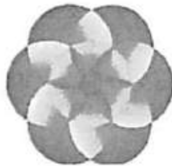
Pioneer
PAIN MANAGEMENT



Center for Pain Management
New Patient Intake Form

Your completed intake paperwork helps our physician and other providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call (772) 446-4883 if you have any question on how to complete any section on this form.

Patient Information

Today's date: ______________________

Your name: ______________________ Date of Birth: ______________ Age: ________

Referring Physician: ______________________ Primary Care Physician: ______________________

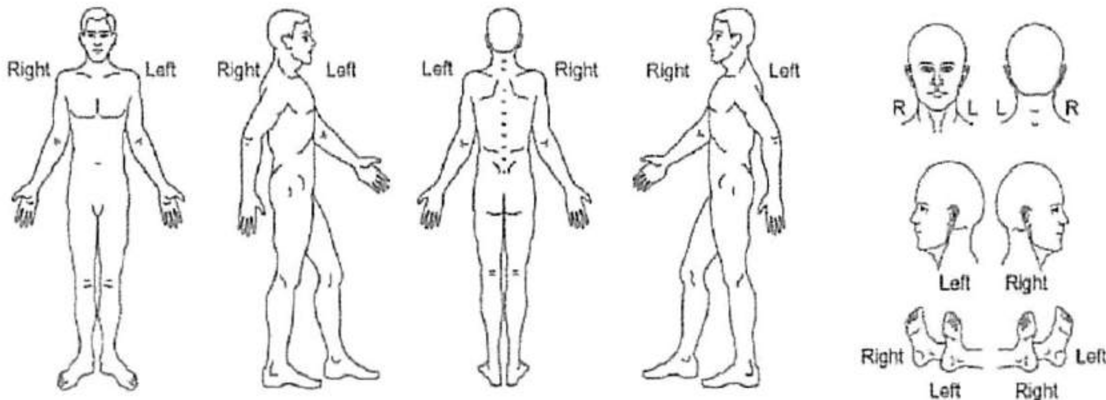
Pain History

Chief Complaint (Reason for your visit today)? ______________________

Does this pain radiate? If so where? ______________________

Please list any additional areas of pain: ______________________

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Onset of Symptoms

Approximately when did this pain begin? ______________________

What caused your current pain episode? ______________________

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

Since your pain began how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Pain Description

Check all of the following that describe your pain:

☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp

☐ Cramping ☐ Numbness ☐ Spasming ☐ Throbbing

☐ Squeezing ☐ Tingling/Pins and Needles ☐ Tightness

When is your pain at its worst?

☐ Mornings ☐Daytime ☐ Evenings ☐ Middle of the night

☐ Always the same

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present

☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now__________ The Best It Gets__________ The Worst It Gets__________

Mark the effect each of the following have on your pain level - ☑

	Increases	Decreases	No Change
Bending Backward	☐	☐	☐
Bending Forward	☐	☐	☐
Changes in Weather	☐	☐	☐
Climbing Stairs	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Driving	☐	☐	☐
Lifting Objects	☐	☐	☐
Looking upward	☐	☐	☐
Looking downward	☐	☐	☐
Rising from seated position	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐

What other factors worsen or affect your pain which is not mentioned above?

____

____

Associated Symptoms

	NO	Yes	Comments
Numbness/Tingling	☐	☐	Where? ________
Weakness in the arm/leg	☐	☐	________
Balance Problems	☐	☐	________
Bladder Incontinence	☐	☐	________
Bowel Incontinence	☐	☐	________
Joint Swelling/Stiffness	☐	☐	________
Fevers/chills	☐	☐	________

Please mark all of the following treatments you have used for pain relief: ☑

	No Change	Worsened Pain	Helped Pain
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
Medications	☐	☐	☐
TENS Unit	☐	☐	☐

Other ________________________________

Interventional Pain Treatment History

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar

☐ Joint Injection – Joint(s) ________________________________

☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar

☐ MILD (Minimally Invasive Lumbar Decompression) - ________________________________

☐ Nerve Blocks – Area/Nerve(s) - ________________________________

☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar

☐ Spinal Cord Stimulator – Trial Only/Permanent Implant ________________________________

☐ Trigger Point Injections – Where? ________________________________

☐ Vertebroplasty/Kyphoplasty – Level(s) ________________________________

☐ Other - ________________________________

Which of these procedures listed above have helped with your pain? ________________________________

____

Diagnostic Tests and Imaging

Mark all of the following tests that you have related to your current pain complaints:

☐MRI of the: ______________________ Date: __________

☐X-Ray of the: ______________________ Date: __________

☐CT Scan of the: ______________________ Date: __________

☐EMG/NCV study of the: ______________________ Date: __________

☐Other Diagnostic Testing: ______________________ Date: __________

☐ I have not had ANY diagnostic tests for my current pain complaint

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist ☐ Neurosurgeon ☐ Psychiatrist/Psychologist

☐ Chiropractor ☐ Orthopedic Surgeon ☐ Rheumatologist

☐ Internist ☐ Physical Therapist ☐ Neurologist

☐ Other ____

Past Medical History

Please list the names of other Pain Physicians you have seen in the past?________________________

____

Mark the following conditions/diseases that you have been treated for in the past:

General Medical
- ☐ Cancer – Type ______________
- ☐ Diabetes – Type______________

Cardiovascular/Hematologic
- ☐ Anemia
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stoke/TIA
- ☐ Heart Valve Disorders

Gastrointestinal
- ☐ GERD (Acid Reflux)
- ☐ Gastrointestinal Bleeding
- ☐ Stomach Ulcers
- ☐ Constipation

Urological
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Dialysis

Neuropsychological
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar Disorder

Head/Ears/Eyes/Nose/Throat
- ☐ Headaches
- ☐ Migraines
- ☐ Head Injury
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Glaucoma

Respiratory
- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD

Musculoskeletal/Rheumatologic
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Joint Pains

Other Diagnosed Conditions
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

1) ________________________ Date? __________

2) ________________________ Date? __________

3) ________________________ Date? __________

4) ________________________ Date? __________

5) ________________________ Date? __________

☐ I have **NEVER** had any surgical procedures performed.

Current Medications

Are you currently taking any blood thinners or anti-coagulants? ☐ YES ☐ No

If YES, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other __________

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

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

Please list all past pain medications that you have been on at any point for your current pain complaints?

Medication Name	Dose	Frequency
1)		
2)		
3)		
4)		
5)		

Allergies

Do you have any drug/medication allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

Medication Name	Allergic Reaction
1) ______	______
2) ______	______
3) ______	______
4) ______	______
5) ______	______

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

Family History

Mark all appropriate diagnoses as they pertain to your first degree relatives:

☐Arthritis ☐Cancer ☐Diabetes

☐Headaches/Migraines ☐High Blood Pressure ☐Kidney Problems

☐Liver Problems ☐Osteoporosis ☐Rheumatoid arthritis

☐Seizures ☐ Stroke

☐Other Medical Problems: ______

☐ I have no significant family medical history

Social History

Occupation: ______ When was the last time you worked? ______

Who is in your current household? ______

Are there any stairs in your current home? ______ If so how many? ______

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

Are you currently under worker's compensation? ☐ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

Alcohol Use:

☐ Social Use ☐ History of alcoholism ☐ Current alcoholism ☐Never

☐ Daily use of alcohol

Tobacco Use:

☐ Current user ☐ Former user ☐ Never used

☐ Packs per day? ______ ☐ How many years? ______ ☐ Quit Date: ______

Illegal Drug Use:

☐ Denies any illegal drug use ☐ Currently uses illegal drugs

☐ Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

Review of Systems

Mark the following symptoms that you currently suffer from:

Constitutional:	☐ Chills	☐Difficulty sleeping	☐ Easy bruising
	☐ Night Sweats	☐Fatigue	☐ Fevers
	☐ Insomnia	☐ Low sex drive	☐ Tremors
	☐ Unexplained Weight Gain		☐ Weakness
	☐ Unexplained Weight Loss		

Eyes:	☐ Recent Visual changes

Ears/Nose/Throat/Neck:	☐ Dental Problems	☐ Earaches	☐ Hearing Problems
	☐ Nosebleeds	☐ Sinus problems	

Cardiovascular:	☐ Chest Pain	☐ Bleeding Disorder	☐ Blood Clots
	☐ Fainting	☐ Palpitations	☐ Swelling in feet
	☐ Shortness of breath during sleep		

Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of breath

Gastrointestinal:	☐ Constipation	☐ Acid Reflux	☐Abdominal Cramps
	☐ Diarrhea	☐ Nausea/Vomiting	☐ Hernia

Musculoskeletal:	☐ Back Pain	☐ Joint Pains	☐ Joint Stiffness
	☐ Joint Swelling	☐ muscle spasms	☐ Neck Pain

Genitourinary/Nephrology:	☐ Flank Pain	☐ Blood in Urine	☐ Painful Urination
	☐ Decreased Urine Flow/Frequency/Volume		

Neurological:	☐ Dizziness	☐ Headaches	☐ Tremors
	☐ Numbness/Tingling		☐ Seizures

Psychiatric:	☐ Depressed Mood	☐ Feeling Anxious	☐ Stress Problems
	☐ Suicidal Thoughts	☐ Suicidal Planning	
	☐ Thoughts of Harming Others		

Date/Time: ____________________

☐ All other review of systems negative

Physician Signature: ____________________

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's HIPAA Privacy Notice:

By subscribing my name below, I acknowledge that PIONEER PAIN MANAGEMENT has provided a copy of the HIPAA Privacy Notice, and that I have read (or had the opportunity to read if I so chose), understand my rights and ask questions regarding my rights and receive answers to my satisfaction, and agree to its terms.

______________________ ______________________________ ________________

Name of Patient | Signature of Patient/Parent/Guardian | Date

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: ______________________________ Last four digits of his/her SSN or password (required): ________
Print Name: ______________________________ Last four digits of his/her SSN or password (required): ________
Print Name: ______________________________ Last four digits of his/her SSN or password (required): ________

I, ___________________________, acting on behalf of my minor son/daughter_______________________

Parent/Guardian (print) | Name of Patient

as legal Personal Representative in all matters. If representative is a court appointed legal guardian, a copy of court documents must be provided and kept in medical records.

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home / Cell Telephone Number:

____

______ OK to leave message with detailed information
______ Leave message with call back numbers only

Written Communication Address:

____

_____ OK to mail to address listed above
_____ E-mail me at: ______________________

Work Telephone Number: Fax Communication:

____

______ OK to leave message with detailed information
______ Leave message with call back numbers only

____

OK to Fax to the number listed above

Other:

______________________________ ______________________________

Name of Patient (Print) | Signature | Date

______________________________ ______________________________

Witness: | Date:

HIPAA PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be released to other healthcare professionals within the organization for the purpose of providing you with quality healthcare.
- Your confidential healthcare information may be released to your insurance provider for the purpose of the organization receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. This provision includes but is not limited to any psychotherapy notes, for marketing purposes and any disclosures that may constitute a sale of your protected healthcare information. Any other uses or disclosures not described in this notice can only be made with your express authorization. You may revoke your permission to release confidential healthcare information at any time.
- You may restrict the disclosure of your protected health information for any services provided whereby you or somebody else pays "out of pocket", in full, for the services.
- You may be contacted by the organization to remind you of any appointments.
- You have the right to opt out of notifications regarding healthcare treatment options, marketing and fundraising, or other health services that might be of interest to you.
- You may be contacted by the organization for the purposes of raising funds to support the organization's operations. It is your express right to opt out of any fund raising communications.
- You have the right to restrict the use of your confidential healthcare information. However, the organization may chose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.

PRIVACY NOTICE (continued)

- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- The organization is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information.
- The organization will promptly contact you should there be any breach of your protected health information.
- The organization will abide by the terms of this notice. The organization reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information.
- You have the right to complain to the organization if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the organization:

  Facility Name: Pioneer Pain Management

  Facility Address: 266 NW Peacock Blvd #205

  Port St. Lucie, FL 34986

  Facility Phone: 772-446-4883

  - All complaints will be investigated. No personal issue will be raised for filing a complaint with the organization.
- For further information about this Privacy Notice, please contact:

  Privacy Officer Name: Miranda Poto

- This notice is effective as of 03/31/2017. This date must not be earlier than the date on which the notice is printed or published.

INFORMED CONSENT AGREEMENT FOR TREATMENT OF INTRACTABLE PAIN WITH NARCOTICS

Please initial all boxes:

___ I understand I have a pain condition that may require the prescription of a controlled substance.

___ Any side effects such as constipation, sedation, itching, nausea, and vomiting and the use of substances to counteract these side effects have been explained to me. The issues of tolerance, drug dependence and addiction have also been explained to me to my satisfaction.

___ I understand that there are alternatives to narcotic drug therapy which include multidisciplinary therapies such as physical therapy, and/or exercise, TENS, cognitive/behavioral therapy, acupuncture, and interventional treatment (i.e. steroidal injections). .

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my daily functioning.

___ I understand that daily narcotic use may increase certain risks, which include, but are not limited to:

- Addiction
- Nausea, vomiting and constipation
- Impaired judgment, sleepiness and confusion
- Allergic reactions, overdose and fatal complications
- Breathing Problems
- Dizziness
- Development of tolerance
- Kidney/Liver Damage
- Cardiac Damage
- Possible Sexual Dysfunction
- Complications to Pregnancy or Breast feeding
- Impaired ability to operate machines or drive motor vehicles

___ I also understand the following guideline: As a patient I understand I will not receive more than 5 prescriptions for controlled substances per month. Prescription will not exceed a 30 day supply and may have two refills per MD discretion and DEA regulations. Prior authorizations will not be done and it is the responsibility of each patient to know or bring their insurance formulary.

___ I also understand that if I do not follow the substance abuse guidelines and any additional testing requirements as necessary (separate contract), my treatment may be terminated.

___ I have discussed the benefits, risks, and alternatives to narcotic treatment with my provider. I have had an opportunity to ask questions and have received answers to those questions to my satisfaction.

DIVERSION POLICY

WHAT IS DIVERSION? — "The act or an instance of diverting from a course, activity or use."
Diversion is against the law and Pioneer Pain Management takes this very seriously. If diversion occurs, you will be immediately discharged from our practice without a refund.
Here are some examples of what diversion is when discussing controlled and non-controlled medications.

1. Having a friend, family member, neighbor, or co-worker give you or sell you medication because you missed your appointment with your doctor which is scheduled every 30 days.
2. Going to multiple doctors for the same medication without notifying all physicians.
3. Giving away or selling your medications.
4. Having a positive urine test result for medications when you have not seen a doctor for over 30 days. 5. Having a negative urine test result for medication prescribed within the last 30 days of visit.
6. A positive urine test result for an illicit drug is a mandatory discharge.

I READ THE ABOVE AND UNDERSTAND IT TO THE BEST OF MY KNOWLEDGE

Patient Signature ______________________________ Date____________________

Provider Signature ____________________________ Date____________________

Pioneer Pain Management
266 NW Peacock Blvd #205
Port St. Lucie, FL 34986

PAIN MANAGEMENT CONTROLLED SUBSTANCE ACKNOWLEDGEMENT AND AGREEMENT

The purpose of this agreement is to ensure that the patient has given accurate information upon which the doctor can rely in implementing a pain management program. It is also to prevent misunderstandings about certain medications you will be taking for pain management. This is to help both you and your physician comply with the law regarding controlled pharmaceuticals.

PLEASE READ AND INITIAL THE FOLLOWING:

_____ I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor under takes to treat me based on this agreement.

_____ I understand that if I break this agreement, my doctor will stop prescribing these pain-control medications, I will be discharged from my doctor's care, and I may be criminally prosecuted. In this case, my doctor may taper off the medication over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment program maybe recommended.

_____ I will communicate fully with my doctor and staff about the character and intensity of my pain, the effects of the pain on my daily life, and how well my medicine is helping to relieve my pain.

_____ I will NOT use any illegal controlled substance, including marijuana, cocaine, etc., or any other medication prescribed to anyone other than myself.

_____ I will not share, sell or trade my medication with anyone.

_____ I will not attempt to obtain any controlled medicines, including opiod pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor, unless coordinated with this office.

_____ I will safeguard my medicine from loss or theft. I understand that lost or stolen medication will not be replaced.

_____ I agree that refills of my medication will only be available during my regularly scheduled office visits. I understand that it is my responsibility to make and keep timely appointments. Prescriptions will not be phoned in or picked up outside of these visits. Refills will not be available during evening, weekends or holidays.

_____ I authorize the doctor, facility and pharmacy to cooperate fully with any city, county, state or federal law enforcement agencies, in the investigation of any possible misuse, sale or other diversion of my medication. I authorize my doctor to provide a copy of this agreement to my pharmacy, primary care provider and referring physician. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ I agree that I will submit to blood, urine or saliva tests (at my own expense) if requested by my doctor to determine my compliance with my program of pain control medication.

_____ I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time.

_____ I understand that my pain medications have the potential to impair my judgement and caution should be used when driving or operating heavy machinery.

_____ I understand that alcohol may potentate the effects and duration of my medication. I acknowledge that I have been advised to avoid alcohol consumption.

_____ I have been fully informed of the psychological dependence (addiction)of a controlled substance. I fully understand the behavioral effects of medications and agree to maintain appropriate behavior at all times with my clinicians and support staff. I will notify clinicians for assistance as needed for concerns regarding side effects. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the same effect of pain control, and I do know that I will become physically dependent on the medication.

_____ I understand that it is a criminal offense in the state of Florida to acquire or obtain or attempt to acquire or obtain possession of a controlled substance by misrepresentation, fraud, forgery, deception or subterfuge. I understand that if I make any false statements in this agreement, I will be subject to criminal prosecution.

____ I understand that I may be called into the office for random urine drug screening and/or medication counts. I will be required to present myself to the office by the close of business on that day or I may be discharged from the practice.

Print Name: ____ Date of Birth: ____________________

Signature: ____ Today's Date: ____________________

1. Have you seen any other physicians regarding any condition that requires pain management within the last year?
   ☐ YES ☐ NO

If you have seen other physicians you must list each and every physician name here:

____

____

____

Patient Signature ____________________

2. Have you obtained a prescription for a controlled substance from another physician within the last year?
   ☐ YES ☐ NO

If you have received such medication from another physician you must list each and every medication as well as the physician who prescribed it here:

____

____

____

Patient Signature ____________________

3. I am not presently being treated or attempting to be treated by another physician for any condition that requires pain management.

Patient Signature ____________________

4. I am not exaggerating any of the symptoms of any condition that requires pain management.

Patient Signature ____________________

5. I have been completely honest with my doctor regarding any condition that requires pain management.

Patient Signature ____________________

6. I will not see any other physician regarding any condition that requires pain management unless I notify my doctor prior to visiting the other physicians.

Patient Signature ____________________

7. If my doctor prescribes pain medications I will only use the following pharmacy to fill any and all prescriptions. If I intend to use any other pharmacy I will notify my doctor immediately.

Pharmacy________________________ Patient Signature ____________________

Patient abuse of medication is a serious problem. Please read this form carefully. You will be held to this agreement by your physician and by any law enforcement agency investigation for any possible abuse of the doctor/patient relationship with regard to pain management.

Print Name: ______________________________ Date of Birth:____________________

Signature: ______________________________ Today's Date:____________________

I do hereby state that I have read this form completely, and that all of the information is true and accurate. I understand that any false statements given in conjunction with this agreement will subject me to criminal prosecution. I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this documentation has been given to me.

This agreement is entered into on this ___________ day of __________ month _________year

Patient Signature _________________________

Licensed Provider Signature: ______________________

Physician Signature: ______________________

PATIENT INFORMATION

Patient Name ____________________________ Date of Birth______________________

Address____

City____________________________ State________ Zip___________________

Age _____Sex _____SS# _______________Preferred Language__________________

Occupation ___________________________

Marital Status: ☐ Married ☐Single ☐ Divorced ☐ Other

Home Phone #_______________ Cell Phone #_______________ Work Phone #_______________

Emergency Contact______________________ Relationship______________________

Phone # ______________________ Alternate #______________________

IS YOUR INJURY RELATED TO

☐ Work Injury ☐ Auto Accident If Yes, what is the Date of Injury ______________________

Claim # Assigned to Injury Case ______________________ Do you have an Attorney? ☐ Yes ☐ No

Attorney or Case Worker Name______________________

Attorney or Case Worker Info: Phone #______________________ Fax # ______________________

PLEASE INITIAL EACH LINE AND SIGN BELOW

_____ I consent to treatment necessary for the care of the patient indicated on this form. I hereby authorize payment of medical benefits directly to the attending physician for services rendered.

_____ Authorization is hereby granted to release information as necessary to process and complete my claim.

I understand that I am financially responsible for this account

______________________________ ________________

Patient/Guardian/Guarantor Signature Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name:________________________________ Date of Birth:____________

Patient's Address:____

PHI Recipient Name: Dr. Antonio Poto Phone#: 772-446-4883 Fax#: 772-446-4875

Address: 266 NW Peacock Blvd., #205 Port St. Lucie, FL 34986

PHI Sender Name:________________ Phone#:____________ Fax#:____________

Address:____

I authorize and request the disclosure of all PHI for the purpose of review and evaluation. I expressley request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

Records Requested Include:	Date(s)
___ 6 Months of OV/Notes/Progress Notes from last DOS	________
___ History and Physical	________
___ Consult Report	________
___ Operative Report	________
___ 6 Months of Urine Drug Screens	________
___ Imaging/Radiology Reports including MRI, CT Scans and X-Rays	________
___ Medication Record	________
___ Demographics	________
___ Clearance Letter	________
___ Discharge Letter	________
___ Other: ____________________	________

I understand the following (See CFR 164.508 (c)(2)(I-III):

A. I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
B. The information released in response to this authorization may be re-disclosed to the other parties.
C. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

I have read the above and authorize the disclosure of the protected health information as stated.

____

Signature of Patient/Guardian/Patient Representative Date

____

Printed Name of Patient/Guardian/Patient Representative Relationship to Patient

Cancellation/No Show Policy

Cancellation/No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 1 business day in advance you will be charged a $50.00 fee; this will not be covered by your insurance company.

Scheduled Appointments

We understand that delays can happen, however we must try to keep the other patients and the doctor on time. **If a patient is more than 15 minutes late for an appointment, the appointment may need to be rescheduled.** This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day, if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

Cancellation/ No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 2 business days in advance you will be charged a $75.00 fee; this is will not be covered by your insurance company.

Account balances

We will require that patients with self-pay balances have an account balance of $0.00 prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over $100 must make payment arrangements prior to future appointments being made.

Collection Agency

I understand if I have an unpaid balance to Pioneer Pain Management Inc and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so, incurred during collection efforts.

In order for Pioneer Pain Management Inc or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Pioneer Pain Management Inc and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

____________________ ____________________ ___/___/___

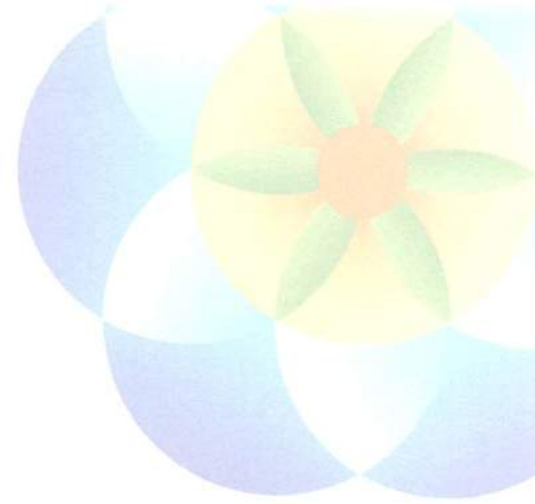
Print Name Patient Signature Date

Patient Account #________________

Pioneer
PAIN MANAGEMENT

8491 S US Highway 1
Port St. Lucie, FL 34952

P. 772.446.4883
F. 772.446.4875



Acknowledgement of "Abuse Free Zone"

At Pioneer Pain Management, we appreciate and respect our staff. It is our belief that our staff should have a work environment free from any form of verbal or physical abuse. We expect each one of our patients to treat each one of our staff members as you would like to be treated. Outbursts against any of our staff member will not be tolerated and may result in your DISCHARGE from this practice.

My signature below indicates that I agree to abide by the above "abuse free zone environment "policy.

__________________________ ____________________

Signature of patient or legal guardian Date

www.PioneerPainManagement.com • APoto@pioneerpainmanagement.com