CHARLOTTE PAIN MANAGEMENT CENTER

Dear Patient,

We are pleased to welcome you to our practice and look forward to helping you with your medical condition. You are important to us, and we look forward to developing a positive and healthy relationship. To start things off, we will be contacting your other medical providers and gathering all your medical records for review by the Doctors.

Attached is our New Patient Packet which should be **filled out completely with fax numbers** and returned to our office before we can schedule your first appointment.

Thank you,

New Patient Coordinator

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

Email: _____

How did you hear about us (check one):

☐Google ☐ Facebook ☐ Yelp

☐Referred by Dr._____ ☐Referred by friend ☐ Other: _____

Previous Pain Management Doctor:

Name: _____

Phone Number: _____

PAYMENT POLICY

As a service to our patients with insurance, we fill out and send your insurance claim into your insurance carrier. Upon admission to Charlotte Pain Management Center, you have contractually agreed to pay for services rendered to you. If you have health insurance coverage, CPMC will agree to file your initial claim(s) provided we have complete information at the time of service. However, your health insurance contract(s) is between you and the insurance carrier. Because of this relationship, you have a primary responsibility to pay for the services and provide follow-up communication with your health insurance carrier(s) if necessary. Should insurance reject your claim, for any reason, you are financially responsible. If your health insurance coverage requires you to pay a deductible percentage and/or co-pay, these amounts will be due the day of service. We will try to give you an estimate of the amount you may owe before your visit upon request. If we are contracted providers with your plan, you are not eligible for any additional discounts beyond the discount agreed upon with your health insurance carrier.

- We require all balances to be paid in full by a patient sixty (60) days after processing claim(s) by insurer.

Your responsibility is to know your plan:

- Know your yearly deductible and when it is due
- Know your maximum allowed fee for services in a calendar year.
- Know your visit co-pay and be prepared to pay at time of service
- Know that you have to follow up on claims submitted to your insurance company.

UNINSURED ONLY

A new patient office visit for patients without insurance is $295.00 and will require a $100.00 deposit when we receive this packet. The deposit is 100% refundable provided you cancel your appointment with at least 48 hours' notice, less than 48 hours cancellation will result in forfeiture of deposit. Follow-up appointments are $230.00.

We do not accept attorney lines. All services must be paid for on the day of your appointment. No payment plans are available at this time.

I have read and understand the office policy on payment for services rendered by Charlotte Pain Management Center.

_____	_____ _	_____
Print Patient Name	Signature Patient or parent/legal guardian	Date

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DRUG TESTING POLICY

It is the policy of Charlotte Pain Management Center to not accept any patient that abuses any illegal substance or takes any medication that has not been prescribed for them by a licensed medical provider. We do enforce our policy by doing urine drug screening randomly and discharge any patient found to be positive for any illegal or not prescribed controlled substance. Medical Marijuana users must have an up-to-date card from the State of Florida Office of Medical Marijuana Use.

PATIENT INFORMATION:

Name: _____ DOB: _____ Street Address: _____

City: _____ State: _____ Zip: _____

Select one:
❑Full Time Resident (Year-Round) ❑Winter Resident (Oct-Apr) ❑Summer Resident (May-Sep)

Home Phone: _____ Cell Phone: _____ SSN: _____

Sex: Sex assigned at birth: Relationship status:

❑Male ❑Female ❑Male ❑Female ❑Prefer not to say ❑Married ❑Single ❑Divorced ❑Widowed

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EMERGENCY CONTACTS:

Name: _____ Relationship: _____ Phone #: _____

GUARANTOR (if other than the patient):

Name: _____ Relationship: _____

Street Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION (Fill any that apply):
Do you have insurance? ❑Yes ❑No

Primary: _____ ID #: _____ Group #: _____

Secondary: _____ ID #: _____ Group #: _____

Workers Compensation Carrier: _____ Claim: _____

Date of Injury: _____ State: _____ Adjuster Name: _____

Adjuster Phone #: _____ Adjuster Fax #: _____

A copy of insurance cards must be attached to packet, or a copy will be taken in our office when the packet is dropped off

PRIMARY CARE PHYSICIAN AND/OR GROUP:

Physician Name: _____ Phone: _____

Fax: _____

Address: _ _____ City/State/Zip: _____

CHARLOTTE PAIN MANAGEMENT CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ **D. O. B.:** _____

REQUEST OF PATIENT INFORAMTION:

Name of Person or Facility: _____State: _____Last Visit: _____

Phone #: _____ **Fax #:** _____ Email: _____

Name of Person or Facility: _____ State: _____ Last Visit: _____

Phone #: _____ **Fax #:** _____ Email: _____

Name of Person or Facility: _____ State: _____ Last Visit: _____

Phone #: _____ **Fax #:** _____ Email: _____

Name of Person or Facility: _____ State: _____ Last Visit: _____

Phone #: _____ **Fax #:** _____ Email: _____

Name of Person or Facility: _____ State: _____ Last Visit: _____

Phone #: _____ **Fax #:** _____ Email: _____

PLEASE SEND THE FOLLOWING MEDIAL RECORDS TO (941) 883-0041 BEFORE, IF POSSIBLE, BEFORE _____: (If you have any questions, please call (941) 629-3000 or email GinaD@PainPC.com)

✖ Last 6 office visits

✖ Imaging reports – MRI/CT/X-RAY

This authorization expires in one year OR upon occurrence of the following events that relate to me or to the purpose of the intended use or disclosure of information about me.

I authorize the above information to be sent to, Charlotte Pain Management Center. This authorization extends to history of illness, diagnosis, and therapeutic information: including any treatment for drug and alcohol abuse, FIV testing, and/or AIDS related information. Incompliance with Florida Statute 397.507(7), 394, 4615, and Federal Law CFR 4.2, 064.058, 164.508.

_____ _____ _____

Print Patient Name Signature Patient or parent/legal guardian Date

CHARLOTTE PAIN MANAGEMENT CENTER

HIPPA PRIVACY CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosure of health information about the patient to carry out treatment, payment or health care 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 to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment and payment of heal care operations, in order to provide health care that is in your best interest.

We also want you to know that we support full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of you Personal Health Information (PHI) but this must be in writing. Under the law, we have the right to refuse to treat you, should you close to refuse to disclose your PHI. If you choose to give consent in the document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA compliance officer. You have the rights to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

_____ _____

Print Patient Name Signature Patient or parent/legal guardian Date

_____ _____

Print Witness Name Signature Witness or parent/legal guardian Date

CHARLOTTE PAIN MANAGEMENT CENTER

CONDITIONS OF MEDICAL SERVICE AND AGREEMENT

In consideration of and as a condition of the medical services I will receive at Charlotte Pain Management Center, I agree to the following:

1. I hereby assign and authorize payment of covered insurance benefits, including major medical benefits, whether payable to me by Blue Cross/Blue Sheild, Medicare and commercial insurance company or managed health care plan or directly payable to Charlotte Pain Management Center, now or in the future.

2. I understand that my health insurance may not cover some of any of the medical services I may receive. I understand that I am responsible for any and all charges actually paid by my health insurance to Charlotte Pain Management Center. That means, among other things, that I am responsible for deductibles, coinsurance and payments from an insurance company directly to me. I will take responsibility for making certain that any payment I send gets to the billing office of Charlotte Pain Management Center, located at 3109 Tamiami Trail, Unit 1-3, Port Charlotte, FL 33952.

3. I promise to pay Charlotte Pain Management Center all balances due within (60) days of final claim processing after 60 days, my bill becomes delinquent, accrues interest at the rate of ten (10) percent per month, and may be submitted for collection. If my bill has to be submitted for collection, I promise to pay all costs associated with it, including any attorney's fees that may be incurred. A collection fee of thirty percent (30%) of the balance is assessed. I will notify Charlotte Pain Management Center promptly of any change of address.

4. I have disclosed to Charlotte Pain Management Center the names of all my health insurance providers and any tie-in health coverage. *My health care coverage is in full force and in effect now*. If my health care coverage requires that I receive a referral for these medical services and I did not obtain one, I promise to do so immediately and submit it to Charlotte pain Management Center. I authorize the release of any and all medical information that may be required to process the claims for payment of the medical services I receive at Charlotte Pain Management Center and I waive all privilege and confidentiality to that extent.

5. I will ask clarification of any medical service, treatment or procedure I may not understand prior to receiving it and I acknowledge and accept that the results of any such service, treatment or procedure are not and cannot be guaranteed.

6. If I am currently involved, or, if after beginning my treatment at Charlotte Pain Management Center, I become involved in pursuing a personal injury claim against a third party, I understand that at my request and with my authorization Charlotte Pain Management can and will provide my attorney with all of my records of treatment. As a condition of treatment, I agree that having requested and received copies of my medical records, I (or my attorney) will not seek to subpoena my physician(s) at Charlotte Pain Management Center to provide factual information already contained in or covered by my records nor to provide expert testimony (or include their names on any list of expert witnesses) in my case without their prior written consent.

I have read through this document and assert that I understand it and sign it freely. Any signed copy of this document may be considered as valid as the original

_____ _____

Print Patient Name | Signature Patient or parent/legal guardian | Date

MEDICARE LIFETIME MEDIGAP ASSIGNMENT. Sign below if you have a MEDIGAP insurance policy.
I assign and authorize payment of MEDIGAP benefits to Charlotte Pain Management Center for any services I receive there. I authorize any holder of medical information that may be necessary to determine benefits to release it to the Health Care Financing Administration (HCFA) and its agent

_____ _____

Print Witness Name | Signature Witness or parent/legal guardian | Date

MEDICAL HISTORY

Patient Name: _____ **D. O. B.:** _____

1. Your chief pain complaint(s) are: _____
2. When did you first notice your pain?

   Month: _____ Day: _____ Year: _____
3. When did you first see a doctor for the pain you now have?

   Month: _____ Day: _____ Year: _____

4. What are your expectations regarding relief of your pain? _____

5. Where is your pain located? (check areas)

☐	Low back	☐	Left Ankle or Foot
☐	Mid Back	☐	Right Ankle or Foot
☐	Upper Back	☐	Left Shoulder
☐	Neck	☐	Right Shoulder
☐	Chest	☐	Left Arm
☐	Abdomen	☐	Right Arm
☐	Groin	☐	Left Hand or Wrist
☐	Left Buttock	☐	Right Hand or Wrist
☐	Right Buttock	☐	Head
☐	Left Thigh	☐	Face
☐	Left Calf	☐	Other (List) _____
☐	Right Calf		_____

6. Would you describe your pain as

Burning	☐	Yes	☐	No
Sharp	☐	Yes	☐	No
Aching	☐	Yes	☐	No
Throbbing	☐	Yes	☐	No
Shooting	☐	Yes	☐	No

   Other (describe) _____
   _____

7. Does your pain travel anywhere?

   ☐ Yes ☐ No

   ☐ If yes, where? _____

8. What time of day is your pain worse?

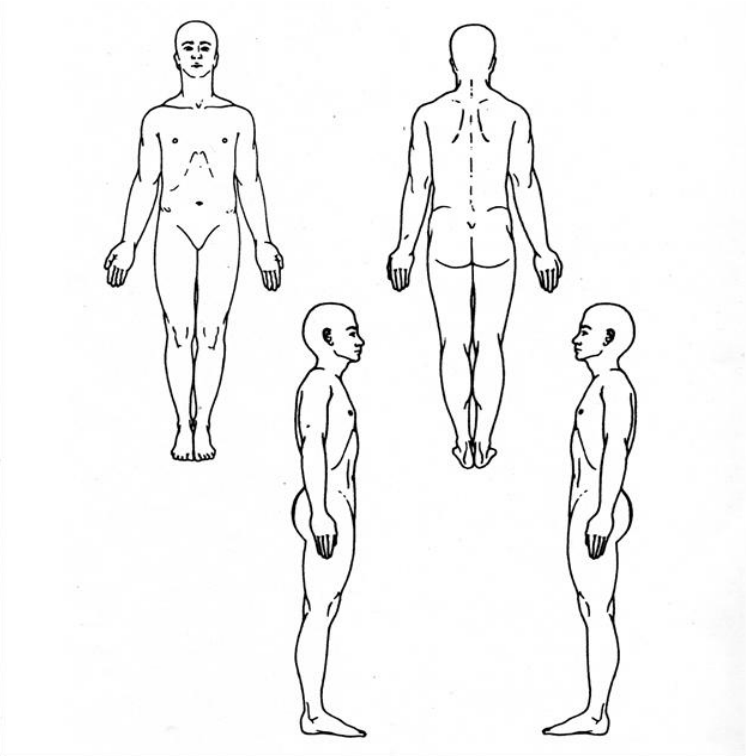
☐	Morning	☐	Later in the morning
☐	Afternoon	☐	Evening
☐	Bedtime	☐	Night (during usual sleeping hours)
☐	Pain varies, but is not worse at any particular time	☐	Pain is always the same

9. Do you have:

Numbness	☐	Yes	☐	No
Tingling, pins and needles	☐	Yes	☐	No

Weaknesses	☐	Yes	☐	No
Coldness	☐	Yes	☐	No
Increased Sweating	☐	Yes	☐	No
Muscle spasm, tightness	☐	Yes	☐	No
Skin Discoloration	☐	Yes	☐	No
Bowel or Bladder problems	☐	Yes	☐	No

10. Please indicate on this diagram where your pain occurs by shading the painful area(s)



11. Do any of the following make your pain feel worse?

Coughing, Sneezing	☐	Yes	☐	No
Sitting	☐	Yes	☐	No
Standing	☐	Yes	☐	No
Lying Down	☐	Yes	☐	No
Walking	☐	Yes	☐	No
Physical Activity	☐	Yes	☐	No
Sexual Activity	☐	Yes	☐	No
Bending forward/backward	☐	Yes	☐	No

Other (describe) _____

_____

12. Do any of the following make your pain feel better?

Relaxation	☐	Yes	☐	No
Sitting	☐	Yes	☐	No
Lying Down	☐	Yes	☐	No
Alcoholic Drinks	☐	Yes	☐	No
Sexual Activity	☐	Yes	☐	No
Heat	☐	Yes	☐	No

Medicines	☐	Yes	☐	No
Walking	☐	Yes	☐	No
Bending forward/backward	☐	Yes	☐	No
Other (describe) _____				
_____				
Nothing makes me feel better	☐	True	☐	False

13. Do you take medicines for pain relief?
    - ☐ No
    - ☐ Yes – less than one time per week
    - ☐ Yes – several times per week
    - ☐ Yes – one or two times per day
    - ☐ Yes – three or four times per day
    - ☐ Yes – five or more times per day
14. List any side effects/reactions you experienced from pain medications. _____
    _____
15. Have you had nerve blocks (injections) for pain relief?

    ☐ Yes ☐ No

    Name of Physician who performed blocks: _____
    Date of Procedure_____
    If yes, did they relieve pain?

    ☐ Yes ☐ No

    If yes, how long did you get relief:

    ☐ Less than one day ☐ A few days
    ☐ A few weeks ☐ More than one month
16. Have you had any of the following for relief of pain?

	If yes, did it relieve your pain?				
☐	Hypnosis	☐	Yes	☐	No
☐	Biofeedback	☐	Yes	☐	No
☐	Tens (electrical stimulation)	☐	Yes	☐	No
☐	Acupuncture	☐	Yes	☐	No
☐	Chiropractic Treatment	☐	Yes	☐	No
☐	Heat Therapy	☐	Yea	☐	No
☐	Bed rest	☐	Yes	☐	No
☐	Traction	☐	Yes	☐	No
☐	Osteopathic Treatment	☐	Yes	☐	No
☐	Psychotherapy/ Psychiatric	☐	Yes	☐	No
☐	Other (describe) _____				

If you suffer from headaches, please answer questions 17-20

17. Do you have a family history of migraine headaches?

    ☐ Yes ☐ No
18. Associated with your headache do you experience?

☐	Blurred vision	☐	Unequal pupils
☐	Double Vision	☐	Nausea
☐	Sensitivity to light	☐	Fatigue

☐ Loss of vision ☐ Eye tearing
☐ Other: _____ ☐ Vomiting

19. Location of your headaches:

☐ Back of head ☐ Forehead
☐ Around eyes ☐ Behind eyes
☐ Other: _____

20. Are your headaches "triggered" by:

☐ Exercise
☐ Alcohol
☐ Stress
☐ Other: _____

21. Have you had any of the following conditions?

	You		Family	
Arthritis (rheumatoid, osteo.)	☐ Yes ☐ No		☐ Yes ☐ No	
Asthma	☐ Yes ☐ No		☐ Yes ☐ No	
Bowel problems (IBS; diverticulosis)	☐ Yes ☐ No		☐ Yes ☐ No	
Bronchitis, other lung diseases	☐ Yes ☐ No		☐ Yes ☐ No	
Cancer (Type: _____)	☐ Yes ☐ No		☐ Yes ☐ No	
Diabetes (insulin; oral; diet)	☐ Yes ☐ No		☐ Yes ☐ No	
Epilepsy, seizures	☐ Yes ☐ No		☐ Yes ☐ No	
Hearing problems	☐ Yes ☐ No		☐ Yes ☐ No	
Hepatitis	☐ Yes ☐ No		☐ Yes ☐ No	
High Cholesterol	☐ Yes ☐ No		☐ Yes ☐ No	
Hypertension	☐ Yes ☐ No		☐ Yes ☐ No	
Irregular heart rhythm	☐ Yes ☐ No		☐ Yes ☐ No	
Kidney Stone	☐ Yes ☐ No		☐ Yes ☐ No	
Liver disease (jaundice; hepatitis)	☐ Yes ☐ No		☐ Yes ☐ No	
Migraine headaches	☐ Yes ☐ No		☐ Yes ☐ No	
Psychiatric disorder (depression; bipolar)	☐ Yes ☐ No		☐ Yes ☐ No	
Skin rash	☐ Yes ☐ No		☐ Yes ☐ No	
Stroke	☐ Yes ☐ No		☐ Yes ☐ No	
Thyroid disease	☐ Yes ☐ No		☐ Yes ☐ No	
Tuberculosis	☐ Yes ☐ No		☐ Yes ☐ No	
Ulcers, other stomach problems	☐ Yes ☐ No		☐ Yes ☐ No	
Other (list): _____	☐ Yes ☐ No		☐ Yes ☐ No	

22. Have you ever had surgery?

☐ Yes ☐ No

Please List:

Operation	Hospital	Date	Surgeon

23. Please list <u>all medication</u> you are currently taking (including herbal and over the counter):

Medication	Amount	Times

24. Do you have any allergies to drugs, foods, or grasses?

☐ Yes ☐ No

If yes, please describe _____

25. Are you presently experiencing any of the following?

- ☐ Depression
- ☐ Anxiety
- ☐ Useless feelings
- ☐ Poor Memory
- ☐ Active suicidal plan
- ☐ Crying, nearly crying
- ☐ Irritability
- ☐ Poor concentration
- ☐ Activity suicidal ideation

26. Do you suffer from any of the following? (check all that apply)

CARDIOVASCULAR

- ☐ Chest pain/ tightness
- ☐ Non-exertional
- ☐ Exertional
- ☐ Low blood pressure
- ☐ Rapid heartbeat
- ☐ Swelling of Ankles
- ☐ Varicose veins

EARS, NOSE, AND THROAT

- ☐ Bleeding gums
- ☐ Difficulty swallowing
- ☐ Earache
- ☐ Hay fever
- ☐ Hoarseness

CONSTITUTIONAL

- ☐ Fevers
- ☐ Weight gain _____ lbs past year
- ☐ Weight loss _____ lbs past year

EYES

- ☐ Loss of vision
- ☐ Blurred vision
- ☐ Crossed vision
- ☐ Double vision
- ☐ Vision-flashes

INTEGUMENTARY

- ☐ Brittle hair
- ☐ Bruise easy
- ☐ Change in moles

- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Sinus problems

GASTROENTEROLOGY

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Incontinence, fecal
- ☐ Indigestion
- ☐ Nausea
- ☐ Pain, abdominal
- ☐ Pain, stomach
- ☐ Pain, rectum
- ☐ Rectal bleeding
- ☐ Vomiting
- ☐ Vomiting
- ☐ Vomiting blood

ENDOCRINE

- ☐ Hyperglycemia
- ☐ Hypoglycemia
- ☐ Night Sweats
- ☐ Dry skin or rash on _____

MUSCULOSKELETAL

- ☐ Joint pain/stiffness/swelling
- ☐ Shoulder
- ☐ Elbows/wrist/hands
- ☐ Hips
- ☐ Knees
- ☐ Ankles/Feet

GENITOURINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Incontinent, urination
- ☐ Painful urination

REPIRATORY

- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Wheezing

NEUROLOGICAL

- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetful
- ☐ Headache
- ☐ Light-headed
- ☐ Near-fainting
- ☐ Numbness in _____

_____ _____

Print Patient Name Signature Patient or parent/legal guardian Date

Thank you for completing this questionnaire

CHARLOTTE PAIN MANAGEMENT CENTER

DRUG USE QUESTIONNAIRE (SOAPP-R)

Name: _____ Date: _____

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide answer of each question as honestly as possible, there are NO right or wrong answers.. Then, fill in the appropriate response beside the question. an non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions do not include alcoholic beverages. Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months.

Fill in the circle your response

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

_____ _____

Print Patient Name Signature Patient or parent/legal guardian Date

_____ _____

Print Witness Name Signature Witness or parent/legal guardian Date