CENTRAL FLORIDA PAIN MANAGEMENT
PATIENT REGISTRATION INFORMATION

PATIENT NAME ____ D.O.B __________ AGE __________

ADDRESS _____________________________ CITY ________________ STATE _____ ZIP ___________

TELEPHONE _______________________ SS # ______________________ MALE ____ FEMALE ______

E-MAIL ADDRESS _____________________________________ CELL ___________________________

EMPLOYER ______________________ OCCUPATION ______________ PHONE ____________________

MARITAL STATUS: MARRIED ____ SINGLE ____ DIVORCED ____ SEPARATED ____ WIDOWED ___

SPOUSE NAME _________________________ S.S # ______________________ D.O.B. _______________

PERSON TO NOTIFY IN CASE OF EMERGENCY ____

PHONE ________________________ RELATIONSHIP ______________________________________

PRIMARY INSURANCE: ____

ADDRESS _____________________________ CITY ________________ STATE _____ ZIP ___________

PHONE _____________________________ POLICY ____

GROUP ____________________________ INSURER ____

SECONDARY INSURANCE: ____

ADDRESS _____________________________ CITY ________________ STATE _____ ZIP ___________

PHONE _____________________________ POLICY ____

GROUP ____________________________ INSURER ____

IF WORK RELATED INJURY, PLEASE FILL OUT THE FOLLOWING INFORMATION:

CONTACT PERSON ___________________________________ PHONE ___________________________

NAME OF EMPLOYER AT TIME OF INJURY ____

ADDRESS _____________________________ CITY ________________ STATE _____ ZIP ___________

NAME OF INSURANCE COMPANY ____

DATE OF ACCIDENT _________________

Continued on back

CENTRAL FLORIDA PAIN MANAGEMENT
Responsibility of Payment Agreement

I understand that Central Florida Pain Management will verify my insurance Benefits. I also understand at time of verification my insurance company provides Central Florida Pain Management with a disclaimer that states “Verifying benefits does not guarantee payment of services rendered”

I understand that if Central Florida Pain Management does not participate with my insurance carrier and is not required to file my insurance claim but will do so as a courtesy.

I understand that should my insurance deny or not pay the entire balance due for any reason (e.g. deductible, co-pays, non-covered services, over usual & customary rates “UCR”, etc..) I will be held responsible and will make arrangements for payment on my account as soon as I receive notice from Central Florida Pain Management.

In the event I do not pay my account balance or fail to make arrangements for payments I understand that my account is subject to be turned over to a collection agency. I will be responsible for any additional costs of collection and any reasonable attorney fees.

I understand if my insurance carrier or coverage should change or terminate during the course of treatment I am responsible for informing Central Florida Pain Management of such changes.

______________________________	______________________________
Patient Name (Please Print)	(If a minor) Guarantor’s Name (Please Print)
______________________________	______________________________
Patient Signature	(If a minor) Guarantor Signature

CENTRAL FLORIDA PAIN MANAGEMENT
CONSULTATION AND EVALUATION

The Villages
1503 Buenos Aires Blvd Bldg 150
The Villages, FL 32159
Phone: 352-750-5882
Fax: 352-750-9947

Leesburg
704 Doctors Court, Suite 101
Leesburg, FL 34748
Phone: 352-750-5882
Fax: 352-750-9947

Date: ___________________

Name ____ Age: _______________ Sex: ___M ___F

Family Physician: ____ City: ____

Where is your pain located? ____

Does it go anywhere else? ____

How long have you had it? ____

Did your pain result from: ___Accident ___Cancer ___Fall ___Injury at work Other: ____________________

Do you have a lawsuit going on or pending, or are you hiring an attorney regarding this matter? ___*YES* ___*NO*

Intensity of your pain *(Circle one)* 0 (No pain) 1 2 3 4 5 (Moderate Pain) 6 7 8 9 10 (Worst pain you can imagine)

How does this pain feel? ___Burning ___Aching ___Stabbing ___Stinging ___Throbbing ___Sharp ___Tingling ___Numbness Other: ___________________________

Is the pain always present or is it off and on? ____

What increases your pain? ___Sitting ___Walking ___Lying down ___Lifting ___Standing ___Bending ___Change in position ___Weather Changes Other__________________________

Does this pain awaken you from sleep? ___*YES* ___*NO* How often? _______________________________

Do you use: ___Cane ___Wheelchair ___Brace ___Orthopedic Shoes ___Crutches ___Walker ___Quad Cane ___Artificial Limb Other______________________________

What do you do to feel better? ____

____

List pain medications you have used in the past: Did it help?

_____________________________________ ___*YES* ___*NO*

_____________________________________ ___*YES* ___*NO*

_____________________________________ ___*YES* ___*NO*

_____________________________________ ___*YES* ___*NO*

How active are you (circle one)?

0 Bed Ridden 1 Very Limited 2 Limited 3 Normal 4 Active 5 Very Active

What Pain Treatments have you had? (Mark all that apply)

Treatment	Did it help?	
❑ Nerve Blocks/ Epidural injections	____*YES*	____*NO*
❑ Physical Therapy	____*YES*	____*NO*
❑ TENS	____*YES*	____*NO*
❑ Acupuncture	____*YES*	____*NO*
❑ Massage Therapy	____*YES*	____*NO*
❑ Hypnotherapy	____*YES*	____*NO*
❑ Biofeedback	____*YES*	____*NO*
❑ Psychotherapy or Psychiatric Care	____*YES*	____*NO*
❑ Chiropractic	____*YES*	____*NO*
❑ Other__________________	____*YES*	____*NO*

List Surgeries for Pain: ____

____

Allergies: ____

Past Medical History (Check all that apply)

Heart Problems ___YES ___NO
Angina ___YES ___NO
High Blood Pressure ___YES ___NO
Heart Attack ___YES ___NO
Date ________________
Congestive Heart ___YES ___NO
Heart Surgery ___YES ___NO
Irregular Heartbeat ___YES ___NO
Pacemaker ___YES ___NO
Other ___________________________________

Digestive Problems ___YES ___NO
Ulcers ___YES ___NO
Hepatitis ___YES ___NO
Gallbladder ___YES ___NO
Hiatal Hernia ___YES ___NO
Diverticulitis ___YES ___NO
Colitis ___YES ___NO
Crohn's Disease ___YES ___NO
Pancreatitis ___YES ___NO
Cirrhosis ___YES ___NO
Liver Disease ___YES ___NO
Other ___________________________________

Bleeding Problems ___YES ___NO
Anemia ___YES ___NO
Sickle Cell Disease ___YES ___NO
Clotting Abnormalities ___YES ___NO

Neurological Problems ___YES ___NO
Headache ___YES ___NO
Stroke ___YES ___NO
Head Injury ___YES ___NO
Seizures/Convulsions ___YES ___NO
Polio ___YES ___NO
Multiple Sclerosis ___YES ___NO
Memory Loss ___YES ___NO
Visual Disturbance ___YES ___NO
Nose Bleeds ___YES ___NO
Hard of Hearing ___YES ___NO

Musculoskeletal Problems ___YES ___NO
Arthritis ___YES ___NO
Fracture ___YES ___NO
Phlebitis ___YES ___NO
Fibromyalgia ___YES ___NO

Endocrine Problems ___YES ___NO
Diabetes ___YES ___NO
Insulin Dependent ___YES ___NO
Hypothyroid (slow) ___YES ___NO
Hyperthyroid (over-active) ___YES ___NO

Respiratory Problems ___YES ___NO
Asthma/Wheezing ___YES ___NO
Bronchitis ___YES ___NO
Emphysema ___YES ___NO
Pneumonia ___YES ___NO
Sinus Infection ___YES ___NO

Have you ever had any of the following?

Loss of Kidney Function ___YES ___NO
Kidney Stone ___YES ___NO
Sexually Transmitted Disease ___YES ___NO
Bowel Incontinence ___YES ___NO
Bladder Incontinence ___YES ___NO

Review of Systems (*check all that apply*)

___ Chest Pain ___ Shortness of Breath
___ Heart Murmur ___ Constipation
___ Diarrhea ___ Vomiting Blood
___ Blood in Stool ___ Fainting
___ Dizziness ___ Blood in Urine
___ Jaundice

List all surgical Procedures you have had and when:
____
____
____
____

Have you ever had Cancer: ___ Yes ___ No
If yes, where? _____________________________
____

Treatment: Surgery Chemo Radiation

Social History

Tobacco products ___YES___NO # Packs/day________ How long? _____________ Quit # years_______
Alcohol ___YES___NO How much per day? ____

Have you ever been treated for or had a problem with alcohol or drugs? ___YES ___NO
Have you ever used recreational drugs? ___YES ___NO Which?: ____________________________

Current Occupation: _______________________________
Marital Status: _____________________________________

Previous Occupation ________________________________
Lives With? ____

List all the medications you are currently taking with dosages.

____ ____
____ ____
____ ____
____ ____

Please list your family medical problems
(Cancer, heart disease, diabetes, etc.)
____
____
____
____
____

Diagnostic Studies

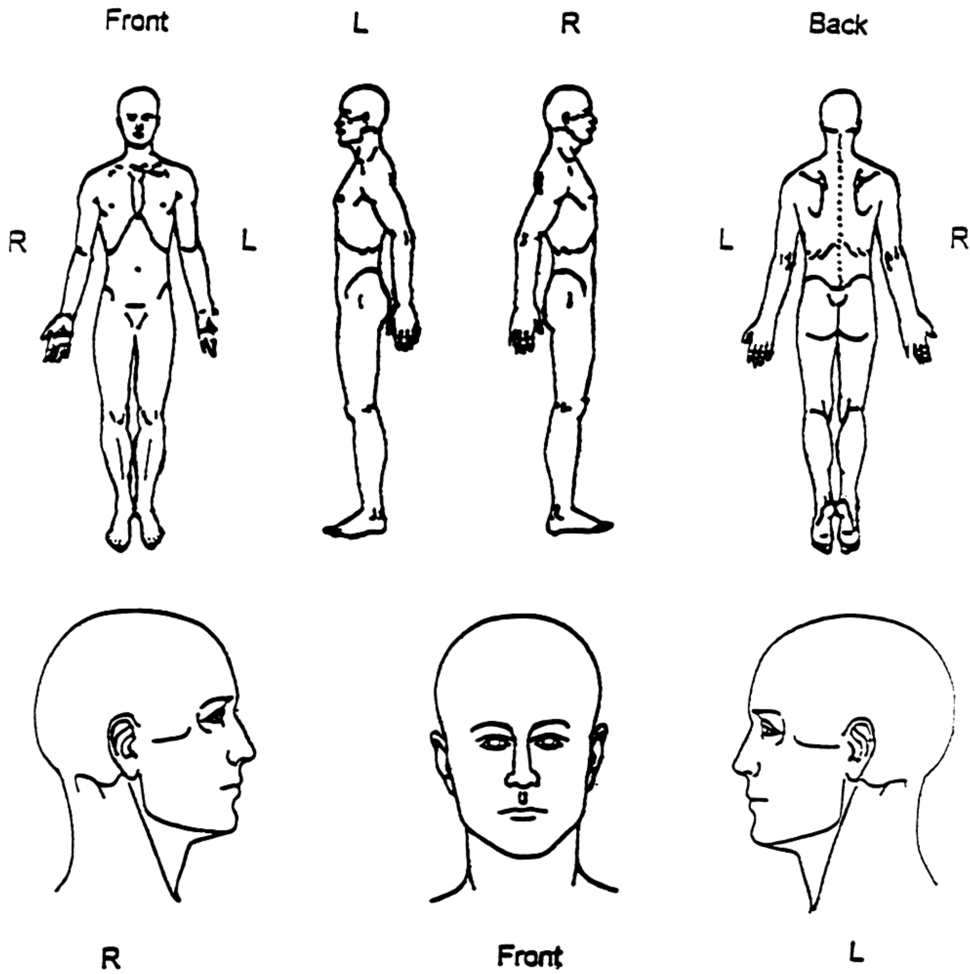
___ X-Ray ___ CT Scans ___ Bone Scans
___ Myelogram ___ MRI ___ EKG
___ EMG/Nerve conduction Studies
___ Blood work - why?_______________
Other ___________________________

Psychiatric:

___ Hospitalization
___ Depression
___ Bipolar
___ Suicide thought or attempt

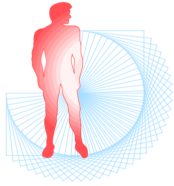
What are your expectations about us and goals for your pain management? ___________________________________
____
____

Use these drawings to show where your pain is.



I have answered all questions to the best of my ability. I authorize and give my consent for Central Florida Pain Management Center to evaluate and treat my condition for which I have been referred. I understand that all information will be kept confidential and will not be given out unless authorized by me to do so in writing.

______________________________	______________________
Patient Signature	Date
______________________________	______________________
(Person authorized to consent for patient)	Date



CENTRAL FLORIDA PAIN MANAGEMENT

PATIENT CONSENT FORM

Addition to HIPAA Notice of Privacy Practices

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that the privacy of personal healthcare information is protected. The "Privacy Rule" was also created to provide a standard for certain healthcare providers to obtain their patients' consent for use and disclosure of their health information to carry out treatment, payment, or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive always to take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum information necessary only to those we feel are in need of your healthcare information and information about treatment, payment, or healthcare operation, in order to provide your healthcare needs.

There are times when you may wish other family members and friends to inquire about your appointments or have access to your medical information. We will not release any information to anyone that is not listed below. If you wish us to leave messages on answering machines/voicemail other than to say "please call us back," please indicate this also.

Answering Machine/Voicemail: _____ Do not leave message other than to return our call
_____ You may leave messages with information

List any family member or others you wish to have access to your records, for example, who may call us regarding your condition or who may call for you. ***We will not release information to spouses or children unless you list them below***. We will require signed releases from you for anyone wanting access to your records other than the insurance companies you have listed with us, your healthcare provider as necessary for your care, or persons listed below.

Name	How related to you
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________

I acknowledge that I have received a copy of Central Florida Pain Management's Notice of Privacy Practices. This notice describes how Central Florida Pain Management may use and disclose my protected healthcare information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected healthcare information. I also understand that I may revoke this authorization at any time or receive a copy of this authorization.

PRINTED NAME ____________________________________

SIGNATURE _______________________________________ DATE _____________

The Villages
1503 Buenos Aires Blvd # 150
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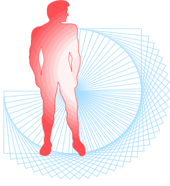
We Can Help You®



CENTRAL FLORIDA PAIN MANAGEMENT

Consent to Release Information

FACILITY RELEASING INFORMATION: ____________________________________

PATIENTS FULL NAME: ____

PATIENTS ADDRESS: ____

PATIENTS DATE OF BIRTH: ____

PURPOSE FOR RELEASE OF INFORMATION: ________________________________

____

INFORMATION AND/OR REPORTS TO BE RELEASED:
I do hereby release the above facility releasing information from all legal liability that may arise from the release of information, including psychiatric, alcohol, substance abuse, HIV testing, ARC, or AIDS information.

I understand that this consent is subject to revocation by me at anytime except to the extent that action has been taken based on this authorization. I understand that this authorization shall expire without my express revocation, 90 days after the affixed below.

______________________ **DATE**	________________________________ **SIGNATURE OF PATIENT**
	________________________________ **Relation if signed by other than patient**
______________________ **DATE**	________________________________ **WITNESS**

NOTICE

TO ACCOMPANY RELEASE OF ALCOHOL AND SUBSTANCE ABUSE RECORDS
This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Law regulation (42 CFR, Part2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

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We Can Help You®

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW **CENTRAL FLORIDA PAIN MANAGEMENT** MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Central Florida Pain Management is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by **CFPM** or received by **CFPM** from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. **CFPM** will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.

CFPM reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not requiring Your Consent
CFPM may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any tie have received services for mental illness, develop mental disabilities, alcoholism, or drug dependency. These are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies;

For example, **CFPM** may determine that you require the services of a specialist. In referring you to another doctor, **CFPM** may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by **CFPM** to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example**, CFPM** will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include:

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, **CFPM** may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

CFPM may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power or attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when **CFPM** is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law.
  In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.
  Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

- For public health activities.
  We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV results to other providers or persons when there has been or will be risk of exposure.

We may report to the state epidemiologist the name of any person know to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose or reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- For health oversight activities.
  We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

- Judicial and Administrative Proceedings
  Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order.
  A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

- For activities related to death.
  We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

- For research.
  Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

- To avoid a serious threat to health or safety.
  We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient.

- For worker's compensation
  We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

CFPM will not make any other use or disclosure of your protected health information without your authorization. You may revoke such authorization at any time, except to the extent that **CFPM** has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by **CFPM** to carry out treatment, payment, or healthcare operations. You must request such restrictions in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restrictions, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. **CFPM** may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that **CFPM** send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that **CFPM** not send information to a particular address or location or contact you at a specific location, perhaps your place or employment. This request must be submitted in writing. We will accommodate reasonable request by you.

You have the right to request that **CFPM** amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your health information made by **CFPM** for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization. You may request and receive a paper copy of this Notice.

Any person or patient may file a complaint with **CFPM** and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with **CFPM**, please contact the Privacy Officer at the following:

Nancy Bankston, Office Manager
1503 Buenos Aires Boulevard, Building 150
Lady Lake, FL 32159
352-750-5882 Fax: 352-750-9947

It is the policy of CFPM that no retaliation action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003

This notice is prepared in accordance with the Health Insurance Portability and Accountability Act 45 C.F.R. 164.520