PATIENT INFORMATION

Date:_____

Patient Name:_____Date of Birth:_____Sex:_____Marital Status:_____

Address:_____City:_____State:____Zip:_____

Home Phone:_____Cell Phone:_____Social Security #:_____

State of Driver's License:_____Driver's License Number:_____

Primary Care Physician:_____Referring Physician:_____

Employer's Name & Address:_____Employer's Phone:_____

Pharmacy Name:_____Pharmacy Phone:_____

Pharmacy Address: _____ City:_____State:_____ Zip:_____

If Patient is Married, Spouse's Name:_____Spouse's Phone#_____

Language: □ English □ Spanish □ Other:_____

Does the patient have health insurance? (Pleasecheck one) Yes___No___

Health Insurance:

Primary Health Insurance Carrier:_____

Policy/ID #:_____ Group #:_____

Policy Holders Name: Date of Birth:_____ Secondary Insurance Carrier(s):_____

Secondary Health Insurance Carrier:_____

Policy/ID #:_____ Group #:_____

Policy Holders Name: Date of Birth:_____ Secondary Insurance Carrier(s):_____

Is your pain being as a result of an AUTO accident □ Yes □ No

Name of Auto Insurance Carrier:_____

Auto Policy #_____Name of Insured:_____

Claim # _____Date of Accident:_____

Attorney Name: _____Phone # _____Fax #_____

Is your pain being as a result of work related accident and do you have WORKERS COMPENSATION case. □ Yes □ No

Employer: _____Date of Injury: _____

Claim #: _____Workers' Comp. Insurance Name:_____

Adjuster's Name:_____Adjuster's Phone#: _____Fax#:_____

Emergency Contact:_____Relationship to Patient: _____

Emergency Contact Phone:_____Emergency Contact Cell:_____

Patient Signature:_____Date: _____

HISTORY AND PHYSICAL INTAKE FORM

Name: ----------DOB: ----------Age: ------Todays Date----------

Height: ----------Weight: ---------- Occupation---------- PT ( ) FT ( ) Disabled ( )

Primary Care Physician:_____Referring Physician: _____

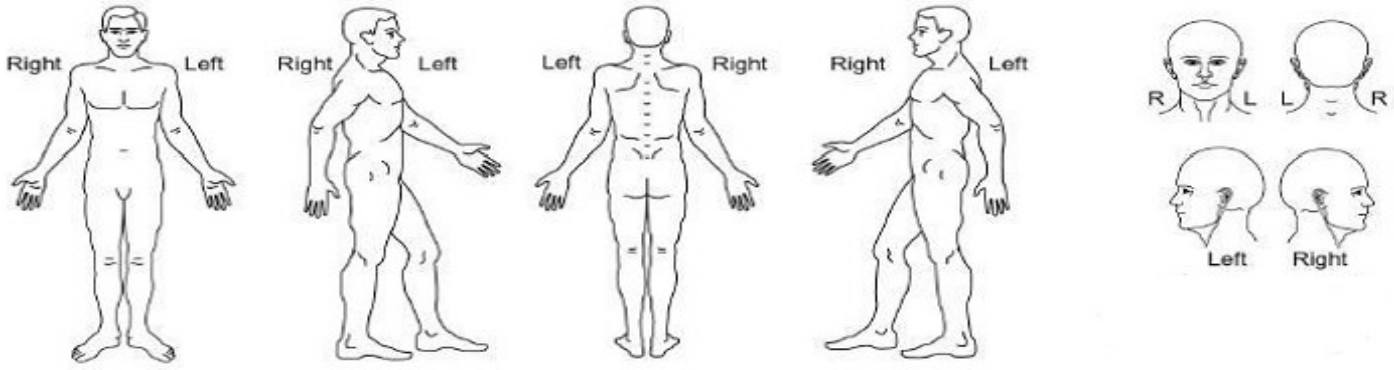
Chief complaints: ----------

When and how it started: ----------

Does your pain radiate anywhere---------- ?

Please **circle** the areas where you are experiencing pain & **rate** the area you are having pain from a 1 out of 10 (**1** being minor and **10** being sever):

Pain score: _____ _____



Pain score: ___/ 10 ___/10 ___/10 ___/10 ___/10_____

Describe your pain:

Aching----Burning----Cramping----Dull----ElectricShock-----Sharp-----Shooting----Stabbing--- Throbbing—

What makes the pain worse?

Standing---Sitting----Walking----Movement----Lying Down----Bending forward------Arching backward---Coughing---Sneezing---others----------

What makes the pain better?

Standing---Sitting----Walking----Movement----Lying Down----Bending forward------Arching backward---Coughing---Sneezing---others----------

- Are you involved in any litigation or lawsuit regarding your pain? Yes-------No-------

- Are you seeking Worker's Compensation because of your pain? Yes------No----------

Patient Name:_____ **DOB:**_____

Do you have any of the following symptoms associated with your pain?

Numbness/Tingling No……. yes……where? ----------

Weakness No……yes……where?----------

Bowel/Bladder Incontinence No……yes…….when it started? ----------

- List the names of other doctors or specialists you have seen for your pain: ----------
  ----
- Did you have any treatments done by another Pain Doctors? ----------
  ----
- Did You have any test done: X Ray--------- CT Scan ---------- MRI----------NCS ---------- Other ----------

Current Medications: Check here if none ( )

Name of Pain Medication Dosage

_____ _____

_____ _____

_____ _____

Name of other Medication:

_____ _____

_____ _____

_____ _____

_____ _____

Allergies:

	Yes	No
No Known Drug Allergies	___	___
IV Dye	___	___
Iodine	___	___
Seafood/Shellfish	___	___
Adhesive Tape	___	___
NSAIDS	___	___
Penicillin	___	___

Other ----------

Are you taking any Blood thinner medication Plavix/Clopidogrel, Warfarin, Coumadin, or Effient/Prasurgel or others? Yes-----No----

Pharmacy Name: _____ Pharmacy phone # _____

Pharmacy Address: _____

Medical History: Check here if none ( )

	Yes	No		Yes	No		Yes	No
High blood pressure	___	___	Hepatitis/liver disease	___	___	Phlebitis/blood clots	___	___
Heart disease	___	___	Kidney problems/Stones	___	___	Stomach Ulcer disease	___	___
Heart attack	___	___	Thyroid disease	___	___	Bleeding disorder	___	___
Irregular heart rhythm	___	___	Diabetes	___	___	Asthma	___	___
Stroke	___	___	Osteoporosis	___	___	Emphysema/COPD	___	___
Seizures	___	___	Rheumatoid Arthritis	___	___	Cancer	___	___
Glaucoma	___	___	Depression	___	___	Trauma	___	___
Fibromyalgia	___	___	HIV positive	___	___	Other: _____		

Patient Name:_____ DOB:_____

Surgical History: Check here if none ( )

( ) Low back surgery (Date)_____Surgeon _____

( ) Neck surgery (Date)_____Surgeon _____

( ) Heart surgery ( ) Joint replacement (Which)_____( ) Cancer surgery

( ) Appendix ( ) Hernia ( ) Gallbladder ( ) Hysterectomy ( ) OTHER SURGERY _____

Social History: Right Handed **( )** Left Handed **( )**

Alcohol: ( ) YES ( ) NO ( ) Daily ( ) Few per week ( ) Once per week ( ) Few per month

Illicit Drug Use: ( ) YES ( ) NO ( ) Type _____

Drug/Alcohol treatment? ( ) YES ( ) NO If yes, name of facility:_____Year _____

Past Suicide Attempt? ( )YES ( ) NO If yes when _____

Smoker: ( ) YES ( ) NO # packs daily:_____How many years: _____

Occupation:_____ None( ) Full Time( ) Part time ( ) disabled ( ) Retired ( )

Family History:

Mother ( ) Alive ( ) Deceased Age:____ Cause/medical conditions:_____

Father ( ) Alive ( ) Deceased Age:____ Cause/medical conditions: _____

Family Medical Problems ( ) Diabetes ( ) Heart Disease ( ) Cancer (type):_____( ) Other: _____

Review of Systems: (circle all that apply): Pregnant ( ) Yes ( ) No

General: Weight changes, fatigue

HEAD/EYES: Headache, Blurry vision

Lung: Chronic cough, Shortness of breath

ENT: Ears ringing, Sinusitis, Sore throat

Heart: Chest pain, Palpitations

Blood: Anemia, Easy bruising, Bleeding

Abdomen: Heartburn, Nausea, Constipation

Urinary: Blood in urine, Painful urination

Neurology: Stroke, Seizures, Weakness

Psych.: Depression, Anxiety, Sleepproblems

Endocrine: Thyroid problems, Diabetes

Vascular: Leg cramps, Aneurysms Skin:

Bruising, rashes, sores

Immunologic: Itching, Frequent colds or infections

I certify that the information given on the Initial Visit Intake is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this paperwork.

_____ **Date:** _____

Patient/Family/Legal Guardian Signature

CONSENT FOR TREATMENT

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment at **FAMILY MEDICINE & REHAB INC.**

PRIVACY NOTICE ACKNOWLEDGEMENT

During your treatment it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- During your treatment, a referral to other services may be necessary.
- During health care operations, we may need a second opinion.
- During the payment process, we may need to release notes and other laboratory results.
- Release information to legal authorities or case workers.

I acknowledge that I have had the opportunity to review a copy of the **FAMILY MEDICINE & REHAB NOTICE OF PRIVACY PRACTICES**. I understand that I am responsible for reading this notice and for notifying Family Medicine & Rehab Inc. in writing of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand that the notice includes electronic access to my medication history. Family Medicine & Rehab Inc. has the right to revise this notice at any time and will post a copy of the current notice in the office in a visible location at all times. Family Medicine & Rehab Inc. may also provide me with a copy of its most recent notice upon my request.

CONSENT FOR DISCLOSURES

We understand that at times you may need members of your family or friends to contact the office to make inquiries about your health status, diagnosis, treatment options, schedule, reschedule, cancel appointments or to be contacted in the event of an emergency. To do so, please list the person, or persons you are authorizing to make such inquires or changes. Please be advised that we may require them to confirm personal information to verify their authorization, such as your date of birth.

Name:_____Relationship:_____Contact #: _____

Name:_____Relationship:_____Contact #: _____

I DO NOT give authorization for medical information, lab work results and any other information regarding my appointments or treatment to be released to anyone_____.
(Your Initials)

MEDICAID INSURANCE WAIVER

This notice is to inform all patients that we are **only STAYWELL MEDICAID PROVIDERS.** If you decide to seek treatment at Family Medicine & Rehab Inc. **you are required to sign this waiver in acknowledgment that you have received this waiver (even if you do not have Medicaid insurance),** and that you will be responsible for any portion of your bill that is not covered by any other insurance.

FINANCIAL POLICY AND AGREEMENT

I understand that in consideration of the services provided to me, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered by **FAMILY MEDICINE & REHAB INC.** I am responsible for any applicable deductible, co-payments and coinsurance prior to the provision of services. Family Medicine & Rehab Inc. may file ALL claims for payment with my insurance company as a courtesy to me. 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 due.

I hereby authorize and assign all payments, insurance or Medicare benefits for medical services and/or procedures rendered to the me, directly to Family Medicine & Rehab Inc. I hereby authorize Family Medicine & Rehab Inc. to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance company or Medicare.

If my insurance company requires me to obtain referrals/authorizations, it is my responsibility to obtain such and if not, then I will be responsible for any unpaid balance.

By signing this agreement, I acknowledge that I have carefully read, understand and agree to the above terms and conditions. I also understand that it is mandatory to tell Family Medicine & Rehab Inc. if another party is responsible for paying for my treatment (i.e. Automobile Insurance, Workers' Compensation, slip and fall). Section 1128B of Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

FEE POLICY

Appointment Cancellation/No Show Fees:
If you do not call within 24hrs of your scheduled appointment to cancel, reschedule, or if you "no show" for a scheduled appointment, the following fees will apply:

Follow up = $25.00
Procedure = $100.00

Paperwork Fees: (FMLA) $50.00

Medical Records Fees:
$1.00 per page for the first 25 pages, $0.25 per page thereafter

By signing this agreement, I acknowledge that I have carefully read, understand, and agree to the terms and conditions of the Consent for Treatment Agreement, the Privacy Notice Acknowledgment, the Consent for Disclosure, the Financial Policy and Agreement, the Medicaid Insurance Waiver, and the Fee Policy. I have completed these forms accurately and to the best of my knowledge and will be financially responsible if I have failed to provide Premier Spine and Pain Center with all of my applicable insurance information.

Patient/Legal Guardian Name (print):

_____

Patient/Legal Guardian Signature:_____ **Date:**_____

NARCOTIC MEDICATION POLICY/CONTRACT

We are committed to doing all we can to treat your chronic pain condition. In some cases, opioids and other controlled substances are used as a therapeutic option in the management of chronic pain and related conditions all of which are strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws for proper controlled substance use.

According to Florida State Law (893.13) Section 7, it is illegal for persons to see multiple physicians to obtain a controlled substance medication. You can be arrested for this violation. We, at Family Medicine & Rehab Inc. will assist the Sheriff's office in all aspects regarding this law.

I give consent to Family Medicine & Rehab Inc. and all its employee to make report to or otherwise cooperate with any law enforcement officials or regulatory agencies in any investigation which may arise as a result of or related to my receiving prescriptions as a patient of Family Medicine & Rehab Inc. I waive any and all rights of privacy and privilege in this regard and these authorities may be given full access to my medical record without order of the clerk of court.

1. All controlled substances have a potential for dependency, addiction and other side effects.

2. All controlled substances must come from the physician whose signature appears below, or during his absence, by the covering physician, unless specific authorization is obtained for an exception.

3. All controlled substances must be obtained at the same pharmacy, where possible.

The Pharmacy I have selected is _____ Phone_____.

3. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purpose of maintaining accountability.

5. I will never share, sell or otherwise, permit other including family members to have access to these medications.

6. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized or illegal substances may result in your discharge from the facility.

7. I will not consume any alcohol in conjunction with narcotics and I will not use any illegal drugs.

8. Medications may not be replaced if they are lost or stolen. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told is not enough.

9. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived, and these authorities may be given full access to our records of controlled substances administration.

10. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

11. In the event you are arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given and may result in your discharge from the facility.

12. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately notify premier spine and pain physicians. I am aware that should I become pregnant I will be given a weaning dose of medications and will be released from this facility and will be followed by my Obstetric physician for any medications requirement, I will be able to resume pain management care at premier spine and pain center after delivery.

13. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribed by the physician.

14. **By signing this agreement, I affirm that I have read, understand and accept all of the terms of this Narcotic Medication Contract. I affirm that I have full right and power to sign and be bound by this agreement.**

Patient Name: _____ Patient Signature: _____ Date: _____

Syed Hussain, M.D.

Opioid Risk Tool

Patient Name: _____ Date _____

Mark each box that applies		Female	Male
Family history of substance abuse			
Alcohol	( )	1	3
Illegal drugs	( )	2	3
Rx drugs	( )	4	4
Personal history of substance abuse			
Alcohol	( )	3	3
Illegal drugs	( )	4	4
Rx drugs	( )	5	5
Age between 16—45 years	( )	1	1
History of preadolescent sexual abuse	( )	3	0
Psychological disease			
Attention deficit disorder, Bipolar, Obsessive compulsive, Schizophrenia	( )	2	2
Depression	( )	1	1
Scoring totals	( )		

For office use only
Risk Assessment: Low risk (0-3) Moderate risk (4-7) High risk (> 8)

Physician signature:_____ Date:_____

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk tool. Pain Med.2005;6(6):432

Acknowledgment of Receipt of Notice of Privacy Practices

PATIENT:

I certify that I have been offered to receive a copy of the Notice of Privacy Practices and I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information.

***Printed Patient Name: _____ Patient Date of Birth: _____

***Patient Signature: _____ Date: _____

AUTHORIZED PATIENT REPRESENTATIVE:

I certify that I am the authorized representative of the above-mentioned Patient and I have received the Notice of Privacy Practices on behalf of this individual. I had the opportunity to review this document and ask questions to assist me in understanding his/her rights relative to the protection of his/her health information.

Representative Name: _____

Representative Signature: _____

Printed Patient Name: _____

Relationship to Patient: _____

Date: _____

Patient or Representative refused to sign or declined Acknowledgement of Privacy Notice.

***Patient Signature or Representative Signature: _____

***Date: _____

FOR OFFICE USE ONLY:

Witness, Office Personnel Printed Name: _____

Date: _____

OFFICE RULES AND POLICIES

CO-PAYMENTS

Co-payments are due at the time of your visit.
Insurance regulations REQUIRE us to collect co-payment.
Under no circumstance are we able to waive co-payment. If you do not have your co-pay for your visit, your appointment may be re-scheduled.

BOUNCED CHECK

A $25.00 CHARGE WILL BE ASSESSED FOR RETURNED CHECKS.

NO SHOW OR CANCELLATIONS

A $100 (New Consult) or $50 (Follow-up, Procedure) charge will be assessed if you fail to keep your appointment and do not notify the office. Failure to provide 24-hour advance notification for a cancellation or rescheduled appointment will result in a fee charged.
Established Patients: Patient may be discharged from the practice after THREE "NO SHOWS" or CANCELLATIONS occurring within 24 hours.

PHONE CALLS

Patients are limited to a maximum of two phone calls per day. Callbacks from the Hartford Hospital Pain Treatment Center Staff will be returned within 24 hours depending on the urgency of the call.

LANGUAGE

Rude or disrespectful language will not be tolerated.

AGREEMENT

In order to become and continue as a patient of the Hartford Hospital Pain Treatment Center, I understand the rules and policies set by the Practice and agree to abide by set office rules and policies.
Thank you for your consideration.
Printed Name Signature Date

PLEASE SIGN AND BRING THIS WITH YOU TO YOUR FIRST VISIT.

PATIENT NAME: _____ DOB:_____

DATE OF SERVICE:_____