Thank you for choosing Elite Pain and Spine Specialists to assist with your care.

Attached is the new patient packet. In addition to the new patient packet, please bring:

- A copy of your Photo ID,
- Insurance card and RX card
- Copy of Medical Marijuana Card
  *if you have one
- Medical Records, and
- Any imaging you may have had.

If another pain management doctor has recently seen you, we will also need a discharge letter/release of care notification.

Please make sure to read the entire new patient packet, initial, sign, and add your date of birth on every page.

**Please bring, fax or mail your completed paperwork to:

13141 Spring Hill Drive
Spring Hill, FL 34609
Phone: (352) 515-0025
Fax: (352) 515-0174

Again, thank you for choosing Elite Pain and Spine Specialists.

REGISTRATION FORM

Today's date			❑ Office ❑ Facility ❑Home	
PATIENT INFORMATION				
Patient's Name Last First MI				Single / Mar / Div / Sep / Wid
Date of Birth	Age	❑ M ❑ F	Social Security #	Driver's License #
Street address			City, State, Zip	
Phone (day)	Phone (evening, cell)		Email address	
Referred By	Race		Ethnicity	Primary Language
Pharmacy Name	Pharmacy Address			Pharmacy Phone
IN CASE OF EMERGENCY				
Emergency Contact			Relationship to patient	
Street address			City, State, Zip	
Phone (day)			Phone (evening, cell)	
INSURANCE INFORMATION				
❑ **Medicare** ❑ **Medicaid** ❑ **HMO** ❑ **PPO** ❑ **POS** ❑ **PPC**			❑ **Worker's Comp** ❑ **Auto Accident Date of Injury / /**	
Primary Insurance Name			**WC or Auto Insurance Company**	
Address			Address	
City, State, Zip			City, State, Zip	
Phone	Fax		Employer at time of injury	
Policy Subscriber Name			Address	
Patient's relationship to subscriber			City, State, Zip	
Subscriber ID# or Social Security #			Phone	Fax
Plan Name			Claim #	
Policy #	Group #		Claim Adjuster	
Primary Care Physician			Phone	Fax
Phone	Fax		Case Manager	
Secondary Insurance Name			Phone	Fax
Address			Name of attorney	
City, State, Zip			Contact Person	
Policy #	Group #		Phone	Fax
Phone	Fax		Lawsuit pending? ☐ Yes ☐ No	
Policy Subscriber Name			Auto accident deductible: $	Met? ❑ Yes ❑ No
Patient's relationship to subscriber			LIEN? ❑ Yes ❑ No LOP? ❑ Yes ❑ No	
CO-PAY? $	Self-pay? ❑ Yes ❑ No			
EMPLOYMENT INFORMATION				
Employer			Occupation	
Street Address			City, State, Zip	
Phone	Fax		Email	

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Occupation: _____ ☐ N/A Reason: _____

_____

PAIN HISTORY

Where is your pain located? If in more than one place, please list in order of severity, the worst pain first.

_____

_____

_____

How long have you had this problem?

_____

How did the pain start? (accident, etc.?)

_____

_____

_____

VISUAL ANALOG SCALE OF PAIN INTENSITY (VASPI)

On a scale from 1-10, please rate the intensity of your pain. Ten represents the pain at its worst; zero represents the absence of pain. Please draw a line above the scale that represents your level of pain.

0 1 2 3 4 5 6 7 8 9 10

When pain is at its worst: _____ out of 10.

When you have the least pain: _____ out of 10.

At the present time: _____ out of 10.

What words would you use to describe your pain?

☐ Dull ☐ Aching ☐ Throbbing ☐ Burning ☐ Radiating ☐ Sharp/Stabbing ☐ Pulsating

☐ Other: _____

When does your pain occur?

☐ Always there ☐ Intermittent - # times per day: _____ # of times per week: _____

Intensity of Pain:	☐ Steady	☐ Increases and decreases		
My pain is better:	☐ Upon arising	☐ Mid-day	☐ End of day	☐ Late at night
My pain is worse:	☐ Upon arising	☐ Mid-day	☐ End of day	☐ Late at night
How well do you sleep?		☐ Well	☐ Poorly	☐ Only with pills

Name: _____ Date of Birth: _____

What seems to make your pain worse?

☐ Movement ☐ Daily Activity ☐ Sitting ☐ Walking ☐ Standing ☐ Bending

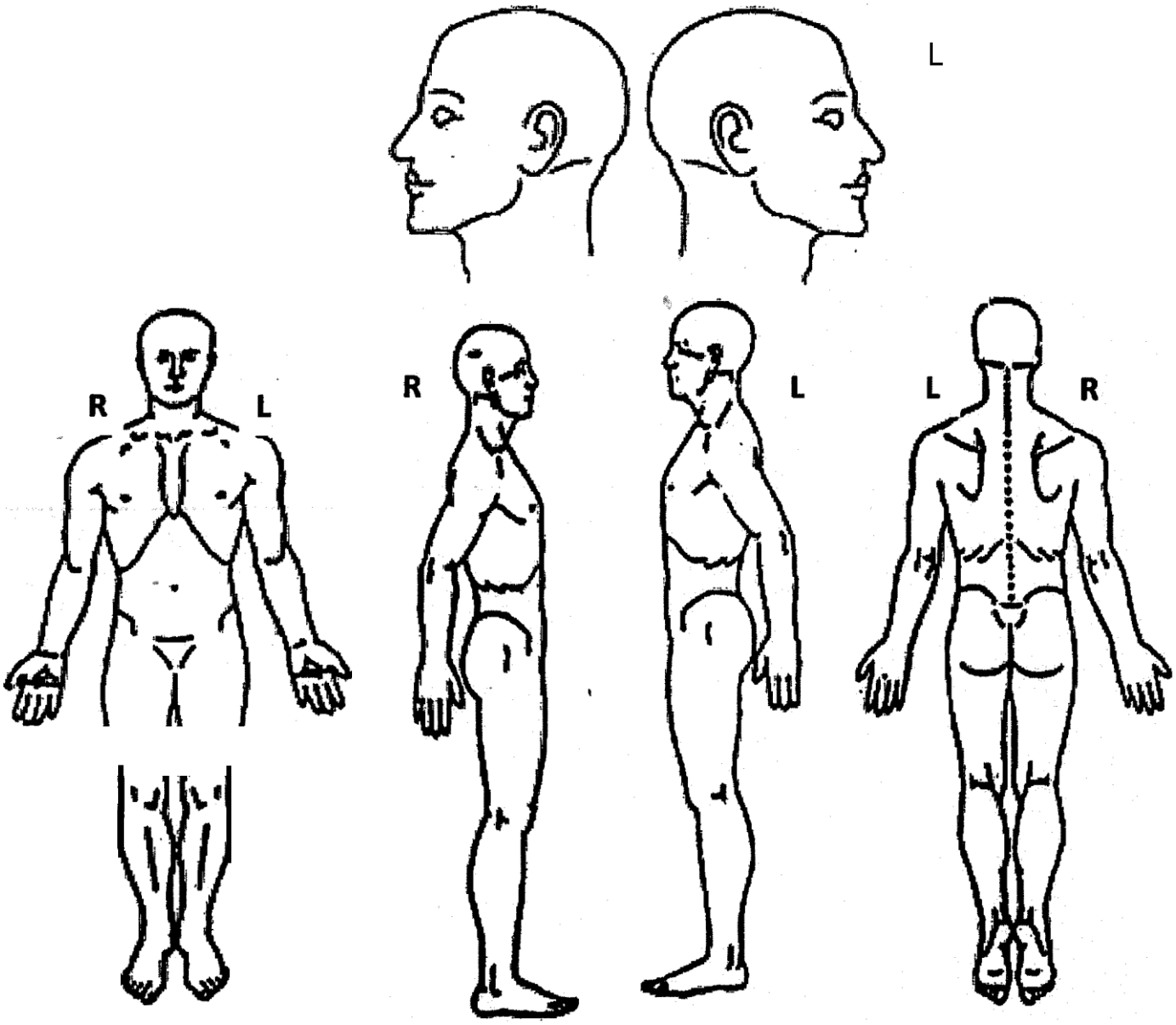
☐ Lying Down ☐ Sexual Activity ☐ Other: _____

What seems to make your pain better?

☐ Rest ☐ Movement ☐ Exercise ☐ Inactivity ☐ Lying Down ☐ Medication only

☐ Certain positions: _____

Please indicate the areas of pain on the diagram below:



GENERAL HEALTH REVIEW

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name: *Last* *First* *MI*

Today's Date: **Reason for Visit:**

Previous or referring doctor:	**Patient sex :** ☐ **M** ☐ **F**	**DOB:**

Personal Health History (Past Medical History)

Conditions you have had in the past (check all that apply):

☐ AIDS/HIV +	☐ Bulimia	☐ Goiter	☐ Liver Disease	☐ Stroke
☐ Alcoholism	☐ Cancer	☐ Gonorrhea	☐ Migraine Headache	☐ Suicide Attempt
☐ Anemia	☐ Cataracts	☐ Gout	☐ Mononucleosis	☐ Thyroid Problems
☐ Anorexia	☐ Chemical Dependency	☐ Heart Disease	☐ Multiple Sclerosis	☐ TB
☐ Arthritis	☐ Chicken Pox	☐ Hepatitis	☐ Pneumonia	☐ Ulcers
☐ Asthma	☐ Diabetes	☐ Hernia	☐ Polio	LIST ANY OTHERS
☐ Bleeding Disorders	☐ Emphysema	☐ Herpes	☐ Prostate Problem	☐
☐ Breast Lump	☐ Epilepsy	☐ High Cholesterol	☐ Rheumatic Fever	☐
☐ Bronchitis	☐ Glaucoma	☐ Kidney Disease	☐ Scarlet Fever	☐

Surgeries (unrelated to pain)

Year	Reason	Hospital

Surgeries (related to pain)

Year	Reason	Hospital

Allergies (including medication and food)

Intolerances (side effects from previous medications such as nausea, constipation, gastritis, etc)

Year	Effect	Outcome

Patient Name: _____			Date of Birth: _____		
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers					
Drug Name	Strength	Frequency Taken	**Drug Name**	Strength	Frequency Taken
1			9		
2			10		
3			11		
4			12		
5			13		
6			14		
7			15		
8			16		

Do you have any of the following?				
Check all that apply:				
☐ Chest Pain	☐ Diarrhea	☐ Headache	☐ Rashes	☐ Urinary Problems
☐ Chronic Fatigue	☐ Difficulty Swallowing	☐ Hearing Problems	☐ Shortness of Breath	☐ Vision Problems
☐ Constipation	☐ Dizziness	☐ Nausea	☐ Stomach Pain	☐ Vomiting

History:

Have you ever had any of the following?

1. Epidural steroid injection? ☐ Yes ☐ No
2. A surgical operation requiring an anesthetic? ☐ Yes ☐ No
3. A cold within the last two weeks? ☐ Yes ☐ No
4. Frequent headaches? ☐ Yes ☐ No
5. Muscle weakness in arms or legs? ☐ Yes ☐ No
6. Are you pregnant? ☐ Yes ☐ No
7. Do you faint easily? ☐ Yes ☐ No

Domestic Situation

With whom do you live with? _____

Are there any substance abuse issues in the household? Yes_____ No_____

If yes, please explain: _____

Are you able to take care of yourself? Yes_____ No_____

If not, please enter the name of your caregiver: _____

PATIENT NAME:				DOB:
HEALTH HABITS AND PERSONAL SAFETY (SOCIAL HISTORY)				
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.				
Exercise	☐ Sedentary (No exercise) ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting?	☐ Yes	☐ No	
	If yes, are you on a physician prescribed medical diet?	☐ Yes	☐ No	
	# of meals you eat in an average day?			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?	☐ Yes	☐ No	
	If yes, what kind?			
	How many drinks per week?			
Tobacco	Do you use tobacco?	☐ Yes	☐ No	
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No	
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No	
Personal Safety	Do you live alone?	☐ Yes	☐ No	
	Do you have frequent falls?	☐ Yes	☐ No	
	Do you have vision or hearing loss?	☐ Yes	☐ No	
	Physical and/or mental abuse have become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your doctor or his staff?	☐ Yes	☐ No	

FAMILY HEALTH HISTORY			
Relation	**AGE**	**AGE AT DEATH**	**SIGNIFICANT HEALTH PROBLEMS**
Father			
Mother			
Brothers			
Sisters			

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

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

Employment Impact

☐ N/A

What type of work do you do?

_____

_____

How many hours per week do you work? _____

How much time from work, if any, have you missed in the past month due to pain? _____

_____

Legal Matters

If your pain is due to an accident, is litigation (legal suit) or an insurance settlement pending? If yes, please describe the current status of litigation or settlement.

_____

_____

Do you plan to pursue a legal or insurance settlement in the future? If yes, please describe.

_____

_____

_____
Patient or Legal Representative Signature

_____
Physician Signature

_____
Date

SOAPP 1.0-14Q

Name: _____ Date of Birth: _____ Date: _____

The following are some questions given to all patients at this office who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0=Never 1=Seldom 2=Sometimes 3=Often 4=Very Often

1.	How often do you have mood swings?	☐ 0	☐ 1	☐ 2	☐ 3	☐4
2.	How often do you smoke a cigarette within an hour after you wake up?	☐ 0	☐ 1	☐ 2	☐ 3	☐4
3.	How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	☐ 0	☐ 1	☐ 2	☐ 3	☐4
4.	How often have any of your close friends had a problem with alcohol or drugs?	☐ 0	☐ 1	☐ 2	☐ 3	☐4
5.	How often have others suggested that you have a drug or alcohol problem?	☐ 0	☐ 1	☐ 2	☐ 3	☐4
6.	How often have you attended an AA or NA meeting?	☐ 0	☐ 1	☐ 2	☐ 3	☐4
7.	How often have you taken a medication other than the way that it was prescribed?	☐ 0	☐ 1	☐ 2	☐ 3	☐4
8.	How often have you been treated for an alcohol or drug problem?	☐ 0	☐ 1	☐ 2	☐ 3	☐4
9.	How often have your medications been lost or stolen?	☐ 0	☐ 1	☐ 2	☐ 3	☐4
10.	How often have others expressed concern over your use of medication?	☐ 0	☐ 1	☐ 2	☐ 3	☐4
11.	How often have you felt a craving for medication?	☐ 0	☐ 1	☐ 2	☐ 3	☐4
12.	How often have you been asked to give a urine screen for substance abuse?	☐ 0	☐ 1	☐ 2	☐ 3	☐4
13.	How often have you used illegal drugs in the past five years? (for example, marijuana, cocaine, etc.)	☐ 0	☐ 1	☐ 2	☐ 3	☐4
14.	How often in your lifetime, have you had legal problems or been arrested?	☐ 0	☐ 1	☐ 2	☐ 3	☐4

PATIENT SELF-DETERMINATION QUESTIONNAIRE - YOUR RIGHT TO DECIDE

While you cannot remove all uncertainty about your future health care needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance.

- Declaration to Decline Life-Prolonging Procedures (Living Will)

  ☐ I have ☐ I have NOT made a Living Will

- Health Care Surrogate

  ☐ I have ☐ I have NOT designated a Health Care Surrogate

- Durable Power of Attorney

  ☐ I have ☐ I have NOT appointed a Durable Power of Attorney for Health Care Decisions

If you have signed an advance directive outlining your wishes, we will gladly make a copy and place it in your chart. If you have not created an advance directive, we will gladly provide you with a packet of information and forms.

PATIENT PRIVACY QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: _____ Name: _____

Address: _____ Address: _____

Phone Number: _____ Phone Number: _____

Relationship: _____ Relationship: _____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

- Name: _____ Phone #: _____
- Name: _____ Phone #: _____

III. ☐ I understand that all correspondence from our office will be sent in a sealed envelope marked "CONFIDENTIAL"

IV. Confidential messages (i.e., appointment reminders) ☐ May ☐ May **not** be left on answering machine or voicemail.

V. Please print the phone number where you want to receive calls about your appointments: _____

☐ I am fully aware that a cell phone is not a secure and private line.

_____ _____

PLEASE *PRINT* PATIENT NAME **DATE OF BIRTH**

_____ _____

LEGAL REPRESENTATIVE **RELATIONSHIP TO PATIENT**

_____ _____, 20_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE **TODAY'S DATE**

HIPAA OMNIBUS NOTICE OF PRIVACY PRACTICES

Effective Date: March 24, 2017

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. ✧ We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. ✧ We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care. • Share information in a disaster relief situation. • Include your information in a hospital directory. • Contact you for fundraising efforts. • *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations such as: ✧ Preventing disease. ✧ Helping with product recalls. ✧ Reporting adverse reactions to medications. ✧ Reporting suspected abuse, neglect, or domestic violence. ✧ Preventing or reducing a serious threat to anyone's health or safety.
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Our Uses and Disclosures (continued)

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: ✧ For workers' compensation claims. ✧ For law enforcement purposes or with a law enforcement official. ✧ With health oversight agencies for activities authorized by law. ✧ For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

COMPLAINTS

If you believe your privacy rights have been violated, you may submit a comment or complaint about our privacy practices by:

1) Mail to Corporate Privacy Officer, Elite Pain and Spine Specialist, 13141 Spring Hill Drive, Spring Hill, Florida 34609;

2) Email to admin@elitepainllc.com

3) Phone (352) 515-0025;

4) Written communication to the facility following the process outlined in our Company's Patient Rights documentation; and/or

5) Written communication to the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

You will not be penalized for filing a complaint.

CONSENT TO TREAT

I, the undersigned, voluntarily give consent to my Elite Pain Specialists medical professional to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

_____ **Date:** _____ **DOB:** _____

Patient Printed Name

_____ **Relationship to Patient:** _____

Signature of Patient/Legal Representative

. . . . . .

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, have received/reviewed a copy of the Elite Pain Specialists Notice of Privacy Practices and the Florida Patient Bill of Rights.

_____ **Date:** _____

Signature of Patient/Legal Representative

. . . . . .

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date	Initials	Reason

AUTHORIZATION AND ASSIGNMENT

I hereby authorize Elite Pain Specialists to release any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to Elite Pain and Spine Specialists (or named physicians or affiliates) for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to cross-over medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above-named entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.

_____ **Date:** _____

Signature of Patient/Legal Representative

Patient Controlled Substance Agreement

Patient Name: _____ **DOB:** _____

The following agreement relates to the prescribing practices of Elite Pain and Spine Specialists a Florida limited liability company, and the prescribing practices of its Affiliates, with respect to controlled substances for the treatment of pain and other conditions. Because the long term use of such substances poses potential for abuse or diversion, strict accountability is necessary. For this reason, I, the undersigned patient, agree to the following policies as consideration for, and as a condition of, the willingness of the physician whose signature appears below to prescribe controlled substances to treat my pain.

By signing below, I agree that I will only be prescribed controlled substances while I am actively participating in my treatment and **only** by agreeing to the following restrictions:

1. I understand that strong medications, which may include opiates and other controlled substances which I may be prescribed, have potential risks and side effects, including the risk of addiction. An overdose with an opiate medication may cause injury or death. Other possible complications include, but are not limited to, constipation, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function.
2. (Males Only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my physician may check my blood or request that my primary care provider do routine testing to see if my testosterone level is normal.
3. (Females Only) If I plan to become pregnant or believe that I have become pregnant while taking this medication, I will immediately call my obstetric doctor and the undersigned prescribing physician to inform them. I am aware that, should I carry a baby to delivery while taking these medications, the baby may be physically dependent upon opioids. Infant drug withdrawal can be life threatening. If a female of child-bearing age, I certify that I am not pregnant and will use appropriate contraceptive measures during the course of treatment with opioids/controlled substances.
4. I understand that all controlled substances must be prescribed by the physician whose signature appears below, or during his or her absence, by the covering physician, unless specific authorization is obtained for an exception.
5. I understand that if I break this agreement, my doctor will immediately begin to taper off the medication over a period of several days, as necessary to avoid withdrawal symptoms, and recommend a drug-dependence treatment program.
6. I understand and agree to submit to routine and unannounced urine and/or toxicology screens as may be required to detect the presence of prescribed or non-prescribed substances and that refusal of such testing may subject me to an abrupt rapid weaning schedule in order for the medication to be discontinued or prompt termination from care. Your insurance will be billed for this, any amount not covered is your responsibility. If you don't have insurance, you will be responsible for the cost. We use a specialized lab which may be out of network.

7. I understand that any controlled substances found during random or routine drug testing which are not prescribed by the physician listed below (or a covering physician) will lead to discontinuation of treatment by the prescribing physician.
8. I agree not to sell, share or otherwise permit others to have access to these medications and I will take the highest possible degree of care with my medication and prescription.
9. Since the medications may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, I agree to keep them out of reach of such people.
10. I agree to use _____ pharmacy located at _____ whose phone # is _____ for filling all of my pain medication prescriptions and authorize the undersigned physician to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to this authorization.
11. I understand that a maximum of thirty (30) days supply of medication will be prescribed at any one time. No refills will be prescribed for medications classified as Schedule II controlled substances.
12. I agree that I will use my medication at a rate no greater than the prescribed rate, and that the use of my medication at a greater rate will result in my being without medication for a period of time.
13. Refills are contingent on keeping scheduled appointments and will <u>not</u> be granted over the telephone after hours or on weekends.
14. Early refills will not be given. Refills will only be granted so long as the physician sees a demonstrable improvement in my condition.
15. I agree to bring all unused pain medication to every office visit.
16. If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, the physician may modify or discontinue my treatment or refer me for further specialty treatment.
17. I agree to be amenable to seek psychiatric treatment, psychotherapy and/or psychological treatment as the undersigned physician deems necessary.
18. I agree to communicate fully with my physician about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.
19. I will not attempt to obtain any controlled pain medicines from any other physician while under the care of the undersigned physician.
20. I will not alter my medication in any way or use any other administrative method other than as prescribed.
21. I understand that long-term agents (MS Contin, OxyContin, etc.) must be taken whole and are not allowed to be broken, chewed, crushed, injected and/or snorted. Potential toxicity could occur due to rapid absorption if taken inappropriately, which may lead to death.
22. I agree not to use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Any use of alcohol will be infrequent and limited to a time when I am not driving or operating machinery.

Patient Initials: _____

23. I understand that medications will not be replaced if they are lost, stolen, destroyed, etc. If my medication has been stolen, I understand that a valid police report regarding the theft must be presented to the prescribing physician for consideration of an exception.
24. I understand that changing date, quantity, or strength of medicines or altering a prescription in any way, shape or form is against the law.
25. I also understand that forged prescriptions and/or forged provider signatures are also against the law.
26. I authorize the undersigned physician and my pharmacy to cooperate fully with any county, city, state or federal law enforcement agency, including the Florida Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my controlled medications.
27. If the responsible legal authorities have questions concerning my treatment, I agree to cooperate by signing the relevant authorization to release patient records to these authorities. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to this authorization.
28. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances and could result in disclosure to legal authorities.
29. I affirm that I have full right and power to sign and be bound by this Agreement, and that I have read, understand, and accept all of these terms and am receiving a copy of the signed Agreement.

This Agreement is entered into on this _____ day of _____, 20_____.

Patient Name: _____ **DOB:** _____

Patient Signature: _____

Physician Signature: _____**, MD/DO/ARNP/PA-C**

Physician printed or stamped name and credentials: _____

Witness Signature: _____

Witness Printed Name: _____

FINANCIAL POLICY

The information listed below was designed to provide our patients with a detailed explanation of our financial policies. We realize this information may not always address your specific situation and encourage you to speak with a member of our billing department whenever you have any questions or concerns regarding your account.

Registration

Information gathered provides us with contact information as well as ensures your claims will be filed to the correct insurance company.

Upon arrival for your appointment, you will be asked for basic information:

- Current patient information: name, address, telephone number, employer, date of birth, social security number, and emergency contact.
- Current Insurance Card.

Please arrive at least ten (10) minutes prior to your appointment time. Having information readily available will assist us in making the check-in process easier for you. Information obtained in the registration process is kept in your confidential medical record.

You will be asked to make co-payments at the time of service. For your convenience, we can also handle your payments on your account at the Registration Desk. We accept cash, check, debit cards and major credit cards (MasterCard, Visa, and Discover).

Co-payments

Co-payments will be collected at the time of your visit. Please check with your insurance company for the requirements and provisions of your policy to determine the dollar amount of your co-payment prior to your appointment.

NSF Checks

Any negotiable items returned because of Non-Sufficient Funds (NSF) will be sent a 15-day statutory notice letter via certified mail. Receipt of the letter provides the presenter of the NSF item seven (7) days to pay the face amount of the negotiable item, plus a service charge, in the following amounts:

Amount of Check $50.00 or Less..... Fee = $25.00 per Check

Amount of Check $50.01 - $300.00..... Fee = $30.00 per Check

Amount of Check $300.01 or More..... Fee = $40.00 per Check

Or an amount equal to 5% on the face Value of the Check, whichever is greater.

Liabilities

It is the obligation of the responsible party to settle any outstanding liability charges. We cannot act as administrator to resolve financial arrangements. The balance for services rendered is considered due in full at the time of the services.

Participation with Insurance Companies

We reserve the right to determine which insurance companies or programs we participate with on an annual basis.

General Insurance Policy

As a convenience to you, our Insurance Staff will file a claim on your behalf provided we have your current insurance policy information available. However, it is impossible for our staff to determine your coverage and payment levels, since each insurance company offers many options as part of their health care coverage package.

Our staff cannot guarantee that your insurance carrier will pay all or even part of your claim. Your insurance policy is a contract between you and your insurance carrier. Ultimately, the patient is responsible for their charges. Patients should resolve disputed coverage issues directly with their insurer or employer. It is the patient's responsibility to know the details of their insurance contract and if whether your provider is a network provider for their particular plan.

When your insurance company processes your claim, they will provide you with an Explanation of Benefits (EOB). This EOB will explain what the insurance company has agreed to pay. Most insurance companies agree to pay only a percentage of the charges with the remaining balance being the responsibility of the patient. The EOB may use the term "Usual, Customary and Reasonable" (UCR). Insurance companies develop UCRs independently of one another. Therefore, because of policy deductibles, co-payments, non-covered services and UCRs, you may have a balance due after the insurance pays. No UCR adjustments will be honored unless the clinic has a signed contract in effect with that specific insurance carrier.

Medicare Policy

Federal law requires all physicians to file claims to Medicare.

We accept Medicare assignment. This means we agree to accept Medicare's allowance on services provided to you. You will still be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare.

If you carry a supplemental plan to Medicare, please ensure we have your policy information so that a claim can be filed for you.

General Credit Policies

All accounts are payable upon receipt of your first statement. Credit is extended as a courtesy, and arrangements will be based on demonstrated needs.

If you are not covered by a medical insurance plan, payment is expected at the time services are provided.

Questions Regarding Your Account

If you have questions regarding your account or wish to make a payment using MasterCard, Visa, Discover or Debit Card, please contact our Billing Department during the hours of 8:00 am and 5:00 pm, Monday through Friday, at (727) 823-2188

Thank you for your cooperation in helping us serve you with the highest quality, accessible and cost effective health care services.

Authorization for Release of Information

Patient Name: _____ **Phone:** _____ **DOB:** _____

Address: _____

Email: _____

Patient Authorizes the following facility/provider to disclose information specificaly described below:

Facility/Physician: _____ **Phone:** _____ **Fax:** _____

Address: _____ **City:** _____ **State/Zip:** _____

Information to be used/disclosed is specifically described below:

Type of Record(s): _____ **Date(s) of Service:** _____

This information may be disclosed to and used by the following individual or organization for the purpose of continued medical care:

Elite Pain and Spine Specialists
13141 Spring Hill Dr. Spring Hill, FL 34609
Phone: 352-515-0025 Fax: 352-515-0174

Authorization shall expire one (1) year from the date of signature unless otherwise noted here:
Alternative Expiration Date: _____

IMPORTANT: By signing below, the patient understands that this Authorization for Release of Medical Records ("Authorization") shall only include medical records dated prior to and including the date of this Authorization. The patient understands that this Authorization shall only include medical records originated through Elite Pain and Spine Specialists and/or its affiliates (the "Practice") unless otherwise specifically requested. The patient further understands that this Authorization is voluntary and the patient may refuse to sign. If the patient refuses to sign, the patient's refusal will not affect the patient's ability to obtain treatment from the Practice. The patient understands that this Authorization may be revoked at any time by notifying the Practice's Privacy Officer at 13141 Spring Hill Drive, Spring Hill, FL 34609. However, the revocation shall not be valid to the extent the Practice has taken action in reliance on this authorization or to the extent this Authorization is executed as a condition for obtaining insurance coverage. The patient understands that the Practice shall not condition treatment, payment, and enrollment in a health plan or eligibility for benefits (if applicable) on whether the patient provides Authorization for the requested use or disclosure.

_____ _____
Patient/Authorized Representative Signature Date

For Office Use Only:

Request Fulfilled by: _____ Signature: _____ Date: _____

Via: [ ] Mail [ ] Fax [ ] Pick-up [ ] Copy Service

No-Show/Cancellation Agreement

Patient Name: _____ DOB: _____

Please Note: *Effective Immediately*

A 24-hour notification is required prior to your scheduled appointment.

If you fail to inform the office of a cancellation, you will be subjected to a Cancellation Fee for the following:

$25.00 for missed office visits
$75.00 for missed procedure

_____ _____

Signature of Patient/Legal Representative Date

For office use only:
Date Received _____
Paperwork Complete _____
Imaging Center_____
Referred By _____
PCP _____
Date Entered_____
Ins Verified _____
Scheduled_____
Scanned_____
INS & ID Copied_____
Staff Initials_____