



6333 54th Avenue North
 St. Petersburg, FL 33709
 727.548.6100 (Phone)
 727.545.0960 (Fax)

To help us understand your problem, please complete ALL QUESTIONS on ALL of the attached forms.

Name _____ Age _____ Date _____

Who referred you to us? _____ Height: _____ Weight: _____

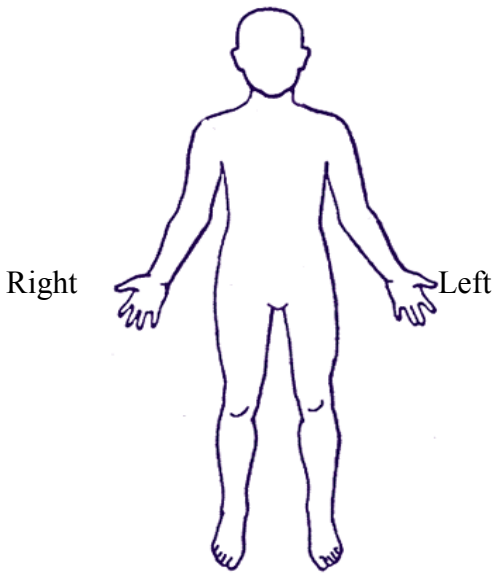
Which part of your body hurts the most? _____

How long have you had this pain? _____

On a scale of 0 to 10, "0" being no pain and "10" being the worst pain imaginable, circle the number that describes your level of pain:

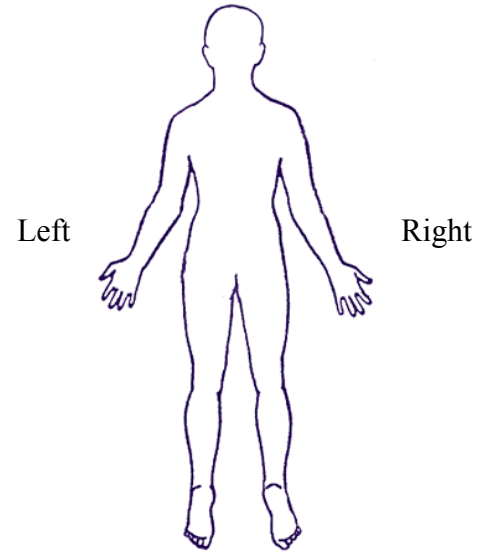
No pain = 0 1 2 3 4 5 6 7 8 9 10 = Worst pain imaginable.

Shade in areas below where you have pain and check **ALL** the words that best describe your pain:



Front

- Aching
- Stinging
- Soreness
- Unbearable
- Shooting
- Burning
- Cramping
- Stabbing
- Tingling
- Numbness
- Radiating
- Excruciating
- Hotness
- Coldness
- Tightness
- Heaviness
- Dullness
- Sharpness
- Constant
- Brief



Back

Pain caused from: Accident –Yes or No Illness–Yes or No Unknown Cause –Yes or No

If accident or illness explain and give dates:

Please indicate the factors or activities that increase or decrease your pain:

Factors	Increase	Decrease	No Effect	Factors	Increase	Decrease	No Effect
Weather Change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bright light/noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Posture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sneeze, cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check any of the following treatments you have had for this pain problem:

	Approximate Date/Details	Improved Pain	
		Yes	No
<input type="checkbox"/> Pain Clinic		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nerve Blocks, Epidurals		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tens Unit		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical Therapy		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acupuncture		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chiropractor		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Psychiatrist/Psychologist		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Massage Therapy		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other		<input type="checkbox"/>	<input type="checkbox"/>

Please indicate which diagnostic procedures (tests) you have had for this pain problem:

	Body Part	Approximate Date	Facility Performed
<input type="checkbox"/> MRI Scan			
<input type="checkbox"/> CT Myelogram			
<input type="checkbox"/> X-Ray			
<input type="checkbox"/> EMG/NCS			
<input type="checkbox"/> Discogram			
<input type="checkbox"/> Bone Scan			

Please list other physicians you have seen for your pain:

Name	Recommendation	Specialty	Appt Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family Physician (Name and Phone) _____

Please list past or current medical problems:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Herpes (Shingles)
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Migraines	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Gerd/Ulcer	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Open Wound	<input type="checkbox"/> Current Infection	<input type="checkbox"/> Other		

Have you ever had cancer? Yes No ***If yes, which type(s)?*** _____

Are you currently receiving treatment? Yes No ***If yes, type(s) of treatment?*** _____

Please list all medications you are currently taking:

1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12.

Do you have any allergies to medication or food? Yes No

Please list your allergies and the reaction below:

Medication	Reaction	Medication	Reaction
1.		4.	
2.		5.	
3.		6.	

Have you ever taken or been given:

Anticoagulants, Blood-thinners, Coumadin, Plavix, Pletal
Cortisone or Steroids

YES NO Adverse Reaction?

Please List any Surgeries:

Surgery/Date	Surgery/Date
1.	5.
2.	6.
3.	7.
4.	8.

Family History:

Describe current health, age, cause of death, illness, diabetes, cancer, hypertension, etc.

	Living		Medical History or Cause of Death
	Age	Yes No	
Father		<input type="checkbox"/> <input type="checkbox"/>	
Mother		<input type="checkbox"/> <input type="checkbox"/>	
Sibling		<input type="checkbox"/> <input type="checkbox"/>	
Sibling		<input type="checkbox"/> <input type="checkbox"/>	

Social History:

Marital Status: Married Divorced Single

Do you currently work? Yes No What is/was your occupation: _____

Smoker ? Yes No If you quit, when? _____ How many cigarettes did you/do you smoke per day? _____ Number of years? _____

Alcohol Use? Yes No If yes, how much? _____

History of street drug use? Yes No If yes, what type? _____

Do you have a history of alcoholism? Yes No
Family history of drug or alcohol abuse? Yes No

Is there any possibility that you are pregnant? Yes No
Have you been tested for the HIV Virus? Yes No Date _____ Positive Negative
Have you ever been treated for depression or any other mental health issue? Yes No

Please explain _____
Treating Physician's Name _____ Phone Number _____
Last Visit _____ Frequency of Visits _____
Origin of Depression _____

Do you have or have you ever had (please check):

Cardiovascular	Respiratory	Genitourinary	Muscle/Joint Disease
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Change in Bowel Control	<input type="checkbox"/> Redness in Joints
<input type="checkbox"/> Leg Swelling	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Change in Bladder Control	<input type="checkbox"/> Arthritis/Joint Disease
<input type="checkbox"/> Chest Pain/Angina	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Frequent Muscle Spasm
	<input type="checkbox"/> Sputum Production		<input type="checkbox"/> Back or Neck Problems
			<input type="checkbox"/> Swelling of Joints

Neurological	Endocrine	Gastrointestinal	Hematologic
<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Nausea	<input type="checkbox"/> Easy Bleeding
<input type="checkbox"/> Weakness	<input type="checkbox"/> Change in Appetite	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Poor Blood Clotting
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Heat or Cold Tolerance	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Fainting	<input type="checkbox"/> Sweating	<input type="checkbox"/> Heart Burn	
<input type="checkbox"/> Numbness		<input type="checkbox"/> Constipation	
<input type="checkbox"/> Headache			

Psychiatric	Constitutional
<input type="checkbox"/> Depression	<input type="checkbox"/> Recent Weight Loss
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Recent Weight Gain
<input type="checkbox"/> Stress	<input type="checkbox"/> Fever/Chills
<input type="checkbox"/> Previous Psychiatric Care	<input type="checkbox"/> Visual Change
	<input type="checkbox"/> Hearing Change

Patient Signature

Date



Florida Pain Management
6333 54th Avenue North
St. Petersburg, FL 33709
(727) 548-6100

**NOTICE TO ALL PATIENTS
REGARDING CANCELLATION POLICY**

You MUST give 24-hour advance notice for any appointment cancellations. If notice is provided less than 24-hours prior to scheduled appointment, the patient will be subjected to a \$35 cancellation fee. All future appointments will be cancelled until the fee is paid.

You must call between the hours of 9:00 am and 4:30 pm Monday through Friday and speak to an attendant.

This policy is enforced for the consideration of all other patients who are currently in the waiting list. Enforcement of this cancellation policy will lead to better overall patient care.

Method of payment: Cash, check, or credit card only.

Please sign and date below and a copy of this notice will be kept in your chart.

PRINT NAME

SIGNATURE

DATE



FLORIDA PAIN MANAGEMENT
 6333 54th Avenue North
 St. Petersburg, FL 33709
 Phone: (727) 548-6100 Fax: (727) 545-0960

Patient Name: _____

SSN: _____ Date of Birth: _____

ASSIGNMENT OF BENEFITS

For treatment provided and other goods and valuable consideration,

I, _____,
 (Hereinafter Patient) hereby assign all rights and benefits that PATIENT has under any group health, HMO plan, individual health, PIP, disability or any other health or medical insurance policy or reimbursement plan that may pay benefits for services and treatment that PATIENT has received or will receive.

This assignment includes but is not limited to, all rights to collect benefits directly from PATIENT'S insurance company or HMO for services and treatment that PATIENT has received and all rights to proceed against PATIENT'S insurance company or HMO in any action including legal suit if for any reason PATIENT'S insurance company or HMO fails to make payments of benefits to which PATIENT is due. This assignment also includes the right to recover attorney's fees and cost for such action brought by the provider as PATIENT'S assignee.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date: _____

 Signature of Policyholder

 Witness

 Signature if other than Policyholder



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St.Petersburg, FL 33709
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STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed

The information covered by this authorization includes:

Patient’s entire medical history, mental or physical condition, diagnoses, treatment including psychiatric, drug or alcohol abuse treatment.

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Physicians and Personnel of Florida Pain Management

Persons to Whom Information May be Disclosed:

Please list anyone that Florida Pain Management will be able to release medical information to regarding your care:

- | | |
|------------------------------|----|
| 1. My referring physician | 4. |
| 2. My primary care physician | 5. |
| 3. | 6. |

Expiration date of Authorization

This authorization is effective indefinitely unless revoked or terminated by the patient or the patient’s personal representatives.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Florida Pain Management. You should contact the Florida Pain Management Compliance Officer to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it was sent. The privacy of this information may not be protected under the federal privacy regulations.

Overall, by signing this form you are giving Florida Pain Management permission to release or receive your medical records to or from any physician office, hospital, attorney, or any persons name from above you approved us to disclose information to.

Name of Patient (please print)

Social Security Number

Signature of Patient

Date

Signature of Patient Representative

Relationship to Patient

Signature of Florida Pain Management employee confirming that this was explained and signed by patient

Florida Pain Management

Kazi Hassan, MD
Sardha Perera, MD
Devang Padalia, MD

6333 54th Avenue North
St. Petersburg, 33709
Tel: (727) 548-6100
Fax : (727) 545-0960

PATIENT CONSENT FORM FOR OPIOID USE

I, _____, agree to the following conditions regarding opioid use:

1. I understand that I have a chronic pain problem that requires the prescription of an opioid pain medication for pain relief and to improve my functional ability. I am aware that the risks **include, but are not limited to, drug dependency, addiction, respiratory depression, cardiovascular depression, liver and/or kidney damage, death, etc.** **The physician has discussed the risks, benefits, and alternatives of medications with me prior to treatment.**
2. I will obtain prescriptions for opioid and other controlled medication(s) **from only one physician**, i.e. Florida Pain Management as long as my treating Physician believes that it is appropriate to use opioid therapy.
3. I will have my prescriptions filled at only one pharmacy and will notify my treating physician of the name of the pharmacy.
4. I will take the medication(s) **only as prescribed** and will notify my physician if I do not. If necessary, I agree to random urine and blood tests to assess my compliance.
5. **I understand that the eventual goal is to taper off the narcotic medication(s) as tolerated.** I agree to meet regularly with my physician to assess my progress.
6. Random urine drug tests may be performed to monitor prescribed pain medication.
7. **Lost, stolen or misplaced opioids controlled substance WILL NOT BE REPLACED . Refills will not be given early for any reason. PRESCRIPTIONS WILL ONLY BE GIVEN DURING REGULAR OFFICE HOURS AND WILL NOT BE GIVEN OR REFILLED BY THE PHYSICIAN DURING WEEKENDS OR EVENINGS. No narcotics can be given over the telephone. If the prescription or the medication(s) are lost or stolen, a police report will be required for replacement.**
8. A psychological evaluation regarding addiction and drug dependency may be necessary at any time the treating physician sees fit.
9. If I deviate from the above guidelines or if the medication loses its effectiveness in increasing my functional ability, I understand that the physician may taper off or discontinue the narcotic.
10. Patient gives Florida Pain Management permission to contact other physicians and pharmacies to confirm compliance.
11. I am not currently using any illegal street drug(s) and will not do so while being treated at this facility. Failure to comply with this rule could be cause for my immediate termination from this practice.

My signature at the bottom indicates my understanding and agreement with the above guidelines.

Patient Signature

Date

Florida Pain Management

Kazi Hassan, MD
(Medical Director)
Sardha Perera, MD
Devang Padalia, MD
Pain Management Specialist & Anesthesiologists)

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Payment Policy

It is the policy of Florida Pain Management that all services be paid for at the time of the visit. We accept Cash, Check, Visa and MasterCard. However if we have made other arrangements with you the following outlines our billing and collection policy.

Insurance Advance Notice Form

This is provider to the beneficiary regarding the services that may or may not be covered by your insurance company. Medical insurance is for your protection against the cost of medical care. Your insurance policy is contract between you and your insurance company. There are literally thousands of insurance programs in existence. It is impossible for us to be familiar with all the programs. It is your responsibility to know if our office is covered by your insurance. If our office is not covered by your insurance, upon leaving our office we will supply you with a bill for the services that you received. It is then your responsibility to file the claim with your insurance company. You may contact your insurance company for information on submitting your claim.

If we elect to accept your insurance and file your claim, it does not guarantee that your insurance will pay the claim. **You are still responsible for any unpaid balance.** Any remaining balances that remain unpaid for a period of 90 days or longer will be considered delinquent and turned over to our collection agency.

Medicare

Our office accepts assignments on Medicare claims, that we will file your claim with Medicare and accept the approved Medicare rate as our total charge. However, **by law we must collect the applicable co-insurance and deductible.** If you have a Medicare supplement that Medi-Gaps cover, we will file with them for your deductible and co-insurance. If your supplemental policy does not cover the deductible and co-insurance or other non-covered services, Payments for these services will still be your responsibility. Also you may be billed for additional services that are not covered by Medicare, which may include Hot & Cold packs, Trigger Point Injections, and Massage Therapy etc.

Workers Compensation

We will bill your workers compensation insurance carrier and accept this as payment in full. However, if your workers compensation carrier denies benefits (such as determination that the injury is not work related), then you will be responsible for any unpaid balance. If you have any questions concerning the payment policy, please feel free to contact Florida Pain Management, Monday-Friday 8:00 am to 5:00 pm @ (727) 548-6100

Signature

Date