

Charlotte Pain Management Center

3109 Tamiami Trail Unit 3, Port Charlotte, FL, 33952

Phone: (941) 629-3000 Fax: (941) 833-0041

Ginad@painpc.com

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

How did you hear about us (check one):

- Google Facebook Yelp Referred by Dr. _____
- Referred by friend Other: _____

Previous Pain Mangement Doctor: _____ Phone Number: _____

This packet must be completed in its ENTIRETY and returned to our office before we schedule your initial consultation

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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 of claim(s) by insurer.

Your responsibility is to know you 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 liens. 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

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.

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PATIENT INFORMATION:

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

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: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

REQUEST OF PATIENT INFORMATION:

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 BEFORE, IF POSSIBLE, BEFORE _____ :

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

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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 health 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 your Personal Health Information (PHI) but this must be in writing. Under the law, we have the right to refuse to treat you, should you choose 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

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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 Charlottte, 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 agents

Print Patient Name

Signature Patient or parent/legal guardian

Date

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NAME: _____

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). Under what circumstances did pain begin? (check one)

Date of Incident: _____

Accident at work

Accident at home

At work, but not an accident

Pain just began, no reason

Motor vehicle accident

Following surgery

Following illness

Other (describe): _____

5). What are your expectations regarding relief of your pain? _____

6). If pain began at work, please list:

Place of employment when pain began: _____

Date of injury: _____

How long were you employed there? _____

Type of work: _____

7). If you were injured at work, describe how:

Fall

Lifting object

Pushing

Struck by falling object

Struck by object

Injury from repetitive activity

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Not injured at work

Other: _____

8). If injury resulted from motor vehicle accident, were you:

Driving automobile/truck

Automobile/truck passenger

Driving motorcycle

Motorcycle passenger

Pedestrian

Describe details: _____

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

Low Back

Mid Back

Upper Back

Neck

Chest

Abdomen

Groin

Left Buttock

Right Buttock

Left Thigh

Right Thigh

Left Calf

Right Calf

Left Ankle or Foot

Right Ankle or Foot

Left Shoulder

Right Shoulder

Left Arm

Right Arm

Left Hand or Wrist

Right Hand or Wrist

Head

Face

Other (List)

10). Would you describe your pain as:

Burning Yes No

Sharp Yes No

Aching Yes No

Throbbing Yes No

Shooting Yes No

Other (describe): _____

11) Does your pain travel anywhere? Yes No

If yes, where? _____

12) Which statement best describes your pain?

Always present, always the same intensity

Charlotte Pain Management Center

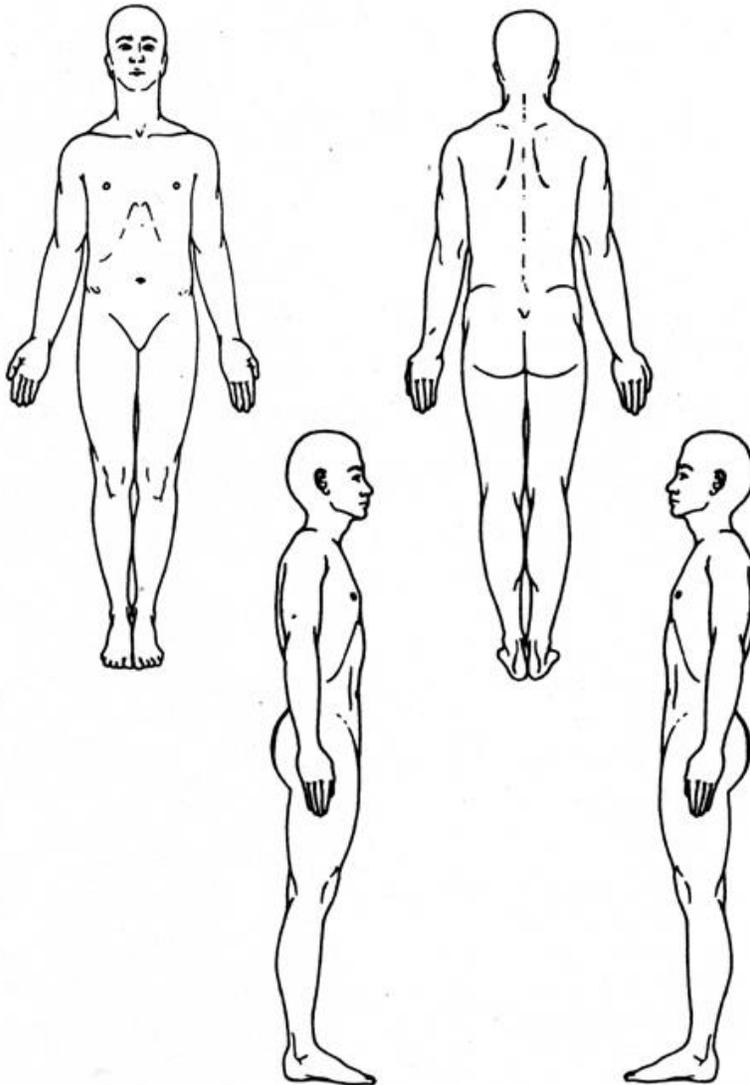
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- ☐ Always present, intensity varies
- ☐ Usually present, but have short periods without pain
- ☐ Often present, but have pain free periods lasting for one to several hours
- ☐ Often present, but am pain free for most of the day
- ☐ Occasionally present – have pain once to several times per day, lasting few minutes to an hour
- ☐ Occasionally present for brief periods, a few seconds to a few minutes
- ☐ Rarely present – have pain every few days or weeks

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



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14). Use the following rating scales to indicate how severe your pain is at its worst, at its least severe and as it usually is. Circle the appropriate number.

Your pain at its worst:

	0	2	3	4	5	6	7	8	9	10	
No pain	_ _ _ _ _ _ _ _ _ _ _										Unbearable Pain

Your pain at its least severe:

	0	2	3	4	5	6	7	8	9	10	
No pain	_ _ _ _ _ _ _ _ _ _ _										Unbearable Pain

Your pain at the present time:

	0	2	3	4	5	6	7	8	9	10	
No pain	_ _ _ _ _ _ _ _ _ _ _										Unbearable Pain

15). What time of day is your pain worse?

☐ Morning, on arising

☐ Afternoon

☐ Bedtime

hours)

☐ Pain varies, but is not worse at any particular time

☐ Later in the morning

☐ Evening

☐ Night (during usual sleeping

☐ Pain is always the same

16). Do you have:

- | | | | |
|----------------------------|-------|------|--|
| Numbness | ☐ Yes | ☐ No | |
| Tingling, pins and needles | ☐ Yes | ☐ No | |
| Weakness | ☐ Yes | ☐ No | |
| Coldness | ☐ Yes | ☐ No | |
| Increased sweating | ☐ Yes | ☐ No | |
| Muscle spasm, tightness | ☐ Yes | ☐ No | |
| Skin discoloration | ☐ Yes | ☐ No | |
| Bowel or bladder problems | ☐ Yes | ☐ No | |

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

- | | | | |
|--------------------|-------|------|--|
| Coughing, sneezing | ☐ Yes | ☐ No | |
| Sitting | ☐ Yes | ☐ No | |
| Standing | ☐ Yes | ☐ No | |
| Lying down | ☐ Yes | ☐ No | |

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Walking Yes No
Physical activity Yes No
Sexual activity Yes No
Bending forward / backward Yes No
Other (describe): _____

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

Relaxation Yes No
Sitting Yes No
Standing 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

19). 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

If you take medication for pain, do you take it:

When needed for pain
 Regularly, by the clock

20) On the average does the medications you take:

Always take the pain away Always make the pain less
 Usually take the pain away Usually make the pain less
 Provide little, if any relief Do not take pain medicine

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21) How long does medicine provide relief?

Less than one hour

2-1 hours

4-2 hours

6-4 hours

More than 6 hours

Do not take pain medicine

22) List any side effects/reactions you experienced from pain medications _____

23) 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

24) 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 Yes No

Bed rest Yes No

Traction Yes No

Osteopathic Treatment Yes No

Psychotherapy/Psychiatric Yes No

Other: _____

25) Since your pain began, has it:

Increased

Decreased

Stayed the same

26) If you suffer from headaches, please use a 0-3 scale to measure the severity of your pain.

On a 30 day cycle, how many days do you have no (0) headaches? _____ days

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On a 30 day cycle, how many days do you have “nagging” only (#1) headaches? ___ days

On a 30 day cycle, how many days do you have “interfering” (#2) headaches? ___ days

On a 30 day cycle, how many days do you have “incapacitating” (#3) headaches? ___ days

If you suffer from headaches, please answer questions 27-32

27) What is your headache like right now? (Circle the number that applies): 0 1 2 3

28) Do you have a family history of migraine headaches? Yes No

29) Associated with your headache do you experience?

Blurred vision

Double vision

Sensitivity of light

Loss of vision

Unequal pupils

Nausea

Fatigue

Eye tearing

Vomiting

Other: _____

30) Location of your headaches:

Back of head

Around eyes

Forehead

Behind Eyes

Other: _____

31) Are your headaches “triggered” by:

Exercise

Alcohol

Stress

Other: _____

32) Have you had any of the following conditions?

You

Family

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

33) Have you ever had surgery? ÿ Yes ÿ No

Please list:

Operation	Hospital	Date	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

34). Please list all medications you are currently taking (including herbal and over the counter):

Medication	Amount	Times
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- ÿ Hay fever
- ÿ Hearing loss
- ÿ Hoarseness
- ÿ Nosebleeds
- ÿ Ringing in ears
- ÿ Sinus problems

NEUROLOGICAL

- ÿ Dizziness
- ÿ Fainting
- ÿ Forgetfulness
- ÿ Headache
- ÿ Light-headed
- ÿ Near-fainting
- ÿ Numbness in _____

GASTROENTEROLOGY

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

RESPIRATORY

- ÿ Double vision
- ÿ Vision-flashes

INTEGUMENTARY

- ÿ Brittle hair
- ÿ Bruise easy
- ÿ Change in moles
- ÿ Dry skin or rash on _____

MUSCULOSKELETAL

- ÿ Joint pain/stiffness/swelling
- ÿ Shoulder
- ÿ Elbows/Wrists/hands
- ÿ Hips
- ÿ Knees
- ÿ Ankles/feet

GENITOURINARY

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

Male Only

- ÿ Breast lump
 - ÿ Ejaculation problem
 - ÿ Erection problem
 - ÿ Penis discharge

Female Only

- ÿ Abnormal Pap
- ÿ Bleeding between periods
- ÿ Excessive with periods
- ÿ Breast lump
- ÿ Hot flashes
- ÿ Nipple discharge
- ÿ Painful intercourse
- ÿ Vaginal discharge

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- ÿ Shortness of breath ÿ At night ÿ At rest ÿ With exertion
- ÿ Chronic cough
- ÿ Wheezing

Patient's Signature

Patient's Name (please print)

Thank you for completing this questionnaire

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DRUG USE QUESTIONNAIRE (SOAPP-R)

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 to each question as honestly as possible, there are NO right or wrong answers. Then, fill in the appropriate response beside the question. a 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.

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

Print Patient Name

Signature Patient or parent/legal guardian

Date

Print Witness Name

Signature Witness or parent/legal guardian

Date