COMPREHENSIVE **PAINCARE** OF SOUTH FLORIDA

Patient Information

First Name	Middle Name	Last Name	Gender
Street Address	City, State, Zip	Email Address(Required)	
Date of Birth / /	SSN - -	Marital Status ☐ Married ☐ Single ☐ Partnered ☐ Widowed	
Home Phone	Cell Phone	Work	May we web enable the Patient Portal (required) ☐ Yes ☐ No
Occupation ☐ Check here if Retired	Employer	Is this Auto Related? ☐ Yes ☐ No Is this Work Comp? ☐ Yes ☐ No	
Primary Care Physician	Referred By	Referred To	

Race ☐ White ☐ Black or African American ☐ Hispanic ☐ Asian ☐ Pacific Islander ☐ American Indian or Alaskan Native ☐ Other Race________________ ☐ Unreported/Decline

Preferred Language	Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unreported/Decline	
Emergency Contact	Contact Phone	Relationship to Patient

Primary Insurance_____________ Subscriber___________________ Subscriber DOB: ____________	Policy #_______________________ Claims Address ________________ _______________________________	Group#_____________ Relationship of Financial Party to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Guardian
Secondary Insurance___________ Subscriber___________________ Subscriber DOB: __________	Policy #_______________________ Claims Address ________________ _______________________________	Group#_____________ Relationship of Financial Party to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Consent to Leave Phone Messages

I understand that as part of my health care and treatment, Comprehensive Pain Care of South Florida (CPCSFL) and/or its' outpatient facilities may need to reach me by phone.

( ) I **DO** authorize CPCSFL or its' outpatient facilities to leave a message on my: ☐ home telephone ☐ cell phone, and/or ☐ work phone regarding communication of my health care/treatment such as instructions for procedures, clinical, billing, and/or appointment needs.

( ) I **DO NOT** authorize CPCSFL or its' outpatient facilities to leave a message on my home, cell or work phone regarding communication of my health care/treatment such as instructions for procedures, clinical, billing and/or appointment needs. **I *understand that selecting this option may result in delayed communication of pertinent treatment information such as preop screenings, appointment confirmations, billing communications or clinical callbacks. I understand that I will be responsible to make appointments to obtain this information.***

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List below any persons/family member whom you authorize access to your medical records and/or authorize us to leave a detailed message regarding all aspects of your medical chart, health condition, medications and financial history.

Name:________________________________ Relationship to Patient:__________________________

Name: ________________________________Relationship to Patient:___________________________

May we leave a detailed message on voice mail/answering machines? ☐ **Yes** ☐ **No**

Patient or Legal Guardian Signature______________________________________

MEDICATION POLICY

1. Medication will only be filled at your monthly medication follow up appointment.
2. Medication issues will not be handled on Friday due to physician availability
3. Medication changes require an appointment.
4. During your appointment please make sure that you receive all of your prescriptions you need for the month.
5. If you have an adverse reaction to the medication you will call the office immediately or go to your nearest emergency room.
6. Please safeguard your medications against theft. Please lock up your medication cabinets, car and/or checked baggage. **Lost, stolen or misplaced medication will not be replaced**.

MEDICATION PRIOR AUTHORIZATION POLICY

As your pain management medical practice, the Comprehensive Pain Care of South Florida providers make every effort to ensure that you receive the safest, most effective, and reasonably priced prescription drugs we feel are best suited for your healthcare. We must also abide by regulations set by your insurance companies and government agencies. Increasingly, many health insurance companies or plans are requiring prior authorization or approval for an increasing number of drugs. As this is an additional and labor-intensive service, our nursing staff completes, Comprehensive Pain Care of South Florida will charge an administrative fee of $25 per authorization. This cost is an out-of-pocket expense to you and is not covered by insurance. The fee must be paid before prior authorization initiation. You can be assured that your provider will take every step necessary to provide you with cost effective treatments and alternatives. We will fully evaluate your medical needs, and if appropriate, recommend a medication that does not require a Prior Authorization. Please also take note that although we will initiate a prior authorization request to the insurance company, the final decision of approval or denial rests with your insurance company. Please feel free to contact our office at 561-795-8655 with any questions.

I acknowledge that I have been advised of the above stated policy.

Patient or Legal Guardian Signature____

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APPOINTMENT NO-SHOW POLICY

Out of courtesy to other patients who are in need of office visits or procedures, to assist with their pain therapy, we require 24 hours advanced notice of cancellation.

If you fail to keep your office visit/non-procedure appointment and do not provide 24 hours advance notice, you will be assessed a **$25.00 cancellation fee.**

If you fail to give our office 24 hours advance notice of cancellation of a procedure appointment, scheduled outpatient or in the office, you will be assessed a **$75.00 cancellation fee**.

This fee will not be billed to your insurance company and must be paid prior to any additional appointment or medication refills. Our intention is to provide effective and timely treatment for our patients. Your assistance and cooperation in this matter is greatly appreciated.

I acknowledge that I have been advised of the above stated policy.

Patient or Legal Guardian Signature ____

ASSIGNMENT OF INSURANCE BENEFITS

By my signature below, I am authorizing COMPREHENSIVE PAIN CARE OF SOUTH FLORIDA to release protected health information contained in my medical record to my insurance company or third party payer in order to process claims being submitted on my behalf by COMPREHENSIVE PAIN CARE OF SOUTH FLORIDA upon written request from the insurance company or third party payer. Only requested information required to process my claim or to determine coordination of benefits will be forwarded to my insurance company. I hereby irrevocably assign to COMPREHENSIVE PAIN CARE OF SOUTH FLORIDA all payments made by my insurance company or third party payer for medical services rendered to me. I understand I am financially responsible for all charges whether or not covered by my insurance company and I will make prompt payment of any balance remaining upon receipt of a billing statement from COMPREHENSIVE PAIN CARE OF SOUTH FLORIDA.

If your account is referred to an outside collection agency, you will be responsible for all attorney fees, collection costs or any fees pertaining to the collection of your debt.

Patient or Legal Guardian Signature:____

REFERRAL/AUTHORIZATION POLICY

I understand that Comprehensive Pain Care of South Florida contracts with health care service plans (i.e., HMOs, PPOs) which **may require** a referral/authorization from my Primary Care Physician/Insurance for my office visits. I understand that it is my responsibility to make sure that I have the proper and necessary referral/authorization at the time of my visit. I understand that it is Comprehensive Pain Care of South Florida's policy to allow a 15-minute grace period to allow me to obtain my referral should I present to my appointment without one. Our intention is to provide effective and timely treatment for our patients. Your assistance and cooperation in this matter is greatly appreciated.

I acknowledge that I have been advised of the above stated policy.

Patient or Legal Guardian Signature: ____

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PAYMENT RESPONSIBILITY AGREEMENT

I understand by obtaining services from Comprehensive Pain Care of South Florida (CPC), I will be responsible for payment at the time of service for any co-payments, co-insurance, deductible or previous balances due upon request. If I have provided adequate insurance information, I understand the claim will be filed with my insurance company as a courtesy and any balances assigned to me by my insurance company will be payable upon request. If my insurance company denies all or part of my services due to termination of coverage, exhausted benefits, or information I have failed to provide to my insurance company for processing of my claim, I will become fully responsible for payment of said services.

I understand if I dispute charges billed to me by Comprehensive Pain Care of South Florida, I must do so by telephone call the business office at (561)795-8655 or in writing within 30 days of receipt of the first billing statement received in order for consideration and investigation of the dispute. I understand I am responsible for being pro-active in the resolution process and must communicate with both my insurance company and the physician's office in order to assist with resolving the billed charges and I agree to make payment without delay.

I understand Comprehensive Pain Care of South Florida, can only determine benefits based on information received from my insurance company the day of my visit, however, my insurance does not guarantee payment based on verification of coverage until the claim is received and processed the their office. I will not hold Comprehensive Pain Care of South Florida or its representatives responsible for misinformation provided by my insurance at the time of my service. If I dispute the results of claims processing by my insurance company, I will settle my account with Comprehensive Pain Care of South Florida, and then contact my insurance company for correction or resolution of the disputed claim(s).

Patient or Legal Guardian Signature_______________________________________

NON-COVERED, NON-AUTHORIZED, DENIED OR NOT MEDICALLY NECESSARY SERVICES

I understand that Comprehensive Pain Care of South Florida, contracts with health care service plans (i.e., HMOs, PPOs) which specifically state services which are "covered" by the health care services plan. Accordingly, the undersigned accepts full financial responsibility for all services, which are determined by the health care services plan not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract or deemed experimental/investigational with a health care service plan or in the benefits summary the plan furnishes to the patient; and treatment or test not authorized, not covered, denied or not medically necessary by the health care service plan. The undersigned agrees to cooperate with Comprehensive Pain Care of South Florida to obtain necessary health care authorizations. I understand that although my insurance plan may require pre-certification, authorization or pre-service determination, this is not a guarantee of payment, benefits are determined at the time the claim is processed as determined by your benefit plan and clinical guidelines. I understand that not all services provided are considered medically covered services by my health plan and payment will be due at time of service.

If I have any questions or would like to discuss fees for my service, I will contact Comprehensive Pain Care of South Florida's billing department before scheduling and/or receiving my services.

Patient or Legal Guardian Signature: ____

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FORM POLICY

We understand that at times, various forms may be required to assist you with your healthcare needs. However, because this requires dedicated time, you will need to make a Form Follow Up appointment in order to have forms filled out. This includes forms such as FMLA, Short-Term Disability, and disabled parking forms. In general, we do not complete Long-Term Disability forms. As an office policy, the staff cannot accept forms that are dropped off, you will be asked to make an appointment. Faxed or mailed forms will require an appointment. Your personal information section(s) must be filled out completely prior to our office completing the form. Your physician may refer you to another physician or for additional testing before completing a form. Comprehensive Pain Care of South Florida reserves the right to refuse to complete forms at the discretion of your physician. Please make sure that you have your form before you leave the office.

Patient or Legal Guardian Signature: ____

CODE OF CONDUCT POLICY

As a patient of Comprehensive Pain Care of South Florida, you have the right to be treated with courtesy and respect. As such, we ask that you and/or your representative treat our staff, other patients, and physicians with respect and courtesy. In order for the practice to maintain good relations with our patients we would like to ask you to read and take note of the occasional types of behavior that would be found unacceptable:

- Using bad language or swearing at practice staff or other patients
- Any physical violence toward a member of the staff or other patients, such as pushing or shoving
- Verbal abuse toward the staff or other patients in any form including, verbal insults
- Racial abuse or sexual harassment will not be tolerated within this practice
- Persistent or unrealistic demands that cause stress to the staff. Request will be met whenever possible and explanations will be given when they cannot.
- Causing damage/stealing from the Practice's premises, staff or patients

Patient or Legal Guardian Signature: ____

PATIENT PORTAL

Comprehensive Pain Care of South Florida offers you access to your own personal web portal where you can obtain your records and contact the office. The portal can be used to request and view appointments, message the office, update demographic information, and view your personal health record. The portal is not for urgent issues. Please call the office directly at (561) 795-8655 for urgent issues. Please provide your email address for this function.

Email:____

I have fully read and understand and accept the terms of Comprehensive Pain Care of South Florida

______________________________	______________________________	________________
Patient Name or Legal Guardian (*printed*)	Patient Signature or Legal Guardian	Date
______________________________	______________________________	________________
Witness Name (*printed*)	Witness Signature	Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ___________________________________, have received a copy of this office's Notice of Privacy Practices.

NAME ____

SIGNATURE____

DATE____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because:

__________________ Individual refuses to sign

__________________ Communication barriers prohibited obtaining the acknowledgement

__________________ An emergency situation prevented us from obtaining acknowledgement

__________________ Other ____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

____

SECTION A: Patient Giving Consent

Name: ____

Address: ____

Telephone: __________________________Social Security Number________________________________

____

SECTION B: To the Patient- Please read the following carefully

Purpose of Consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Privacy Officer

Address: 2585 South State Road 7, Suite 110, Wellington, Florida 33414

Telephone: Phone 561-795-8655 Fax: 561-795-8449

Right to Revoke. You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE

I ____________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy. I understand that, by signing this Consent form, I am giving my consent for your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: ____ Date:_________________________________

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MEDICATION MANAGEMENT AGREEMENT

This agreement between ______________________, ("Patient") and Comprehensive Pain Care of South Florida ("Provider") is for the purpose of establishing between Provider and Patient on clear conditions an agreement between Patient and Provider for the prescription and use of pain controlling medications prescribed by the Provider for the Patient. Provider and Patient agree that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship.

The patient agrees to and accepts the following conditions for the management of pain medication prescribed or provided by the Provider for the Patient:

I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.

I realize that all of the medications have potential side effects and I will have the recommended laboratory studies required to keep the regimen as safe as possible.

I am responsible for my pain medications. I agree to take the medication only as prescribed by the Provider. I understand that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation and respiratory depression and death.

I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal. Withdrawal symptoms include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramps and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks.

I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my medication for a period of time. I agree to use _____________________ Pharmacy, located at ____, telephone number _________________, for all my pain medication. If I change pharmacy for any reason, I agree to notify the Provider at the time I receive a prescription and advise my new pharmacy of my prior pharmacy's address and telephone number.

I understand the side effects that are related to opioid medication. Common side effects are nausea and vomiting (similar to motion sickness), drowsiness and constipation. Less common side effects are mental slowing, flushing, sweating, itching, urinary difficulty, and jerkiness. These side effects would occur at the beginning of my treatment and often go away within a few days without treatment. It is my responsibility to notify my physician of any side effects that continue and/or are severe (i.e. sedation, confusion). I am responsible for notifying my pain physician immediately if I need to visit another physician or emergency room due to pain or if I become pregnant.

I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used my medication for at least four days.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell, or trade my medication for money, goods, or services.

I will not attempt to get pain medication from any other health care provider without telling them I am taking pain medication prescribed by the pain Provider. I understand it is against the law to do so. If my primary care physician is willing to prescribe my medications, the Provider will have to approve the arrangements to make sure there is no duplication. <u>I will discontinue all previously used pain medications, unless told to continue them.</u>

I understand I must contact my pain physician before taking other drugs. Medications like Valium or Ativan, sedatives such as Soma, Xanax, Fiorinal, antihistamines like Benadryl, and alcohol may produce profound sedation, respiratory depression, blood pressure drop, and even death when taken with opioids.

During the time my dose is being adjusted, I will be expected to return to the pain office at least once a month or whenever instructed by my pain physician.

I understand that opioid prescriptions will not be mailed. I will pick up my refill prescription at the office every month during scheduled medication maintenance office visits. If I am unable to obtain my prescriptions monthly, I will be responsible for finding a local physician who can take over the writing of my prescriptions with consultations from my pain physician.

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I am responsible for my opioid prescriptions. I understand that refill prescriptions can only be written for a one-month supply and will be filled at the same pharmacy. Refill prescriptions will only be written during my monthly medication maintenance visits to the office. It is my responsibility to call at least two weeks in advance to schedule these appointments.

I understand medication refills will not be written if I "run out early", "lose a prescription", or "spill or misplace my medications". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen I will report this to my local police department and obtain a stolen item report. Replacement prescriptions will be given at the discretion of my physician.

Refills will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow". NO prescriptions will be filled on days when there is not a medication maintenance visit.

While physical dependence is expected after long-term use of opioids, signs of addiction (and psychological dependence) shall be interpreted as a need for weaning and detoxification. Physical dependence is common to many drugs such as blood pressure medications, anti-seizure medications, and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal response.

Addiction is a psychological and behavioral syndrome that is recognized when the patient abuses the drug to obtain mental numbness and euphoria; the patient shows a drug craving behavior or the patient "doctor shops"; the drug is quickly escalated without correlation to pain relief; and/or the patient shows a manipulative attitude toward the physician in order to obtain the drug. If the patient exhibits such behavior, the drug will be tapered and the patient will be considered not a candidate for the opioid trial. The patient will be discharged from the practice.

Tolerance is a pharmacological property of certain drugs and is defined as a need for higher doses to maintain the same drug-related effect.

If it appears to the physician that there is no improvement to my daily function or quality of life from the controlled substance my opioids may be discontinued. I will gradually taper my medication as prescribed by my physician.

As a rule, prescriptions will be given in advance to accommodate for extended vacations or any other extended period away from home. Otherwise, prescriptions will be written once a month. A 3-day grace period may be given if the prescription ends on a weekend or holiday. Exceptions <u>will not</u> be made for distance traveled to fill prescriptions.

I agree to submit to urine, oral swabs and/or blood screens at any time as determined by my physician to detect the use of both prescribed and non-prescribed medications.

I authorize the release of any information and medical records by the Provider or his/her designee to other health care providers, my family, my employer, my insurance carrier, or other reimbursing agency. I also authorize any pharmacy to release information regarding my prescriptions. I further more understand that Comprehensive Pain Care of South Florida may electronically prescribe(e-prescribe) my medications and may use this method to obtain or release information from other healthcare providers and/or third party pharmacy benefit payors regarding my medication history for treatment purposes. I understand any single violation to the above conditions may result in termination of my opioid medications. I will then be gradually taken off this medication and other therapies will be used or I may also be discharged from the practice.

<u>I understand that if my medication is stolen, missing, or misplaced, I will report this to my local police department and obtain a police report with a case number. It is my responsibility to make sure that I secure my medications or prescriptions when they are given to me. I understand medication refills will not be written if I "run out early", "lose a prescription", or "spill or misplace my medications". I will be required to obtain a police report. Prescriptions will be written at the discretion of the physician. If I do not have a police report, I understand that my medication will not be replaced.</u>

I ____________________________ have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give consent to participate in the opioid medication therapy.

____ ________________________________
Patient signature Date

____
Witness signature

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By Florida Statute 893.13 it is a third degree felony, punishable by up to 5 years in prison and a $5,000.00 fine if:

1. You do not tell a physician who prescribes you narcotic pain medication that you received narcotic pain medications from another physician since your last visit.

2. You possess or attempt to possess narcotic pain medication by misrepresentation, fraud, forgery, deception, or subterfuge.

By signing this document, I hereby swear under penalty of perjury that I have not been prescribed narcotic pain medication from another physician since my last visit to Comprehensive Pain Care and that I am in full compliance with Florida statute 893-13 as it is outline above.

Patient's Signature: ____

Date: ____________________________

Witness' Signature:____

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