  passenger side  head on

Did  airbags deploy  hit your head  hit your knees  hurt your shoulder

Did you  lose consciousness  go to the ER  seek medical help the day(s) after the crash

Did you  have a previous accident  see a doctor in the last year for pain



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## Assignment of Benefits and Direction of Pay

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I hereby irrevocable assign to **Florida Pain Care, PLLC**, all benefits from my insurance carrier(s) due to me under No Fault, Medical Payments or any other applicable insurance coverage under any policy of insurance, for products, services and/or accommodations rendered by Provider as consideration for those products, services and/or accommodations rendered.

I hereby authorize and unequivocally instruct and direct my insurance company to issue payment directly to Provider for any and all products, services and/or accommodations rendered by Provider.

I have read the information herein and it is accurate to the best of my knowledge and belief.

\_\_\_\_\_  
INSURANCE CARRIER

\_\_\_\_\_  
POLICY NO.

\_\_\_\_\_  
CLAIM NO.

\_\_\_\_\_  
CLIENT NAME

\_\_\_\_\_  
CLIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
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:**

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**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: \_\_\_\_\_

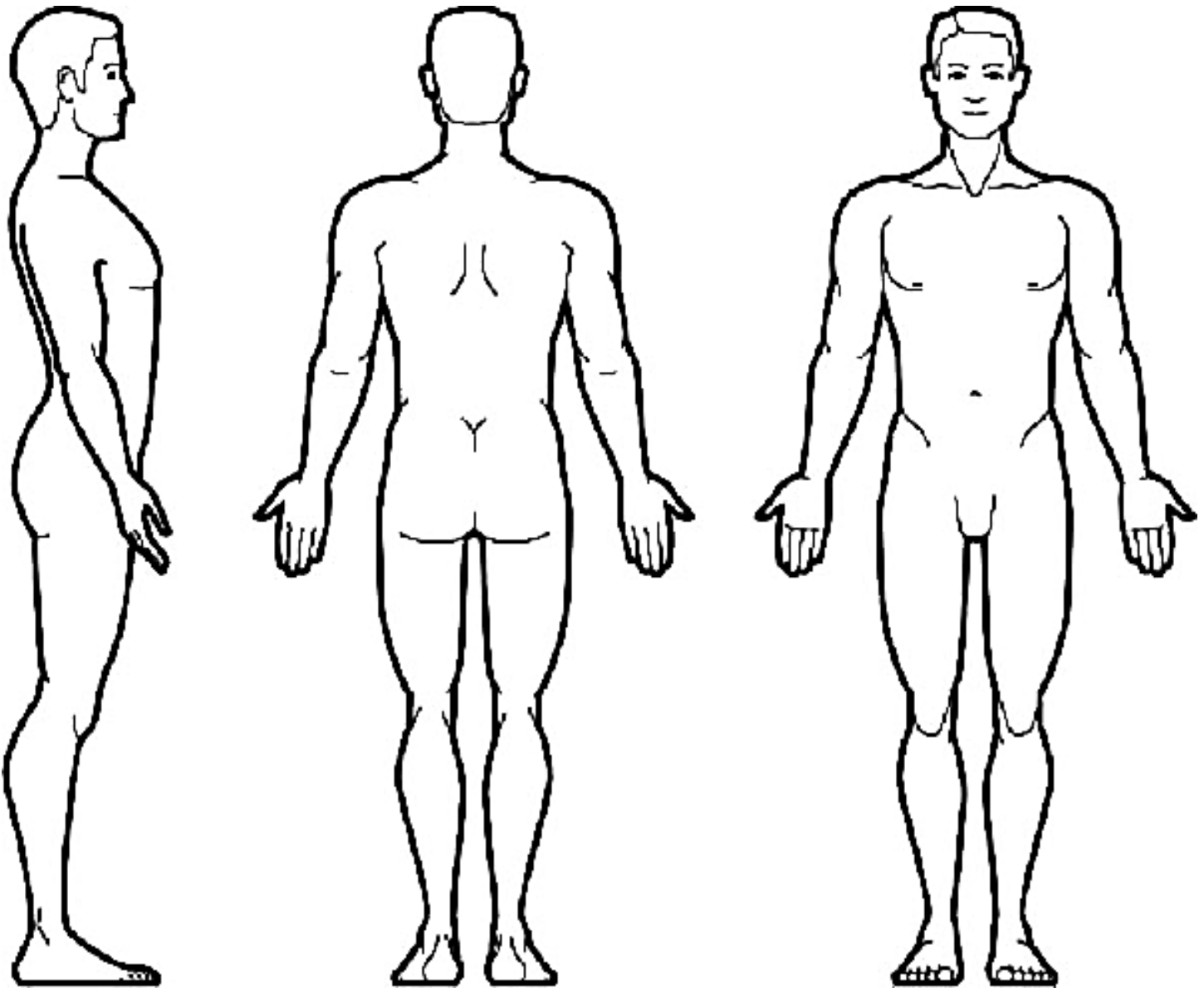
**Family History: check all that apply**

- 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2) Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3) Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4) Feeling tired or having little energy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5) Poor appetite or overeating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6) Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7) Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9) Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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 ]



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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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:

Table with 3 columns: 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



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.

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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



## HIPAA Compliance Patient Consent Form

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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:

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This consent was signed by: \_\_\_\_\_  
(PRINT NAME PLEASE)

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE



Florida Pain Care, PLLC  
Statement of Patient Rights and Responsibilities

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Revised 3-1-2016 Approved by Governing Body

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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**.