COMPREHENSIVE PAIN
OF THE PALM BEACHES

4897 S. Jog Rd. Suite B Greenacres, FL 33467
PHONE 561.434.7577 FAX 561.434.3440

TO OUR PATIENTS:

s.458.320(5)(g)5, FLORIDA STATUTES:

"UNDER FLORIDA LAW, PHYSICIANS ARE GENERALLY REQUIRED TO CARRY MEDICAL MALPRACTICE INSURANCE OR OTHERWISE DEMONSTRATE FINANCIAL RESPONSIBILTY TO COVER POTENTIAL CLAIMS FOR MEDICAL MALPRACTICE. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.

THIS IS PERMITTED UNDER FLORIDA LAW SUBJECT TO CERTAIN CONDITIONS. FLORIDA LAW IMPOSES PENALTIES AGAINST NONINSURED PHYSICIANS WHO FAIL TO SATISFY ADVERSE JUDGMENTS ARISING FROM CLAIMS OF MEDICAL MALPRACTICE. THIS NOTICE IS PROVIDED PURSUANT TO FLORIDA LAW."

EFFECTIVE FOR COMPRENSIVE PAIN OF THE PALM BEACHES' PHYSICIANS, EFFECTIVE AUGUST 31ST, 2002.

PLEASE SIGN BELOW TO ACKNOWLEDGE YOU HAVE READ THE ABOVE.

_____ _____

PATIENT'S SIGNATURE DATE

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MEDICATION LIMITATION DISCLOSURE

I, _____, understand that I may be prescribed a medication or medications that may impair my ability to drive an automobile and/or use machinery or dangerous equipment.

The doctor(s) of Comprehensive Pain of the Palm Beaches have informed me of these dangers. I understand my limitations while taking these medications especially upon initiation of treatment and during dosage increases.

PRINT NAME: _____

SIGNATURE: _____

PRESCRIPTION POLICY

New Prescriptions and refill prescriptions will only be written Monday through Thursday, 9AM-4PM. We will not renew prescriptions at night, on weekends, or on holidays.

Further, please make sure prescription needs are addressed during your visit with the Doctor. Requests for prescriptions or refills made via telephone, unless directed by the physician, may result in a significant delay in filling your prescription.

PRINT NAME: _____

SIGNATURE: _____

NECESSARY DOCUMENTATION REQUIRED FOR PAIN MEDICATION

Please be aware our doctor(s) will need the necessary clinical documentation concerning your medical condition to prescribe pain medication.

Clinical findings from the most recent medical evaluation, including any of the following which has been obtained: findings of physical examination, results of laboratory tests, X-rays, EKG's and other special evaluations or diagnostic procedures and most important medication records.

It is mandatory that the documentation is recorded on your medical doctor's letterhead stationary.

If you are unable to provide the medical documentation, our doctors will not be able to prescribe controlled pain medications.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

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Patient Registration Form

PLEASE PRINT

Patient Name_____ Jr, Sr, II, III **S.S.#**_____-_____-_____
(Last) (First) (Middle)

DriversLicense#_____State Registered_____**D.O.B.**_____ **Age**_____

Address_____City/State _____ Zip Code _____

Secondary Address:_____

Home #(___)_____ Cell #(___)_____ Email _____@_____ Marital Stat: S M W D Sep

Employer Name _____ Work # (____)_____ Ext_____

Emergency Contact: Name: _____ Relationship:_____ Phone(_____)_____

Preferred Hospital: Name: _____ Phone(_____)_____

Primary Care Physician _____ Phone (_____)_____

Insurance Information

Health Ins Name_____ (PPO/HMO) I.D.#_____Grp#_____

Ins Phone(_____)_____ Card Holders Name_____
(ONLY IF DIFFERENT THAN ABOVE)

Card Holder's SS# ____-____-____ Policy Holder's D.O.B. **(VERY IMPORTANT)** _____ Relation_____

Secondary Ins Name_____(PPO/HMO) I.D.#_____Grp#_____

Ins Phone(_____)_____ Card Holders Name_____
(ONLY IF DIFFERENT THAN ABOVE)

Card Holder's SS# ____-____-____ Policy Holder's D.O.B. **(VERY IMPORTANT)** _____ Relation_____

Please Initial: _____

Date _____

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PATIENT QUESTIONNAIRE

Name: _____ DOB:_____

Sex: M F Weight:_____ Height:_____

Please State Pain Complaint:_____

_____

PAIN FREQUENCY (CHECK):

_____Rarely Present _____Occasionally Present _____Frequently Present

_____Always Present _____Only Under Certain Conditions (Explain):_____

_____

WHAT ACTIVITIES WORSENS THE PAIN? _____

WHAT RELIEVES THE PAIN? _____

HAVE YOU BEEN TREATED IN A PAIN PROGRAM BEFORE? YES NO

IF YES, WHERE? _____

HAVE YOU HAD AN MRI/CT SCAN OR XRAYS? YES NO WHERE/WHEN? _____

_____

_____

PLEASE CIRCLE ONE: **RIGHT** OR **LEFT** HAND DOMINANT

LIST ALL ALLERGIES: (IF NONE CIRCLE: N/A)

_____ _____ _____

_____ _____ _____

LIST ALL CURRENT MEDICATIONS: (IF NONE CIRCLE: N/A)

_____ _____ _____

_____ _____ _____

COMPREHENSIVE PAIN
OF THE PALM BEACHES

LIST ALL PAST SURGERIES: (IF NONE CIRCLE: N/A)

_____ _____ _____

_____ _____ _____

_____ _____ _____

DO YOU SMOKE? _____YES _____NO PACKS PER DAY_____ YEAR STARTED:_____

DATE QUIT_____ DOES ANYONE SMOKE IN YOUR HOME?_____

DO YOU DRINK ALCOHOLIC BEVERAGES?_____YES _____NO
IF YES, HOW MUCH? _____

HAVE YOU EVER HAD A CHEMICIAL DEPENDENCY PROBLEM? _____YES _____NO
IF YES, WHEN?_____

EXERCISE: FREQUENCY/WEEK_____ TYPE_____

DATE OF LAST TETANUS SHOT _____ DATE OF LAST PNEUMOVAX SHOT _____

WOMEN ONLY

AGE OF FIRST PERIOD_____ AGE OF MENOPAUSE_____ DATE OF LAST PERIOD_____

PELVIC OR VAGINAL INFECTION: YES / NO CONTRACEPTION USED: _____

OF PREGNANCIES: _____ MISCARRIAGES_____ ABORTION_____

LAST MAMMOGRAM_____ MAMMOGRAM RESULT_____

LAST PAP_____ PAP RESULT_____

LAST COLONOSCOPY_____ COLONOSCOPY RESULT_____

ARE YOU PREGNANT OR PLANNING TO BECOME PREGNANT? _____YES _____NO

MEN ONLY

PROSTATE CONCERNS OR TROUBLE_____

LAST COLONOSCOPY_____ COLONSCOPY RESULT_____

Patient Initials:_____

Date:_____

COMPREHENSIVE PAIN
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REVIEW OF SYMPTOMS: Please check if you have any of the following:

General
__Fever
__Chills
__Sweats
__Anorexia
__Fatigue
__Weakness
__Malaise
__Weight Loss
__Sleep Disorder

Eyes
__Vision Loss – 1 Eye
__Double Vision
__Eye Irritation
__Vision Loss-Both Eyes
__Blurring
__Eye Pain
__Halos
__Eye Discharge
__Light Sensitivity

Ears, Nose, and Throat
__Ringing in Ears
__Ear Discharge
__Earache
__Decreased Hearing
__Nasal Congestion
__Nosebleeds
__Difficulty Swallowing
__Hoarseness
__Sore Throat

Cardiovascular
__Diff. Breathing at Night
__Near Fainting
__Chest Pain or Discomfort
__Racing/Skipping Heart Beats
__Fatigue
__Lightheadedness
__Shortness of Breath with Exertion
__Palpitations
__Swelling of Hands or Feet
__Difficulty Breathing Lying Down
__Fainting
__Leg Cramps with Exertion
__Blush Color Lips/Nails
__Weight Gain

Respiratory
__Breathing Disturbs Sleep
__Cough
__Shortness of Breath
__Coughing up Blood
__Chest Discomfort
__Wheezing
__Excessive Sputum
__Excessive Snoring

Gastrointestinal
__Excessive Appetite
__Loss of Appetite
__Indigestion
__Vomiting Blood
__Nausea
__Vomiting
__Yellow Skin Color
__Gas
__Abdominal Pain
__Abdominal Bloating
__Hemorrhoids
__Diarrhea
__Change in Bowel Habits
__Constipation
__Dark, Tarry Stools
__Blood in the Stools

Genitourinary
__Foul Urinary Discharge
__Blood in Urine
__Urinary Frequency
__Inability to Empty Bladder
__Urinary Urgency
__Kidney Pain
__Trouble Starting Stream
__Painful Urination
__Nighttime Urination
__Inability to Control Bladder
__Genital Sores
__Lack of Sexual Drive
__Erectile Dysfunction
__Excessively Heavy Periods
__Missed Periods
__Unusual Urinary Color
__Abnormal Vaginal Bleeding
__Pelvic Pain

Musculoskeletal
__Muscle Cramps
__Joint Pain
__Joint Swelling
__Joint Fluid Present
__Back Pain
__Stiffness
__Muscle Weakness
__Arthritis
__Gout
__Loss of Strength
__Muscle Aches

Dermatological
__Excessive Perspiration
__Night Sweats
__Suspicious Lesions
__Changes in Nail Beds
__Dryness
__Poor Wound Healing
__Unusual Hari Distribution
__Skin Cancer
__Itching

Dermatological Continued…
__Changes in Skin Color
__Flushing
__Rash

Neurological
__Diff. with Concentration
__Poor Balance
__Headaches
__Coordination Difficulty
__Numbness
__Inability to Speak
__Falling Down
__Tingling
__Brief Paralysis
__Visual Disturbance
__Seizures
__Weakness
__Sensation of Room Spinning
__Tremors
__Fainting
__Excessive Daytime Sleepiness
__Memory Loss

Psychological
__Sense of Great Danger
__Anxiety
__Thoughts of Suicide
__Mental Problems
__Depression
__Thought of Violence
__Frightening Visions/Sounds

Endocrine
__Excessive hunger
__Cold Intolerance
__Heat Intolerance
__Excessive Urination
__Excessive Thirst
__Weight Change

Hematology
__Enlarged Lymph Nodes
__Bleeding
__Skin Discoloration
__Abnormal Bruising

Allergy
__Persistent Infections
__Hives or Rash
__Seasonal Allergies
__HIV Exposure

Breast
__Left Breast Lump
__Right Breast Lump
__Nipple Discharge
__Bloody Discharge from Nipple
__Breast Pain
__Abnormal Mammogram
__Breast Enlargement

COMPREHENSIVE PAIN
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REVIEW OF FAMILY HISTORY	WHO IN YOUR FAMILY WAS DIAGNOSED? (circle N/A if not applicable)
1. Alcoholism	N/A
2. Anemia	N/A
3. Anesthetic Complications	N/A
4. Angina	N/A
5. Anxiety	N/A
6. Arthritis	N/A
7. Asthma	N/A
8. Birth Defects	N/A
9. Blood Clots	N/A
10. Blood Transfusions	N/A
11. Bowel Disease	N/A
12. Breast Cancer	N/A
13. Cervical Cancer	N/A
14. Colon Cancer	N/A
15. Colon Cancer-Father	N/A
16. Colon Cancer-Mother	N/A
17. Coronary Heart Disease Female <65	N/A
18. Coronary Heart Disease male <55	N/A
19. Depression	N/A
20. Diabetes	N/A
21. Endometriosis	N/A
22. Growth/Development	N/A
23. Headaches	N/A
24. Heart Attack	N/A
25. Heart Disease	N/A
26. High Cholesterol	N/A
27. Hypertension	N/A
28. Kidney Disease	N/A
29. Liver Disease	N/A
30. Lung Disease	N/A
31. Melanoma	N/A
32. Osteoporosis	N/A
33. Other Cancer	N/A
34. Other Diseases	N/A
35. Other Medical Problems	N/A
36. Ovarian Cancer	N/A
37. PMS	N/A
38. Psychiatric Care	N/A
39. Respiratory Disease	N/A
40. Seizures	N/A
41. Severe Allergies	N/A
42. Sexually Transmitted Disease	N/A
43. Stroke	N/A
44. Suicide Attempt	N/A
45. Thyroid Disease	N/A
46. Ulcers	N/A
47. Uterine Cancer	N/A
48. Weight Disorder	N/A

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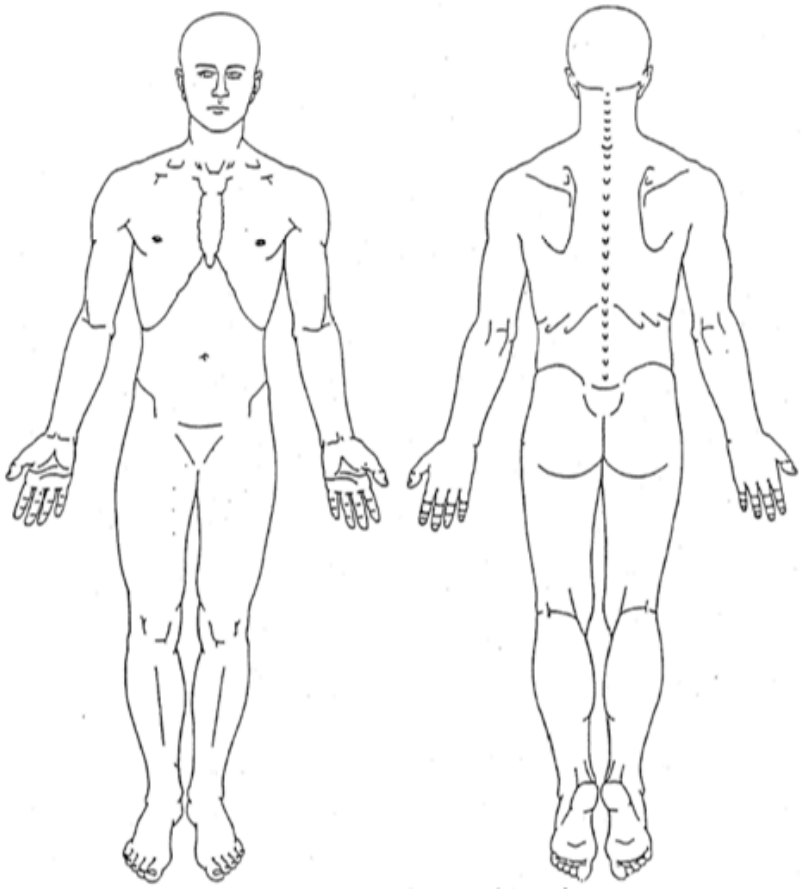
PAIN DIAGRAM

Name:_____ **Date:**_____

Mark the areas on this body drawing where you feel the described sensations.

- Use the appropriate symbols
- Mark areas of radiation
- Include all affected areas

Numbness - - - - -
Pins & Needles 0 0 0 0 0
Burning X X X X X
Aching . . . . .
Stabbing /////



On a scale of 1-10, indicate your current level of pain:

1 2 3 4 5 6 7 8 9 10

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PATIENT PAIN QUESTIONNAIRE

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center 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

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

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Patient Cancellation/No-Show Policy Acknowledgement

I understand that Comprehensive Pain of the Palm Beaches has a cancellation/no-show policy, and that I will be charged for any appointment I cancel or miss with less than 24 hours' notice. Cancellations are reserved for emergencies only, and require a minimum of a 24-hour notice. All cancellations are to be rescheduled to ensure continuity of care. Any arrival 15 minutes or more after the scheduled start time of your appointment will be considered a cancellation/no-show.

I understand that Comprehensive Pain of the Palm Beaches does not overbook patients, my appointment time is set aside specifically for me. Thus, Comprehensive Pain reserves the right to charge a fee of $25.00 for each scheduled appointment that is canceled with less than 24 hours' notice, as well as for no-shows. I also understand that I may be discharged from the care of Comprehensive Pain of the Palm Beaches if I cancel with less than 24 hours' notice, or no-show, more than 3 times within any 6-month period.

I also understand that I will not be seen until any outstanding cancellation/no-show fees have been paid in full and that any self-pay fees are non-refundable.

By signing below, I understand and agree to the above policy.

Patient Name (Print): _____

Patient Signature: _____

Provider Signature: _____

Date: _____

Financial Policy, Consent for Treatment, Release of Medical Information

Thank you for choosing Comprehensive Pain of the Palm Beaches as your health care provider.

PLEASE READ CAREFULLY

You and your insurance carrier are responsible for your bill.
Knowing your insurance benefits plan is your responsibility.

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

- Insurance information must be presented/updated at the time of making your appointment, not at the time of service. Most insurance companies have requirements for authorization of services and/or referrals from the Primary Care Provider prior to the services. If you present for your appointment and you have not provided your correct insurance to ensure verification, authorization of services and all required referrals you will not be seen and your appointment will be rescheduled.

Payment in Full for non-insurance services is expected at the time of service. Co-payments for services are required at the time of registration. Please be advised that we are contractually obligated by your insurance carrier to collect your co-payment at the time of service. If you arrive without the ability to pay for your services or your co-pay you will not be seen and your visit will be rescheduled.

- If you have insurance, as a courtesy to you, we will file your primary and secondary insurance claim for services at no cost to you. However, we will not wait more than 45 days for the insurance to pay. After 45 days it is your responsibility to contact your insurance company and follow up on why your claim has not been paid. You must take the necessary action required to get your claim paid and communicate your actions to our office. Failure to assist our office in timely payment of your insurance claim will result in the total charges being transferred to patient liability. Any patient liability assigned to you by your insurance carrier will be billed to you. Once insurance has paid, payment in full of the patient assigned liability will be expected with the receipt of your statement. You will receive two billing statements regarding your balance. If we do not hear from you after these two statements, your account will be subject to our collection process unless prior arrangements are made with our financial office.

- Comprehensive Pain of the Palm Beaches is committed to providing the highest quality care for our patients and we charge what is usual and customary for our area. You are ultimately responsible for all clinic and surgery fees relating to your care. **You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates.** Your insurance policy is a contract between you and your insurance company. Any disagreement you have concerning the amount your insurance pays should be directed to your insurance company

- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. Your policy may also contain plan specific

limitations that apply to referrals, referral dates and number of visits. We will make every effort to ascertain your coverage for our services before

treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier. The contract of coverage is
between you and your insurance carrier and it is your responsibility to understand your coverage, coverage requirements and limitations due to the variations between policies. You will be expected to pay for the patient liability assigned to you by your insurance carrier.

- For services that are not covered by insurance, the practice requires payment of 100% of the total **estimated charges** unless prior payment arrangements have been set up with our office.

- **Insured individuals electing to be self-pay**. The patient has the right to elect not to file their health insurance and elect to be a self-pay patient for services provided. The patient will be financially responsible for charges incurred and payment will be due at the time of service. After services have been rendered, the patient will not be able to file their health insurance for the services due to insurance claim submission requirements. Comprehensive Pain of the Palm Beaches will not file insurance for any services where the patient elected to be self-pay. The patient's election to not file the services to their insurance company does not affect or reduce any out of pocket financial responsibility for future
services as determined by their insurance plan.

- **If you do not have insurance coverage for the service, are self-pay, or have insurance that Comprehensive Pain of the Palm Beaches does not participate in or accept**, payment is expected at the time of
service. **If financial arrangements have not been made and you arrive without the ability to pay for the
services you will not be seen and your visit will be rescheduled.**

- In accordance with Florida Statute 871.234(7)(a), it is a third-degree felony to waive collection of co-payments and/or deductibles if done as a general business practice, unless it is shown that the provider made a good faith attempt to collect the deductible and/or co-payment. By signing this financial policy, you understand we will collect a portion of the deductible and/or co-payment at this time and each time you are treated. If no deductible and/or co-payment is due, none will be collected. No discount of assigned insurance patient liability (co-pay, deductibles, co-insurance) will be made to
comply with federal insurance regulations and law.

- Out of Network Insurance – Some insurance plans require you to pay different out-of- pocket amounts based on the provider and/or location where the service is performed. Deductibles, co-insurance, and copayments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. It is your responsibility to inquire about any plan specific coverage limitations with your insurance company. You can choose to have the services performed as "Out of Network" or as self-pay. You may also apply for financial hardship review if the "Out of Network" patient liability exceeds your ability to pay.

- Insurance information provided after the services have been provided will be billed or not billed at the discretion of Comprehensive Pain of the Palm Beaches. Due to the Insurance contractual requirements for referrals, authorization of services and timely filing limitations insurance must be presented prior to

services being provided. If Comprehensive Pain of the Palm Beaches agrees to bill your insurance you will be held liable for the charges if the insurance denies your claim as untimely because of late presentation of coverage or for lack of timely authorizations or referrals.

- Patients who request payment arrangements and/or financial hardship adjustments are required to supply financial documentation to support their request. Financial documentation will include income and expenses as outlined on our financial assistance application. Failure to supply the required documentation will result in normal collection activity being adhered to.

- In the event, your account/s must be turned over for outside collections, you will be billed and are responsible for all fees involved in the collection process. Returned checks are subject to a handling fee of $30.00

- Please note that our office charges $25.00 for missed appointments. Please contact our office 24 hours in advance to reschedule your appointment to avoid this fee.

- In the event, you have an account with a credit balance, we reserve the right to transfer credits to any other outstanding account balances prior to issuing a refund.

- Patients with a history of presenting for their appointment without the ability to pay their co-pay, short notice (less than 48 hours) canceling of appointment or not showing up for their appointments will be subject to reviewed for dismissal from our practice.

- There is a charge of $25.00 per page to complete FMLA paperwork, forms for disability claims, accident or injury claims, attorney verification of medical condition or any other non-medical services reimbursement paperwork. Payment must be made at the time the forms are complete. Some third-party forms requests must be paid for prior to the forms being completed.

We realize that temporary financial problems do occur. If such problems do arise, we encourage you to Contact us promptly for assistance. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us.

Authorization: I hereby authorize Comprehensive Pain of the Palm Beaches to administer treatment, diagnostic testing and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to Comprehensive Pain of the Palm Beaches. In the event, my insurance makes payment directly to me for services I will immediately endorse and assign the payment to Comprehensive Pain of the Palm Beaches. If my insurance does not cover services rendered, I agree to be personally, and fully responsible for payment. I give Comprehensive Pain of the Palm Beaches permission to appeal any denials by my insurance for services rendered on my behalf. I will assist Comprehensive Pain of the Palm Beaches with follow-up of timely payment, requests for information and appeals to my insurance as necessary to ensure full and timely payment for services received.

I have read the Comprehensive Pain of the Palm Beaches' Financial Policy, Consent for Treatment, Release of Medical Information, policy and understand and agree to its terms. This authorization is to remain in
full force unless I revoke the same in writing.

_____ _____

(Patient/Responsible Party) Signature Date (Patient/Responsible Party) Printed Name Date