Institute of Pain Management, P. A.

Orlando G. Florete, Jr., M.D., Director

1325 San Marco Blvd., Suite 401 • Jacksonville, Florida 32207
(904)-306-9860 • Fax (904)306-9864

Jawed Hussain, MD • Marisol Arcila, MD • Stephanie Epting, DO • Robert Burns,MD

Jody Crisostomo, PA-C • James Frizzelle, PA-C • George Robinson, PA-C

Date:_________________

Patient Name:____

You have been referred to the Institute of Pain Management by Dr.__________________________ for an evaluation of your pain. Your appointment has been scheduled on our next available date:

____.

APPOINTMENT LOCATION:

_____1325 San Marco Blvd, 4th Floor, Reid Bldg , (904)306-9860, fax (904)306-9864.

_____4243 Sunbeam Road, Suite 6, (904)448-2005, fax (904)448-1185.

_____1210 Kingsley Avenue, Suite 2, Orange Park, FL 32073, (904)264-4490, fax (904)264-5667

_____11513 N. Main Street, Jacksonville, Florida 32218, (904)751-6200

Please read carefully and complete the questionnaire enclosed. **It will be MANDATORY that the questionnaire is completely filled out when you check-in for your appointment or you WILL BE RESCHEDULED.** At the time of your appointment you must provide us with your insurance card, a picture ID along with any pertinent medical records, MRI and/or x-ray reports. You will also need to be prepared to make your co-pay at the time of check-in.

If you have any questions regarding this appointment, please contact the office in which you are scheduled .

IT IS THE PATIENT'S RESPONSIBILITY TO MAKE SURE WE HAVE PRIOR MEDICAL INFORMATION AS WELL AS A CURRENT REFERRAL TO THIS OFFICE FOR ALL APPOINTMENTS!!!!!!!!

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Dear Patient:

We at the Institute of Pain Management are excited about the possibility of being involved in treating you. As a new patient, you will be evaluated by a medical physician or physician assistant who will take a lengthy history, complete a physicial examination, and start you on a treatment therapy program. In order to get all this accomplished in one hour's time, we ask you to perform a few necessary tasks prior to your visit. The following are:

1. Obtain pertinent clinic and hospital notes concerning your care and other important medical disabilities.
2. If you have had any MRIs, CT scans, x-rays, miscellaneous radiographic reports or radiographic procedures performed, please acquire a readout of the procedure and bring this with you to your first visit.
3. Be on time. Arrive at least 30-minutes prior to your appointment time. Some of our offices are difficult to locate on the first visit; therefore, it is best that you leave early and provide yourself with enough time to arrive at the office in time to be checked in at the front desk. Please have your questionnaire and necessary forms completed at the time of check in so that there will be no delay in getting you processed in a timely manner.
4. You are beginning a relationship with a pain management physician or physician assistant that will require a partnership between yourself and the pain practitioner.

Pain management is an exciting new field of medicine that has many options for treatment. We at the Institute of Pain Management feel confident that we will be able to possibly cure, manage, and/or significantly reduce your pain. We also will strive to address all of the issues in your life that have been affected by your pain.

Thank you very much for your cooperation in making your first visit at the Institute of Pain Management as beneficial to yourself as possible.

Sincerely,

Institute of Pain Management, P.A.
Orlando G. Florete, Jr., M.D., Medical Director

Institute of Pain Management, PA- Questionnaire
Please complete prior to your appointment

Your Name: ______________________________ ________________ Today's Date ______________

Patient is referred to IPM by :_________________________________

Date of birth: ________________ / Age: _____ Sex:Male [ ] Female [ ]

Your Address: ____

City: ______________________ State ____ Zip _________

Your Telephone: Home _____________ Work _____________

Referring Physician
Name:
____

Address:
____

Phone:
____

Other Involved Physician
Name:
____

Address:
____

Phone:
____

Primary Care Physician
Name:
____

Address:
____

Phone:
____

Preferred Pharmacy
Name:
____

Address:
____

Phone:
____

Medical insurance: Insurance Plan: ____

Policy # ______________________ Group #: _________________

Contact person _________________ Phone#: _________________

Work Related Injury or Pain

Is your condition somehow work-related? Yes [ ] No [ ] Your Occupation: ______________________________

Describe the work you do in more detail: ____

____

____

Where were you working when the pain began? ____

What type of work were you doing? ______________________________ How long did you work there? ______

What is your current (or most recent if unemployed) job? ____

List prior jobs: ____

Do you receive any payments related to your pain? [ ] Yes [ ] No
Have you received any payments related to your pain'? [ ] Yes [ ] No
Total payments received which were related to your pain or its underlying cause or injury: $_________
Have you retained a lawyer regarding your pain or it's underlying cause or injury? ________________________

Worker Compensation Case Information: (If the condition you are seeing us for has a Worker Compensation Case Number Assigned)

Case #:____________________

WC Contact: ____________________ WC Contact Phone#: _______________

CC - Describe the primary purpose of your visit and the major problem for which you want help:

____

Describe any other problems that need help:

____

____

____

HPI – HOW DID THE PAIN BEGIN

How the pain began…

[ ] Suddenly
[ ] Next Day
[ ] Gradually
[ ] Over the past ???

#_______ Days / Months / Years

[ ] No apparent cause

EVENTS:
[ ] in a Fall
[ ] Bending Over
[ ] Pulling
[ ] Lifting - What? _______________
[ ] Twisting
[ ] Sports
[ ] Previous Surgery
[ ] Injured at work
[ ] Car Accident
[ ] Hit from behind [ ] Frontal Crash?

Date of Event?
____

or ???? ______
Days/Months/Years ago

Describe What Happened?

____

____

____

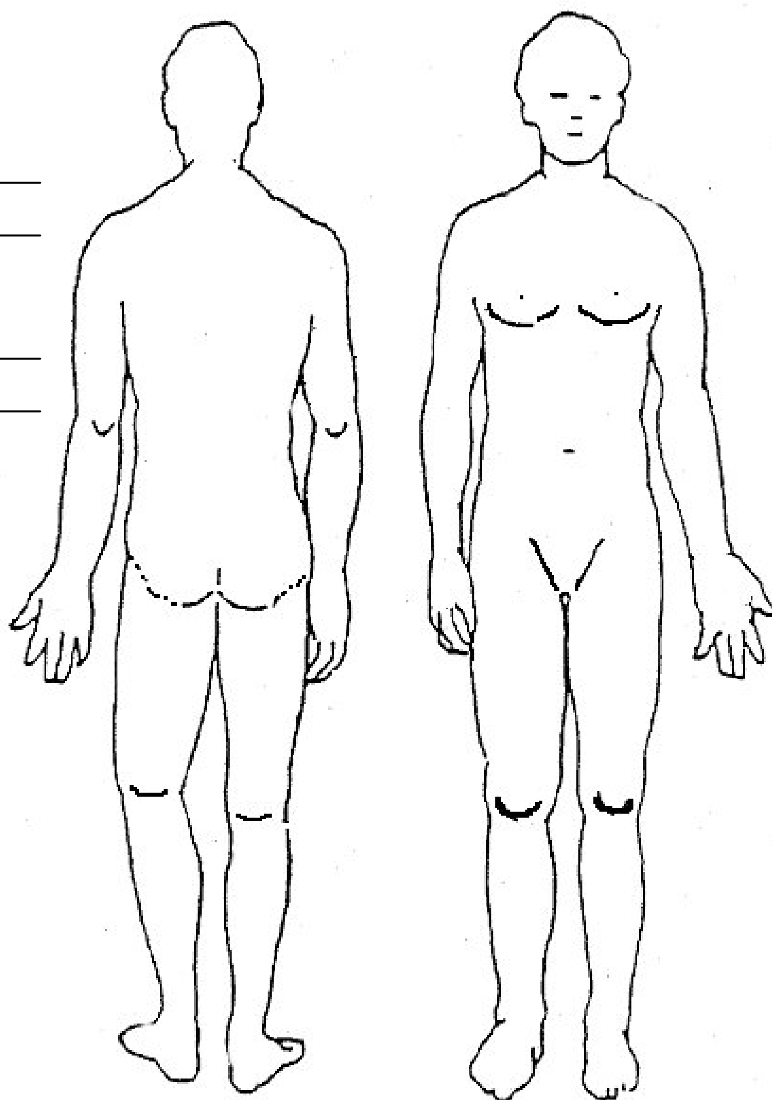
____

____

____

____

LOCATION OF PAIN:



Where is your pain?

____

____

Where does it spread to?

____

____

- Please mark **X**'s on the figures to the right to show where it hurts. (More x's means more pain)
- Please mark **O**'s where you feel weakness in the muscles. (More o's means more weakness)
- Please circle areas of numbness or tingling.

PAIN SEVERITY:

Please mark the pain scale line below with a 'P', an 'M', an "L' and a 'W' to describe the intensity of your pain.

X - Pain Level Right Now	W – the Worst Pain level it gets
M - Pain Level Most of the Time	L – the Least Pain level it gets

No Pain ____ Worst Pain Possible

1 2 3 4 5 6 7 8 9 10

<u>Functional Limitations</u> - What activities are you no longer able to perform due to the pain?

[ ] Drive the car	[ ] Walk at least 1 block	Other Limitations: ____________________
[ ] Perform Housework	[ ] Climb the stairs	____________________
[ ] Do my job	[ ] Do your normal exercise/sport	____________________

How many hours do you spend reclining or in bed due to your pain, excluding sleep time? ____________

Describe in your own words how you spend an average day:

____

____

MODIFYING FACTORS:

What do you do that lessens your pain?

[ ] Rest
[ ] Lying down
[ ] Sitting
[ ] Standing
[ ] Walking
[ ] Ice
[ ] Heat
[ ] Stretching
[ ] Exercise
[ ] Massage
[ ] Rx Pain Pills: ______________________
[ ] OTC Pain Pills: ____________________
[ ] Alcohol
[ ] Other ____________________________

What do you do that makes the pain worse?
____

____

What professional pain treatments have you tried? — Did it help?

[ ] Surgery — [ ] Yes [ ] No
[ ] Medications — [ ] Yes [ ] No
[ ] Physical Therapy — [ ] Yes [ ] No
[ ] Massage — [ ] Yes [ ] No
[ ] Chiropractic — [ ] Yes [ ] No
[ ] Acupuncture — [ ] Yes [ ] No
[ ] Pain Management Prgm — [ ] Yes [ ] No
[ ] Epidural Injections — [ ] Yes [ ] No
[ ] Nerve Blocks — [ ] Yes [ ] No
[ ] Trigger Point Injections — [ ] Yes [ ] No
[ ] TENS (electronic nerve stimulator) — [ ] Yes [ ] No
[ ] Psychology Counseling — [ ] Yes [ ] No
[ ] Biofeedback/Relaxation — [ ] Yes [ ] No
[ ] Group Therapies — [ ] Yes [ ] No
[ ] Other: _______________ — [ ] Yes [ ] No

Have you had any of these tests for your problem?

Test		Date	Where
X-rays	[ ] Yes [ ] No	Date: ____________	Where: _______________
CAT scan	[ ] Yes [ ] No	Date: ____________	Where: _______________
MRI	[ ] Yes [ ] No	Date: ____________	Where: _______________
EMG/Nerve Test	[ ] Yes [ ] No	Date: ____________	Where: _______________
Myelogram	[ ] Yes [ ] No	Date: ____________	Where: _______________
Bone Scan	[ ] Yes [ ] No	Date: ____________	Where: _______________
Discogram	[ ] Yes [ ] No	Date: ____________	Where: _______________

PATIENT MEDICAL HISTORY

General Health Status

Overall – How would you rate your health TODAY? Poor Fair Good Excellent (circle one)

Height: _______ Current Weight: _______ Weight 1 year ago: _______

Appetite: [ ] Good [ ] OK [ ] Poor Sexual Interest: [ ] Good [ ] OK [ ] Poor

Allergies

	Medication Name	Reaction (if known)
Allergies to medications:	____________________	____________________
	____________________	____________________
	____________________	____________________
	____________________	____________________
Other allergies:	____________________	____________________
	____________________	____________________
	____________________	____________________

Medications – (Medicine that you take NOW including non prescription or vitamins)

Medication Name(s):	Why taken? (pain, heart, etc)	How much? (dose in 24hrs)	Date/Year/Age started	Does it help?
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No
				[ ]Yes [ ]No

Medical Problems

#	Problem	Details	Since Yr/Age	Treating Physician
1	Cancer			
2	Diabetes / Glycemic Problms			
3	Heart Disease			
4	High Blood Pressure			
5	Vascular/Circulatory			
6	Liver Disease			
7	Blood / Bleeding Disorder			
8	Stomach / GI problems			
9	Epilepsy/Seizures			
10	Neurological Problems			
11	Bladder/Urinary Problems			
12	Migraines/ Headaches			
13	Asthma / Lung Disease			
14	Arthritis/Rheumatism			
15	Reproductive Health Issues			
16	Alcohol/Substance Abuse			
17	Psych/Emotional Problems			
18	Other problem			
19	Other problem			
20	Other problem			

Line # _____ continued: ______________________________

____

Line # _____ continued: ______________________________

____

Line # _____ continued: ______________________________

____

Past Surgical Hx

Prior Surgeries / Hospitalizations

Year	Name of Hospital/Address	Problem and Treatment

Important Accidents or Broken Bones

Year	Injury Suffered	Treatment and Outcome
______	__________________________	____
______	__________________________	____
______	__________________________	____

Family Medical History - What diseases run in your family?

[ ] Patient is adopted and is unaware of their birth family's medical conditions.
[ ] Patient is adopted but has learned the following regarding their birth family's medical history.

Disease / Condition	Family Member(s) with disease or condition
___________________	____
___________________	____
___________________	____

Is there anyone disabled among your family or friends? ____

Social History

What is your marital status? [ ] Single [ ] Married [ ] Divorced # times _____ [ ] Widowed
Number of Children? ____ Living at home ____ Gone from home ____ deceased
Others living in Household? ____

Last grade you finished in school? _______
What is your religion? ____________________________
Do you practice your religion? [ ] Yes [ ] Somewhat [ ] No

Have you ever used Tobacco? [ ] Yes [ ] No
What Form(s)? [ ] Cigarettes [ ] Cigars [ ] Pipe [ ] Chew
Totals years used? ___________
How much per day? ____packs ____cigars ____times/day
Have you tried to quit? [ ] No [ ] Yes - Tried quitting ______ times.
When did you last use Tobacco? ____________________

Do you ever drink alcohol? [ ] No [ ] Beer [ ] Wine [ ] Liquor
How much? [ ] less than once per week [ ] a few drinks per week
[ ] 1-2 drinks/day [ ] 3+ drinks/day
Do you binge drink? [ ] Yes [ ] No
Have you had problem related to drinking alcohol?
(e.g. DUI, injury, etc) [ ] Yes [ ] No
Do you use recreational drugs? [ ] Yes [ ] No

Do you drink coffee or other caffeinated beverages?
[ ] No [ ] Yes - # of Cups or soda's per day? __________

What would you be doing if you didn't have pain? ____
____
____

ROS - Review of Systems

RESPIRATORY

Do you ever get short of breath? [ ] Yes [ ] No
Do you ever have difficulty breathing? [ ] Yes [ ] No
Do you get repeated chest infections? [ ] Yes [ ] No
Have you had pneumonia or pleurisy? [ ] Yes [ ] No
Have you ever coughed up blood or sputum? [ ] Yes [ ] No

CARDIOVASCULAR

Have you had heart palpitations? [ ] Yes [ ] No
Do you have high blood pressure? [ ] Yes [ ] No
Do you ever have pains in the chest? [ ] Yes [ ] No
Are your ankles often swollen? [ ] Yes [ ] No
Do you ever get short of breath? [ ] Yes [ ] No
Does leg pain sometimes stop you from walking? [ ] Yes [ ] No
Do you have bleeding problems? [ ] Yes [ ] No

GASTROINTESTINAL

Do you experience abdominal pains? [ ] Yes [ ] No
Do you get constipated? [ ] Yes [ ] No
Do you get diarrhea or loose stools? [ ] Yes [ ] No
Have you ever had black tarry stools? [ ] Yes [ ] No
Do you have any swallowing problems? [ ] Yes [ ] No
Do you get nausea? [ ] Yes [ ] No
Have you ever vomited blood? [ ] Yes [ ] No
Have you gained or lost more than 10 pounds in the past year? [ ] No Gained _____lbs Lost _____lbs

GENITOURINARY

Do you urinate too frequently? [ ] Yes [ ] No
Is it sometimes hard to "hold it in"? [ ] Yes [ ] No
Do you dribble urine or use a. catheter? [ ] Yes [ ] No
Have you passed blood in your urine? [ ] Yes [ ] No
Does it burn when you pass your urine? [ ] Yes [ ] No
Is your sexual desire or performance diminished? [ ] Yes [ ] No

GYNECOLOGIC (Women Only)

Have you completed Menopause? [ ] Yes [ ] N
Date of your last menstrual period? ___________
Is your period regular? [ ] Yes [ ] No
Are you taking birth control pills? [ ] Yes [ ] No
Do you experience excessive bleeding? [ ] Yes [ ] No
Do you experience hot flashes, erratic emotions or other menopausal symptoms? [ ] Yes [ ] No
Date of your last "Pap" smear? _____________
Date of your last mammogram? _____________

ENDOCRINE

Do you have cold / heat intolerance? [ ] Yes [ ] No
Do you have excessive sweating? [ ] Yes [ ] No
Do you get faint if you haven't eaten? [ ] Yes [ ] No
Do you get uncontrollably thirsty? [ ] Yes [ ] No

IMMUNOLOGIC

Do you have constant dry mouth? [ ] Yes [ ] No
Do you have swollen neck glands? [ ] Yes [ ] No
Do you catch infections easily? [ ] Yes [ ] No
Have you ever had an HIV test? [ ] Yes [ ] No
Have you been exposed to someone who might have had HIV or AIDS? [ ] Yes [ ] No
Do you have trouble healing? [ ] Yes [ ] No

SKIN, HAIR and NAILS

Have you had rashes or other skin eruptions? [ ] Yes [ ] No
Do you have dry or brittle nails? [ ] Yes [ ] No
Do you have dry or brittle hair? [ ] Yes [ ] No
Is your skin overly sensitive? [ ] Yes [ ] No
Have you ever had an HIV test? [ ] Yes [ ] No

SKELETAL

Do you have any joint stiffness, pain or swelling? [ ] Yes [ ] No
Do you have neck pain or stiffness? [ ] Yes [ ] No
Do you have back pain or stiffness? [ ] Yes [ ] No

NEUROLOGICAL

Do you get faint or dizzy? [ ] Yes [ ] No
Do you get severe headaches? [ ] Yes [ ] No
Do get numbness in your arms or legs? [ ] Yes [ ] No
Do you have problems concentrating? [ ] Yes [ ] No
Do you have problems remembering? [ ] Yes [ ] No
Have you ever had a stroke? [ ] Yes [ ] No
Have you ever had a head injury? [ ] Yes [ ] No

WELL BEING

Have you been less social lately? [ ] Yes [ ] No
Are you often preoccupied with your pain? [ ] Yes [ ] No
Are you an anxious/nervous person? [ ] Yes [ ] No
Have you been irritable or temperamental lately? [ ] Yes [ ] No
Have you been sad or depressed? [ ] Yes [ ] No
Do people often make you angry? [ ] Yes [ ] No
Have you seen a psychiatrist or professional therapist for counseling before? [ ] Yes [ ] No
Is it harder to find enjoyable things to do lately? [ ] Yes [ ] No
In the past year, have you had thoughts of suicide? [ ] Yes [ ] No

SLEEP

Average Hours of Sleep per night: _________

Avg Bedtime: ______ Avg WakeTime: _______
Do you nap during the day? [ ] Yes [ ] No
Do you have trouble falling asleep? [ ] Yes [ ] No
Do you have trouble staying asleep? [ ] Yes [ ] No
Does your pain awaken you at night? [ ] Yes [ ] No

INSTITUTE OF PAIN MANAGEMENT

PRESCRIPTION POLICY AND AGREEMENT

All patients are required to sign this Prescription Policy and Agreement. Failure to adhere to the rules and regulations of this agreement could result in the dismissal of your care.

I, ________________________________, agree to the following conjunction with my pain management treatment under the supervision of the physicians of the Institute of Pain Management and/or staff designated by the physicians of the Institute of Pain Management.

- **Medication refill appointments must be scheduled at least 7 – 10 days in advance. It is the patients, responsibility to keep track of the amount of medication remaining and to schedule appointments appropriately.**
- **Take medications as prescribed. Early refills will NOT be given. If you use up all your medications earlier than the scheduled refill date, the remaining days will be endured with no medications.**
- **All narcotics must come from one physician. You must notify our doctors of any narcotic medication orders made by other physicians while under the care of Institute of Pain Management.**
- **Refills of controlled substance medications will be made only during regular business hours. Monday through Friday, in person, once each month during a scheduled office visits. Refills will not be made at night, on holidays or weekends.**
- **Refills will not be made if I "run out early" or "lose a prescription" or " spill or misplace my medication" or for any other reason. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.**
- **Refills will not be made as an "emergency" such as a Friday afternoon because I "Suddenly realized I will run out tomorrow." I will call at least seventy two (72) hours ahead if I need assistance with a controlled substance medication prescription.**
- **All medications are to be kept in a safe place, especially away from children. They may be hazardous or lethal should they be inadvertently taken by any person other than who they were prescribed for.**
- **All medications must be obtained at a designated pharmacy.**
- **The prescribing physician has complete liberty to discuss fully all diagnostic and treatment details with the dispensing pharmacy for purposes of maintaining accountability.**

- **Random urine toxicology screening may be done at any time. Failure to comply with random drug screens is reasonable cause for discharge from Institute of Pain Management.**

- **Script altering is a Federal offense and we will report any violations with the proper authorities.**

- **Should your prescription need to be changed prior to your "due date", all unused medication must be brought to our office prior to receiving new prescription.**

- **We reserve the right to communicate with previous and present physicians that have cared for you and/or your previous or present insurance carriers**.

If drug dependence, tolerance or addiction occurs, I agree to accept full responsibility for the risks taken secondary to my consent of narcotic consumption for the management of my pain. Should withdrawal symptoms be encountered, I will notify the Institute of Pain Management. This medication should be stopped slowly, with tapering. Mediation is not to be stopped on your own without medical advice. **Evidence of medication hoarding, increasing use of medication without communication to the pain clinic staff, hostile behavior towards our staff, refilling your prescriptions too frequently, getting the medication from multiple physicians or pharmacies, increasing amounts of medications, altering prescriptions, medication sales, unapproved use of other drugs (alcohol, sedatives or street or "illicit" drugs) during narcotic analgesic treatment or other unacceptable behavior will result in dismissal from the Institute of Pain Management.**

Side effects of narcotic medications may include drowsiness, dizziness, constipation, nausea and/or confusion. Risk of psychological dependence with the use of these medications may occur. Physical dependence is frequently encountered in the use of long-term narcotic therapy. Medication needs to be withdrawn gradually to avoid uncomfortable withdrawal symptoms that may include: excessive tearing, runny nose, dilated pupils, "goose-pimple" flesh, sweating, yawning, diarrhea, muscle aches, headache and insomnia. Tolerance to the use of narcotic medication may occur, decreasing its effectiveness.

______________________________	______________________
Patient Signature	Date
______________________________	______________________
Printed Patient Name	Witness Signature

INSTITUTE OF PAIN MANAGEMENT

CONSENT FOR CHRONIC OPIOID THERAPY

I, _______________________________________, am fully aware that Dr.____________ /and or any officially designated representative of the Institute of Pain Management is prescribing opioid medicine, sometimes called narcotic analgesics as part of my pain therapy. I attest to the following statements:

INITIAL ONLY

____1. I am not currently abusing illicit or prescription drugs, and I am not undergoing treatment for substance dependence or abuse.

____ 2. I have never been involved in the sale, diversion or transport of controlled substances.

____3. I will obtain all prescriptions for narcotic analgesics from Institute Of Pain Management and reveal all other medications that I am taking.

____4. I will only use ONE pharmacy for filling prescription analgesics.

____5. I give my permission to allow INSTITUTE OF PAIN MANAGEMENT staff and physicians to discuss my case with my other physicians and pharmacists.

____6. I agree to take my medications ONLY AS PRESCRIBED BY INSTITUTE OF PAIN MANAGEMENT.

____7. I agree to follow the advice of the physicians/physician assistants of the Institute of Pain Management regarding the stopping of controlled substances as they advise.

____8. I understand that Institute Of Pain Management reserves the right to order random urine drug screens at any time and I will comply with such request.

____9. I understand that Institute Of Pain Management will make NO allowance for lost prescriptions or medications.

____10. I understand that Institute Of Pain Management reserves the right to dismiss me from care should any violations of the above occur.

____11. (FEMALES ONLY) I certify that I am not pregnant. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware, that should I carry a baby to delivery while taking these medicines; the baby will become physically dependent upon opioids. I am aware that use of opioids is generally not associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

____12. (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 doctor may check my blood to see if my testosterone level is normal.

I authorize the release of medical records from all previous physicians, including psychological reports to Institute Of Pain Management.

I have read this entire agreement and have had the opportunity to ask questions. All of my questions have been answered satisfactorily. I consent to the use of analgesics under the terms outlined in the agreements. I will be given a copy of this policy for my reference.

______________________________	______________________________	______________________________
Patient Signature	Date	Witness
______________________________	______________________________	
Patient Name, Printed	Physician/ Physician Assistant	

Institute of Pain Management
Financial Policy

Our Financial policy is presented to you to avoid any misunderstanding now and in the future. If you have any questions, please feel free to contact the Institute of Pain Management (IPM) Billing Manager.

- ✓ All self pay accounts are to be paid **when services are rendered**.
- ✓ **All Co-payments** and co-insurance for plans that we accept are due at the time of service.
- ✓ Your insurance is billed as a courtesy. Please understand the patient is financially responsible for all charges whether or not they are paid for by insurance.
- ✓ Checks that are returned to us for insufficient funds are subject to a return check fee determined by our Billing Manager in addition to your appointment charge. We will collect these fees when you come for you next scheduled appointment.
- ✓ No show charges are as follows: **To avoid these, please notify the office within 24 business hours prior to your scheduled appointment to cancel or reschedule.**

For missed office visit appointments - $50.00
For missed procedural appointments - $75.00

If an agency is necessary to collect your past due balance, you will be responsible for any collection or attorney fees.

I hereby authorize the offices and employees of the Institute of Pain Management, PA or their contracted service companies to release information necessary to process claims with my insurance companies, and further authorize payment of insurance benefits directly to same.

I have read and understand the above stated policy and agree to comply with these rules.

____

Patient/Responsible Party Date

Institute of Pain Management, PA (IPM)

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize the Institute of Pain Management, PA (IPM) to use and/or disclose a copy of specific health and medical information described below:

Patient Name ______________________________ **Date of Birth** ________________
(Printed)

Specific Description of the Information to be Used or Disclosed Including (if practicable) the Dates of Services(s) Related to Such Information:

[ ] Entire medical record **[ ] X-ray and/or imaging reports** **[ ] Operative report** **[ ] Discharge Summary**

[ ] Other, please specify documents (s) ____

Authorized Protected Health Information will be used and/or disclosed for the following purpose(s):

[ ] Medical treatment **[ ] At the request of the individual**

[ ] Other

Name of Recipient: ____

Or Class of Recipients: ____

<u>Records to be received from</u>:

Physician/Facility ____

Address ____

Records Requested by IPM should be forwarded to:

___ 1325 San Marco Blvd., Suite 401, Jacksonville, FL 32207 – Fax 904-306-9864
___ 4243 Sunbeam Road, Suite 6, Jacksonville, FL 32257- Fax 904-448-1185
___ 3599 University Blvd. S., Suite 803, Jacksonville, FL 32216-Fax 904-858-9415
___ 1210 Kingsley Road, Suite 2, Orange Park, FL 32073-Fax 904-264-5667

If we are requesting this Authorization from you for our use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonable needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

______________________________ ______________________________
Signature of Patient **Date**

______________________________ ______________________________
Or by Name of Personal Representative **Relationship to Patient**

Institute of Pain Management, PA
Patient Consent Form

By signing this form, you are granting consent to the Institute of Pain Management, PA to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by request in writing to the Privacy Officer, Institute of Pain Management, PA, 4243 Sunbeam Road, Suite 2, Jacksonville, Florida 32257.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent on writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

By signing this consent, I ___________________________________, give my consent to the Institute of Pain Management, PA to use and disclose protected health information about me for treatment, payment and health care operations. I understand that I have a right to revoke this consent in writing by submitting the request to the attention of Privacy Office, Institute of Pain Management, PA, 4243 Sunbeam Road, Suite 2, Jacksonville, Florida 32257 except where the Institute of Pain Management, PA has already made disclosure in reliance on my prior consent.

____
Signature of Individual Consenting to Disclosure

____
Effective Date of Consent