FLORIDA PAIN PHYSICIANS

GENERAL CONSENT AND AUTHORIZATION FOR TREATMENT, EVALUATION, AND INFORMATION RELEASE

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time.

I certify that my Medical History is complete and accurate to the best of my knowledge and ability.

I voluntarily request that Florida Pain Physicians, LLC provide pain management care, treatment, and services to me, as deemed reasonable and necessary by the assigned healthcare provider(s). I consent to reasonable and necessary medical examination, evaluation, testing, and treatment which may include diagnostic, radiology, and laboratory procedures. I understand I may be asked to provide urine, oral swab, and/or blood samples. I have the right to refuse specific tests, but understand this may impact my pain management treatment. If invasive interventional treatment is recommended, I will be informed of the benefits and risk prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

RELEASE OF INFORMATION I specifically authorize the uses and disclosures of my health information as described in the Notice of Privacy Practices provided to me. I authorize Florida Pain Physicians, LLC physicians, and/or their staff, to obtain my medication history and other relevant health care information, verbally, written or electronically, that is deemed necessary for my treatment. I consent to release of my health information to federal or state health plans, insurance companies, collection agencies, employers, or other organizations responsible for payment of services, as appropriate. I understand that this may include information relating to my diagnosis, care, payment for my care, or demographic information.

BY SIGNING BELOW, I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

Printed Name of Patient or Representative	Signature of Patient or Representative
Relationship to Patient	Date

****Please continue to the next page to complete your demographic information. Thank you!****

FLORIDA PAIN PHYSICIANS

Patient Demographic Information

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Gender: _____ ❑ Male ❑ Female

Street Address: _____

City/State/Zip: _____

Email: _____

Physical Address Same as Mailing? ❑ Yes ❑ No If not, please list mailing address: _____

_____

Preferred Phone: _____ ❑ Home ❑ Mobile ❑ Work

Secondary Phone: _____ ❑ Home ❑ Mobile ❑ Work

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Pharmacy Information

Pharmacy Name: _____

Pharmacy Number: _____

Patient Primary Insurance Plan

Payer (example BC/BS): _____ **PLEASE BRING CARD AND OR INSURANCE INFO**

Complete this box if you are NOT the policy holder for your primary insurance

Insurance Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Policy Number: _____

Injury Claim

Is your pain the result of a Motor Vehicle Accident or Personal Injury? (Legal term describing injury sustained to your person by negligence of another) ❑ Yes ❑ No

Certification

I certify that the above information is accurate, complete, and true. I understand that this will become part of my medical record.

Signed: _____ Date: _____

Patient or Guardian or Patient Representative

Printed Name: _____

FLORIDA PAIN PHYSICIANS

HIPAA Authorization for Use or Disclosure of Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

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

I. My Authorization

I authorize Florida Pain Physicians, LLC, its agents and employees to use or disclose the following health information.

All of my health information

My health information for the following condition(s): _____

I do not authorize disclosure of my health information

The above party may disclose this health information to the following recipient(s), please include medical providers, family, and friends:

Name, relationship, and/or organization: _____

_____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature of Patient: _____ **Date:** _____

If the patient is a minor or unable to sign, please complete the following:

Patient is a minor: _____ years of age

Patient is unable to sign because: _____

Signature of Authorized Representative: _____ Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient: ❑ Parent ❑ Legal Guardian ❑ Court Order

❑ Other: _____

FLORIDA PAIN PHYSICIANS

Notice of Privacy Practice

This Notice Describes How Medical Information About You May Be Used, Disclosed and How You Can Get Access to This Information. PLEASE REVIEW IT CAREFULLY.

Our Pledge Regarding Medical Information.
We understand that medical information about you and your health is personal. We are committed to protecting medical information in a reasonable and appropriate manner. We create a record of the care and the services you receive at Florida Pain Physicians, LLC and its affiliates. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by our Practice. This notice will tell you about the ways in which we may use and disclose medical information about you, your rights, and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:
- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and practices concerning medical information about you; and follow the terms of this notice that is currently in effect.

How We May Use and Disclose Medical Information About You. The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing our Privacy Officer.

- **For Treatment.** We can use your Health Information and share it with other professionals who are treating you.
- **For Payment.** We can use and share your Health Information to bill and get payment from health plans or other entities.
- **For Health Care Operations.** We can use and share your Health Information to run our practice, improve your care, and contact you when necessary.
- **Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services.** We can share and disclose Health Information to contact you to remind you that you have an appointment with us. We may also use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.
- **Individuals Involved in your Care or Payment for Your Care.** When appropriate, we can share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend.
- **Research.** Under certain circumstances, we can share and disclose Health Information for research. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.
- **As Required By Law.** We can share and disclose Health Information about you when required to do so by federal, state, or local laws.

- **To Advert a Serious Threat to Health or Safety.** We can share and disclose Health Information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **For All Other Uses and Disclosures.** All other uses and disclosures of information not contained in this Notice of Privacy Practices will not be disclosed without your authorization.
- **Organ and Tissue Donation.** We can share Health Information about you with organ procurement organizations.
- **Workers' Compensation, Law Enforcement and Other Government Agencies.** We can share Health Information about you for workers' compensation, for law enforcement purpose and healthcare oversight agencies for activities authorized by the law, or special government functions such as military, national security, and presidential protection.
- **Public Health Risks.** We can share Health Information about you for certain situations:
- to prevent or control disease;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products that they may be using;
- to notify a person who may have been exposed to a disease or may be at risk.
- **Lawsuits and Legal Disputes.** We can share Health Information about you in response to a court or administrative order, or in response to a subpoena.
- **Comply with the Law.** We will share information about you if state or federal laws require it, including with Health and Human Services should it want to see we are complying with federal privacy law.
- **Coroners, Medical Examiners, and Funeral Directors.** We can share Health Information to a coroner, medical examiner, or funeral director when an individual dies.

Uses and Disclosures that Require Us to Give you an Opportunity to Object and Opt Out.
In these cases, you can tell us what we can share:
1. Share information with our family, close friends, or others involved in your care.
2. Share information in a disaster relief situation.
3. Include your information in a hospital directory.
4. Contact you for fundraising efforts. We may contact you, but you can tell us not to contact you again.

Your Written Authorization is Required for Other Uses and Disclosures.
In these cases, we never share your information unless you have given us written permission:
1. Marketing Purposes
2. Sale of your information
3. Sharing of psychotherapy notes

If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But any disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights.
You have the following rights regarding Health Information we have about you:

Right to Inspect and Obtain a Copy of Your Medical Records. You can ask to see or get an electronic copy of your medical record or other Health Information we have about you. If your Protected Health Information is maintained in an electronic format, you have the right to request that an electronic copy of your records be given to you or transmitted to another individual or entity. We will provide a copy or a summary of your Health Information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Right to Correct Your Medical Records. You can ask us to correct Health Information about you that you think is incorrect or incomplete. We may also say "no" to your request, but we will tell you why in writing within 60 days. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Account of Disclosures. You can ask us for a list (accounting) of the times we have shared your Health Information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except those about treatment, payment, health care operations, and certain other disclosures. We will provide one accounting per year for free. There will be a reasonable cost based fee if you ask for another accounting within the 12 month period. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Limit Information We Share. You have the right to ask us not to use or share certain Health Information for treatment, payment, or health care operations. We are required to agree to your request, unless it would affect your care. If you pay for services out-of-pocket in full, for a specific item or service, you can ask that your Protected Health Information is not shared with your health insurer for the purposes of payment. We will say yes unless a law requires us to share that information.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing to our Privacy Officer. We will say yes to all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy, contact our Privacy Officer. You may obtain a copy of this notice at our website www.floridapainphysician.com.

Changes to this Notice. We reserve the right to change this notice and make a new notice that applies to the Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

Public Fee Schedule

Florida Pain Physicians, LLC and its affiliates has adopted this Public Fee Schedule in order to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Having a posted and published reasonable and appropriate fee schedule, Florida Pain Physicians, LLC is ensuring consistent treatment of its patient's request.

Fee Item	Fee Charged
Failure to cancel your appointment before 24 hours of the scheduled time	$30.00 per clinic incident
within 48 hours of scheduled procedure time	$75.00 per procedure, EMG, or MRI incident
No show for your appointment	$30.00 per clinic incident
Late arrivals. If you arrive 15 minutes past your arrival time and we must reschedule your appointment	$30.00 per clinic incident
Return check fee (including any bank fees)	$30.00 per incident
Copies of medical records	Paper = $20.00 for the first 20 pages and $0.25 for each page thereafter plus the cost of mailing and/or delivery fees. Electronic copies will be the current commercial price of the DVD disc or USB drive, which is currently: • DVD disc - $1.00 each disc • USB drive - 8 GB = $4.00, 64 GB = $15.00, 128 GB = $30.00 (costs are per each drive)
Completion of Disability Forms	Costs below are per each occurrence FMLA = $25.00 per page Temporary Disabled Parking Permit = $10.00 Term Disability Form = $25.00 per page
Request for letters or other written correspondence	$30.00 per page

FLORIDA PAIN PHYSICIANS

Statement of Patient Rights

Patients Have the Right to:

- Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
- Receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
- Receive privacy in treatment and care for personal needs;
- Review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
- Receive a referral to another health care institution if this facility is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
- Participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
- Participate or refuse to participate in research or experimental treatment;
- Receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights;
- Be treated with dignity, respect, and consideration;
- Not be subjected to abuse, neglect, exploitation, coercion, manipulation, sexual abuse, sexual assault, or except as allowed in R910-1012(B), restraint or seclusion;
- Not be subjected to retaliation for submitting a complaint to the Department or another entity;
- Not be subjected to misappropriation of personal and private property by any clinic personnel member, employee, volunteer, or student;
- Consent to or refuse treatment, except in an emergency and to refuse or withdraw consent for treatment before treatment is initiated;
- Be informed of alternatives to medications or surgical procedure and associated risks and possible complications of medications or surgical procedure, except in an emergency;
- Be informed of the clinic's policy on health care directives, and the patient complaint process;
- Consent to photographs before a patient is photographed, except that a patient may be photographed for identification and administrative purposes;
- Provide written consent to the release of information in the patient's medical records or financial records, except as otherwise permitted by law.

Patients Have the Responsibility to:

- Be honest about matters that relate to you as a patient;
- Provide staff with accurate and complete information about present complaints, past illness, hospitalizations, medications, and other matters pertaining to your health;
- Report any perceived risks in your care;
- Report any unexpected changes in your condition to those responsible for your care and welfare;
- Follow the care, service, or treatment plan developed;
- Ask any questions when you do not understand or have concerns about your plan of care;
- Know the staff who are caring for you;
- Be considerate and respectful of the rights of both fellow patients and staff;
- Honor the confidentiality and privacy of other patients;
- Be considerate of the property of Florida Pain Physicians, LLC;
- Assure the financial obligations of your healthcare are fulfilled as promptly as possible.

FLORIDA PAIN PHYSICIANS

How to File a Complaint

Patients or patient's representatives that have any concerns about patient rights, safety, or complaints or grievances, please contact the Territory Manager for that clinic or call 904-800-PAIN and ask to speak with the Territory Manager. Written correspondence will be forwarded to the Territory Manager for the patient. Any patient or patient's representative may submit a grievance without retaliation.

Patients also have the right to contact the Department of Health at any time.

Financial Policy

You are financially responsible for the medical services you receive at Florida Pain Physicians, LLC, (hereafter referred to as the "Practice"). Please carefully review this Financial Policy, initial each section and sign the agreement to indicate your acceptance of its terms.

Appointments

1. **Copayments and Deductibles.** Copayments and deductibles for clinic visits are due at the time of service, in accordance with your insurance carrier's plan. If you are unable to make your copayment at the time of service, the Practice reserves the right to reschedule your appointment until such time that you are able to make your copayment.

2. **Procedure Prepayment.** The Practice may collect your payment for a procedure at the time the procedure is scheduled. Your prepayment is based on an **estimate** of your expected financial responsibility. We reserve the right to reschedule your procedure until prepayment arrangements have been made. You are responsible for any unpaid balance after your insurance carrier has processed your claim. In the event of overpayment, you may request a refund.

3. **Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by the Practice or if you notify us not to contact or bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available at our front desk). Payment is due in full at the time of service.

4. **Missed Appointments and Late Arrivals.** You will be charged a fee for each incident according to the Public Fee Schedule. These charges are your personal responsibility and will not be billed to any insurance carrier.

Initial: _____

Insurance Payments

5. **Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurance carrier will be your responsibility, except as limited by the Practice's specific network agreement with your insurance carrier, if such an agreement is in place.

Insurance Payments (Continued)

6. **Coverage Changes and Timely Submission.** It is your responsibility to timely inform us of any change to your billing or insurance information. Your insurance carrier places a time limit within which the Practice can submit a claim on your behalf. If the Practice is unable to process your claim within this period due to your providing incorrect insurance information or not responding to insurance carrier inquiries, you will be responsible for all charges.

Initial: _____

Benefits and Authorization

7. **Insurance Plan Participation.** The Practice has specific network agreements with many insurance carriers, but not all insurance carriers. It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. Your insurance carrier's plan may have out-of network charges that have higher deductibles and copayments, which you will be responsible for.

8. **Referrals.** Referral and prior authorization requirements vary among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by the Practice, it is your responsibility to obtain this referral prior to your appointment. Although, your referring health care provider, and the Practice, are expressly permitted to disclose your Protected Health Information (PHI) for your treatment, under HIPAA, you have the right to request restrictions on the disclosure of your PHI. Under HIPAA, the Practice is not required to agree with you.

   As a matter of course, the Practice will inform your referring physician of your patient care plan and progress either by using any secure electronic transmission machine or by an employee of the Practice.

9. **Prior Authorization and Non-Covered Services.** The Practice may provide services that your insurance carrier's plan excludes or require prior authorization. The Practice, as a courtesy to our patients, will make a good-faith effort to determine if services we provide are covered by your insurance carrier's plan, and, if so, determine if prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf. Ultimately, it is your responsibility to ensure that services provided to you are covered benefits and authorized by your insurance carrier.

10. **Out-of-Network Payments and Direct Insurer Payments.** You are personally responsible for all charges. If we are not part of your insurance carrier's network (out-of-network) or your insurance carrier pays you directly, you are obligated to forward the payment or payment proceeds to the Practice immediately.

Initial: _____

Account Balances and Payments

11. **Reassignment of Balances.** If your insurance carrier does not pay for services within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. **Balances are due within 30 days of receiving an initial statement.**

Account Balances and Payments (Continued)

12. **Collection of Unpaid Accounts.** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney for collection. This may result in adverse reporting to credit bureaus and additional legal action. **The Practice reserves the right to refuse treatment to patients with outstanding balances over 120 days old.** You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you. We may also contact you by text message or e-mail, using any e-mail address you provide. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device.

13. **Statements.** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within 30 days of the receipt.

Initial: _____

Additional Fees

14. **Medical Records Requests.** The Privacy Rule allows you to receive a copy of your personal medical records, billing records and allows the Practice to require individuals to complete and sign an Authorization for Disclosure and Release of Medical Records Form. However, if you are unable to come into one of the Practice's clinics, the Practice will make every accommodation to fulfill your request. A fee will be charged for medical records requests according to the Public Fee Schedule. There is no charge to transfer a copy of your medical records to a new Provider.

15. **Other Forms.** The Practice will respond (at the provider's discretion) to requests for the completion of certain medical forms (FMLA, Short Term Disability & Temporary Disability Parking Permit) assuming the patient is in good standing and has been active with the Practice for six (6) months consecutively. Other forms not listed may be considered for completion by the Practice. In these cases, the fee will be determined by the Practice Manager. All requests require an office visit.

Initial: _____

Practice Code of Conduct

We are pleased to serve you and glad that you chose Florida Pain Physicians, LLC as your new pain management provider. We will always strive to provide exceptional care for you.

Reasons that Florida Pain Physicians, LLC may ask you to seek health care services elsewhere might include:

- Rude or violent behavior to staff via in-person or telephone - this also applies to your family members and or friends
- Repeated no shows, cancellations, or continual late arrivals for office visits or procedures
- Refusal to adhere to the plan of care as outlined by your Clinician or to follow health insurance or government guidelines
- Unwarranted requests for disability paperwork

Our goal is to help you. Therefore, we ask that you schedule and keep all follow up appointments, participate in all treatments and diagnostic testing.

Initial: _____

FLORIDA PAIN PHYSICIANS

Agreement and Assignment of Benefits

I have read and understand the Financial Policy of Florida Pain Physicians, LLC, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to the Practice. I understand that I am financially responsible for all services I received from the Practice. This financial policy is binding upon me and my estate, executors and/or administrators, if applicable.

Printed Name: _____

Signed: _____ Date: _____

Intracoastal:
4796 Hodges Boulevard
Suite 101
Jacksonville, FL 32224

Northside:
2386 Dunn Avenue
Suite 111
Jacksonville, FL 32218

Orange Park:
859 Park Avenue
Suite 102
Orange Park, FL 32073

St. Augustine:
105 Whitehall Drive
Suite 115
St. Augustine, FL 32086

Phone: (904) 800-PAIN (7246) | **Fax:** (904) 719-7571 | **Website:** www.floridapainphysician.com

FLORIDA PAIN PHYSICIANS

NEW PATIENT INTAKE FORM

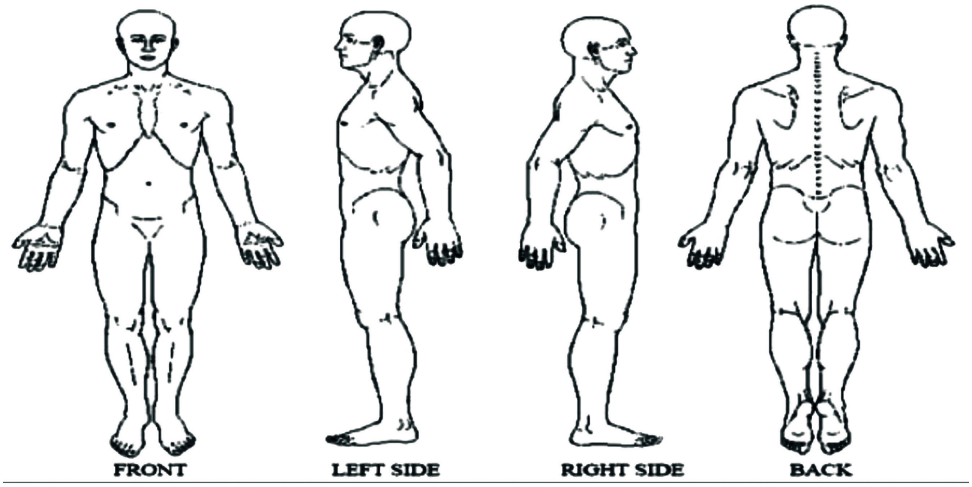
Your Name: _____

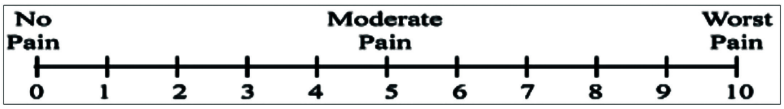
Height: _____ Weight: _____ Age: _____

Phone Number: _____

Onset of Symptoms and Reason for Visit Today

Use the diagram below to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms: "N"umbness "P"ins and Needles "A"ching "S"tabbing "B"urning





What is your current pain level right now? _____ What is your worst level of pain level? _____

Where is your worst area of pain located? _____

Does the pain radiate? _____ If yes, where? _____

Please list additional areas of pain: _____

When did this pain begin? _____

What caused your current pain or injury? _____

Was the pain or injury due to a motor vehicle accident or other personal injury accident? ❑ Yes ❑ No

How did your current pain episode begin? ❑ Gradually ❑ Suddenly

Since your pain began, has your pain: ❑ Increased ❑ Decreased ❑ Stayed the Same

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

When is your pain at its worst? ❑ Mornings ❑ During the Day ❑ Evenings ❑ Middle of Night

Check all that describe your pain today:

❑ Aching	❑ Hot/Burning	❑ Shooting	❑ Stabbing/Sharp	❑ Tiring/Exhausting
❑ Cramping	❑ Numb	❑ Spasming	❑ Throbbing	
❑ Dull	❑ Shock-like	❑ Squeezing	❑ Tingling/Pins and Needles	

FLORIDA PAIN PHYSICIANS

Diagnostic Tests & Imaging – Mark all of the following tests you have had related to your current pain:

❑ Name of Imaging Center _____

❑ Other _____

❑ **I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS**

Pain Treatment History – Mark the following pain treatments you have undergone PRIOR to today's visit:

Treatment	No Relief	Moderate Relief	Excellent Relief
❑ Biofeedback	❑	❑	❑
❑ Bracing	❑	❑	❑
❑ Chiropractic	❑	❑	❑
❑ Decompression Therapy	❑	❑	❑
❑ Physical Therapy	❑	❑	❑
❑ Home Exercise Program	❑	❑	❑
❑ Injections	❑	❑	❑
❑ Rest	❑	❑	❑
❑ Spinal Column Stimulator	❑	❑	❑
❑ TENS Unit	❑	❑	❑
❑ Surgery	❑	❑	❑

Factors that Affect your Pain

	Increases Pain	Decreases Pain	No Change
❑ Bending Backward	❑	❑	❑
❑ Bending Forward	❑	❑	❑
❑ Climbing Stairs	❑	❑	❑
❑ Coughing/Sneezing	❑	❑	❑
❑ Driving	❑	❑	❑
❑ Lifting Objects	❑	❑	❑
❑ Looking Downward	❑	❑	❑
❑ Looking Side to Side	❑	❑	❑
❑ Rising from a Seated Position	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Walking	❑	❑	❑

What other factors worsen or affect your pain that is not listed above? _____

Current Medications

Are you taking a **prescribed blood-thinner or aspirin**, if so, which one? _____

Name of the doctor that prescribes your blood thinner: _____

Please list **ALL** medications you are currently taking. Attach an additional sheet if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

FLORIDA PAIN PHYSICIANS

Activity

How many days a week do you exercise? _____

Type of Exercise: ❑ Bicycle ❑ Cardio ❑ Strength ❑ Swimming ❑ Walking ❑ Other: _____

Allergies – Please list all allergies that you have, DO NOT LIST SIDE EFFECTS:

Medication Name that I'm Allergic to:	The Allergic Reaction I have is:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Are you allergic to any of the following?

Iodine ❑ Yes ❑ No Tape ❑ Yes ❑ No Latex ❑ Yes ❑ No ❑ No Known Drug Allergies

Family History – Mark all appropriate diagnoses as they pertain to your BIOLOGICAL family members only.

❑ Anxiety/Depression	❑ High Blood Pressure	❑ Osteoarthritis
❑ Kidney Problems	❑ Cancer	❑ Liver Problems
❑ Diabetes	❑ Rheumatoid Arthritis	❑ Headaches
❑ Seizures	❑ Heart Disease/Stroke	❑ Substance Abuse

❑ **I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY**

❑ **I AM ADOPTED (No Medical History Available)**

Past Surgical History

Abdominal Surgery:

❑ Gallbladder Surgery _____

❑ Appendectomy _____

Spine/Back Surgery:

❑ Spine Surgery _____

_____

Female Surgeries:

❑ Caesarean Section _____

❑ Hysterectomy _____

❑ Laparoscopy _____

❑ Ovarian _____

Other Common Surgeries:

❑ Hemorrhoid Surgery _____

❑ Hernia Repair _____

❑ Thyroidectomy _____

Heart Surgery:

❑ Valve Replacement _____

❑ Aneurysm Repair _____

❑ Stent Placement _____

Joint Surgery:

❑ Shoulder _____

❑ Hip _____

❑ Knee _____

FLORIDA PAIN PHYSICIANS

Past Medical History/Problem List – Mark all conditions/diseases that you have been DIAGNOSED with:

Cardiovascular/Hematologic
- ❑ Anemia/Bleeding Disorders
- ❑ Coronary Artery Disease
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ Hypertension
- ❑ High Cholesterol
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker/Defibrillator

Gastrointestinal
- ❑ Bowel Incontinence
- ❑ Acid Reflux (GERD)
- ❑ Gastrointestinal Bleeding
- ❑ Constipation
- ❑ Inflammatory Bowel Disease

General Medical
- ❑ Cancer - Type _____
- ❑ Diabetes - Type _____
- ❑ HIV/AIDS

Eyes/Ears/Nose/Throat
- ❑ Glaucoma
- ❑ Hyperthyroidism
- ❑ Hypothyroidism

Kidney
- ❑ Dialysis
- ❑ Kidney Stones
- ❑ Renal Insufficiency

Musculoskeletal
- ❑ Amputation
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Fibromyalgia
- ❑ Joint Injury
- ❑ Osteoarthritis/Osteoporosis
- ❑ Rheumatoid Arthritis
- ❑ Vertebral Fracture

Neuropsychological
- ❑ Alzheimer Disease
- ❑ Anxiety/Depression
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Multiple Sclerosis
- ❑ Peripheral Neuropathy
- ❑ Schizophrenia

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema/COPD
- ❑ Tuberculosis

Additional Past Surgical or Medical History:

_____

_____

_____

_____

_____

Alcohol Use: ❑ Current Alcoholism ❑ History of Alcoholism ❑ Never Drink Alcohol ❑ Social Alcohol Use

Smoker or Tobacco Use: ❑ Current User ❑ Former User ❑ Never

Marijuana Use: ❑ Current User ❑ Former User ❑ Never ❑ Medical Marijuana Card Holder

Drug Use: ❑ I deny any illegal drug use
❑ I am currently using illegal drugs, list: _____
❑ I formerly used illegal drugs (not currently), list: _____

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Suite 111
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Orange Park:
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FLORIDA PAIN PHYSICIANS

SCREEN AND OPIOID ASSESSMENT FOR PATIENTS WITH PAIN – REVISED (SOAPP® – R)

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in the home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					

Please include any additional information you wish about the above answers.

FLORIDA PAIN PHYSICIANS

Opioid Risk Tool (ORT)

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
Psychologic Disease		
ADD, OCD, Bipolar, Schizophrenia	❑ 2	❑ 2
Depression	❑ 1	❑ 1
Scoring Totals		

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