These questions are designed to help your physician to understand the nature of your pain, as well as which tests and treatments might have to be performed

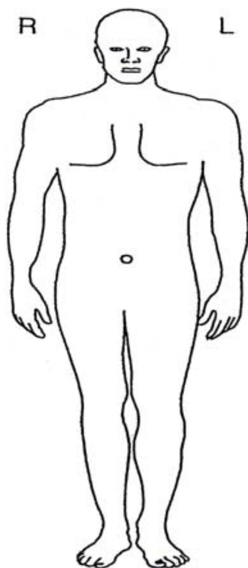
Name: ____ **Date**: ________________________

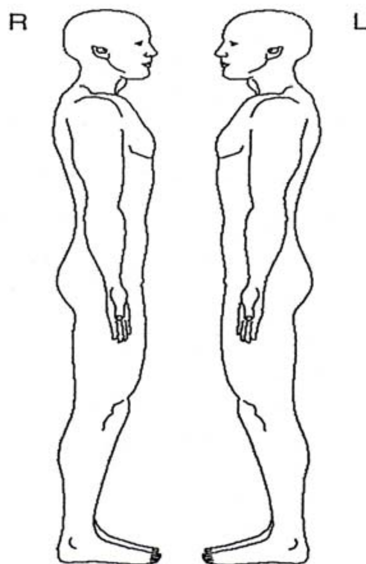
Referring Physician: ______________________ **Primary Physician:**__________________________

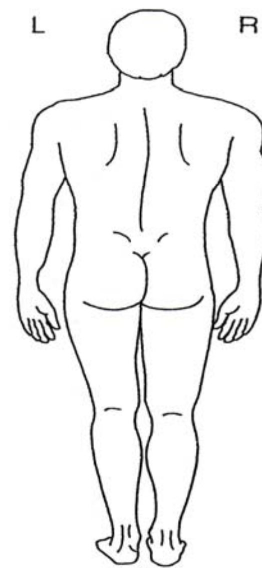
Please describe the pain for which you are seeking help in one sentence (ex. "My back hurts."):

____

Please shade in the areas where you are having pain in the following pictures:
(Shade areas darker for more severe pain and lighter for less severe pain)







Which words describe your pain? (Please circle)

sharp	throbbing	tender	intermittent	burning	shooting
aching	sore	dull	cramping	deep	nagging
stabbing	unbearable	constant	miserable	radiating	exhausting

What makes your pain worse? (Please circle)

walking	standing	sitting	bending	lying down
twisting	heat	cold	anxiety	bowel movements
sneezing	coughing	reaching	lifting	climbing stairs

other (please describe): ____

Fort Lauderdale Pain Medicine●
1930 NE 47th Street ● Suite 300 ● Fort Lauderdale, Florida 33308
Phone: (954) 493-5048 ● Fax: (954) 493-6424

Revised 7/08

Patient Name: ______________________________________ Date: ________________________

REVIEW OF SYSTEMS

Do you have or have you ever had any problems related to the following systems? (Please check)

CARDIAC
- ☐ Heart Disease
- ☐ Heart Attack/MI
- ☐ High Blood Pressure
- ☐ Angina/Chest Pain
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ CHF
- ☐ Other __________

RESPIRATORY
- ☐ Emphysema
- ☐ Asthma
- ☐ Cough
- ☐ Bronchitis
- ☐ Sleep Apnea
- ☐ Shortness of Breath
- ☐ COPD
- ☐ Other __________

NEUROLOGICAL
- ☐ Headaches
- ☐ Fainting/Dizziness
- ☐ Seizures/Convulsions
- ☐ Stroke/TIA
- ☐ Head Injury
- ☐ Balance Problems
- ☐ Weakness/Numbness
- ☐ Other __________

GASTROINTESTINAL
- ☐ Hernia
- ☐ Liver Problems
- ☐ Pancreatitis
- ☐ Ulcers/Gastritis
- ☐ Acid Reflux/GERD
- ☐ Constipation
- ☐ Diarrhea
- ☐ Other __________

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Muscle Pain
- ☐ Joint Swelling or Pain
- ☐ Joint Stiffness
- ☐ Osteoporosis
- ☐ Other __________

PSYCHOLOGICAL
- ☐ Anxiety
- ☐ Depression
- ☐ Panic Attacks
- ☐ Mental Disorders
- ☐ Considered Suicide
- ☐ Other __________

URINARY
- ☐ Kidney Stones
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Urine Retention
- ☐ Other __________

IMMUNOLOGICAL
- ☐ HIV/AIDS
- ☐ TB
- ☐ Hepatitis
- ☐ Cancer
- ☐ Swollen Glands
- ☐ Other __________

SKIN
- ☐ Psoriasis
- ☐ Open Sores
- ☐ Skin Cancer
- ☐ Skin Rash
- ☐ Other __________

HEAD/NECK
- ☐ Eye Glasses
- ☐ Glaucoma
- ☐ Double Vision
- ☐ Persistent Stiff Neck
- ☐ Other __________

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Cortisone Replacement
- ☐ Pituitary Problems
- ☐ Other __________

HEMATOLOGIC
- ☐ Anemia
- ☐ Blood Clots
- ☐ Easy Bruising
- ☐ Bleeding Problems
- ☐ Other __________

CONSTITUTIONAL
- ☐ Fever
- ☐ Chills
- ☐ Weight Change – If yes, how much? __________
- ☐ Difficulty Sleeping
- ☐ Other __________

Physician use only: (Notes/Comments)

R.N /M.A. Signature: ______________________________ **Patient's Initials:** _____________

Physician Signature: ______________________________

Name: ______________________________________ **Date:** ______________________

What makes your pain better? (Please circle)

Heat   Cold/ ice   Rest   Certain positions (describe): __________________________
Pain medications   Physical therapy   other: __________________________

Do you have any of the following related to your pain? (Please circle)

Numbness   weakness   problems with bowels related to pain
Tingling   pins & needles   problems with bladder related to pain

Please mark on the scale below where your pain level is at its LEAST and WORST:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Possible Pain

What is your pain like TODAY? (From 0-10): _______________

What time of day (morning, evening, etc.) is your pain worse? _______________ **better?** _____________

Are you ever free from pain? ☐ **yes** ☐ **no**

How long have you had your pain? ____

Did any particular event lead to the onset or worsening of your pain? ☐ **yes** ☐ **no**

If yes, please explain: ____

____

Is your pain due to an automobile, work, slip and fall or any other type of accident? ☐ **yes** ☐ **no**

If yes, what type of accident and when did it occur? ____

Are you currently involved in, or considering, any litigation or legal activity concerning your pain or events leading up to your pain? ☐ **yes** ☐ **no**

For Doctor Use Only:
Diagnosis: ____
Plan of Treatment: ____

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Phone: (954) 493-5048 ● Fax: (954) 493-6424

FORT LAUDERDALE PAIN MEDICINE, INC. (the "Practice")
NOTICE OF PRIVACY PRACTICES

I. 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.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION.

We are legally required to protect the privacy of your health information. We call this information "protected health information," or "PHI" for short and it includes information that can be used to identify you that we have created or received about your past, present or future health or condition, the provision of health care to you, or the payment of this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice. Your health information is contained in a medical record that is our physical property.

III. HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each category.

A. **Uses and Disclosures Related to Treatment, Payment or Health Care Operations**
We may use and disclose your PHI for the following reasons:

1. For Treatment. We may use your PHI to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.
2. For Payment. We may use and disclose your PHI to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.
3. For Health Care Operations. We may use and disclose PHI about you for operational purposes. For example, your PHI may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to: (i) evaluate the performance of our staff; (ii) assess the quality of care outcomes in your cases and similar cases; (iii) learn how to improve our facilities and services; and (iv) determine how to continually improve the quality and effectiveness of the health care we provide.
4. Appointments. We may use your PHI to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

B. **Certain Additional Uses and Disclosures Do not Require your Authorization**
We may also use and disclose your PHI without your authorization for the following reasons:

1. Required by law. We may use and disclose information about you as required by law. For example, we may disclose information: (i) for judicial and administrative proceedings pursuant to legal authority; (ii) to report information related to victims of abuse, neglect or domestic violence; and (iii) to assist law enforcement officials in their law enforcement duties.
2. Public Health. Your PHI may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.
3. Decedents. PHI may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.
4. Organ/Tissue Donation. Your PHI may be used or disclosed for cadaveric organ, eye or tissue donation purposes.
5. Research. We may use your PHI for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI has approved the research.
6. Health and Safety. Your PHI may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.
7. Government Functions. Your PHI may be disclosed for specialized government functions such as protection of government officials or reporting to various branches of the armed services.
8. Workers Compensation. Your PHI may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.
9. Change of Ownership. In the event that the Practice is sold or merged into or with another entity, your health information/record will become the property of the new entity.

C. **Use and Disclosure Which Requires You to Have the Opportunity to Object.**
We may provide your PHI to a family member, friend or other person that you indicate is involved in your care or in the payment of your health care, unless you object.

D. **All Other Uses and Disclosures Require Your Prior Written Authorization.**
Other uses and disclosures will be made only

with your written authorization and you may revoke the authorization, except to the extent we have taken action in reliance on such authorization.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. **The Right to Request Limits on Uses and Disclosures of Your PHI.**
You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

B. **The Right to Choose How We Send PHI to You.**
You have the right to ask that we send information to you to an alternate address (*for example, sending information to your work address rather than to your home address)* or by an alternate means *(for example, e-mail instead of regular mail).* We must agree to your request so long as we can easily provide it in the format you requested.

C. **The Right to See and Get Copies of Your PHI.**
In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we do not have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request or if the request is for PHI that is not maintained or accessible on-site to us, within 60 days. In certain situations, we may deny your request. If we do, we will tell you in writing our reasons for the denial and explain your right to have the denial reviewed.

If you request copies of your PHI, we will charge $1.00 a page for the first 25 pages and then $.25 for each additional page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. **The Right to Get a List of the Disclosures We Have Made.**
You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment or health care operations, or those uses and disclosures made directly to you or your family. The list also will not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or those uses and disclosures occurring before April 14, 2003.

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made within the last six years (but not disclosures made before April 14, 2003), unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed and the reason for disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you $25.00.

E. **The Right to Correct or Update Your PHI.**
If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and the reason for your request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is: (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. **The Right to Get This Notice by E-Mail.**
You have the right to get a copy of this Notice by e-mail. Even if you have agreed to receive this Notice via e-mail, you also have a right to request a paper copy of this Notice.

V. COMPLAINTS

If you think that we may have violated your privacy rights or you disagree with a decision we have made about access to your PHI, you may file a complaint with the person listed in section VII below. You also may send a written complaint to the Secretary of the Department of Health and Human Services [www.hhs.gov]. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

We reserve the right to change its information practices and to make the new provisions effective for all PHI it maintains. Such revisions shall be effective as of the revision date of such notice. Revised notices will be made available to you at the Practice website WWW.SOLUTIONSFORPAIN.COM and at the time of your next visit to the Practice's office.

VII. CONTACT INFORMATION

If you have any questions about this notice or any complaints about our privacy practices or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact:
Barbara Shapiro, RN
Fort Lauderdale Pain Medicine, Inc.
1930 NE 47th Street, Suite 300
Fort Lauderdale, Florida 33308
Phone: 954-493-5048

VIII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

ACKNOWLEDGEMENT OF RECEIPT OF
FORT LAUDERDALE PAIN MEDICINE INC.
NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of Fort Lauderdale Pain Medicine, Inc.'s Notice of Privacy Practices.

____
Name (Print)

______________________________________ ___________________
Signature Date

-OR-

______________________________________ _____________________
Patient Representative Relationship to Patient

For Office Use Only

Date acknowledgement received: _____________________

-OR-

Reason acknowledgement was not obtained:

____
____
____

Practice Representative: __________________________________

Signature: ______________________________________ Date: _______________

Revised 4/08

New Patient Information

Name: ____ Date: ______________
Last MI First

Date of Birth: _______________ Age: ______ Sex: M/F ______ SS#:_________________

Local Address: ____
Street Apt #

City: __________________________ State: ________ Zip Code: _________________

Home Phone #: ____________________ Cell Phone #: _____________________

Out of State Address: ____
Street Apt #

City: ________________________ State: ________ Zip Code: _________________

Out of State Home Phone #:_______________________

Employer: _____________________________________ Work Phone #:_____________________

Marital Status: S M W D Spouse's Full Name: _______________________________________

Spouse's Date of Birth: ___________________ Spouse's SS #:_________________________

Emergency Contact Name: __________________________________ Phone #:_______________

Who referred you to our office? (Name) ____

I would like a copy of my dictation (Dr's Notes) to be sent to the following physicians:

Referring Physician

Name: ____

Phone: _______________ Fax: ___________________

Primary Physician

Name: ____

Phone: ________________ Fax: ___________________

I allow the following people access to my medical information (i.e. this person can call and speak to the office about me):

____

____

____

Insurance Information

PRIMARY INSURANCE COMPANY: ________________________________

Policy #: ________________________________ Group #: __________________

Claims Address: ____

Subscriber's Name: ____

Relationship to Subscriber: _________________________

SECONDARY INSURANCE COMPANY: ______________________________

Policy #: ______________________________ Group #: _________________

Claims Address: ____

Subscriber's Name: ____

Relationship to Subscriber: _______________________

Payment Policy

As a courtesy to our patients, we will file with your Insurance company. This does not relieve the patient of any responsibility. As a patient, I hereby agree that I am financially responsible for payment of all fees incurred from procedures performed at Fort Lauderdale Pain Medicine, Inc. We try our best to get the most accurate information regarding insurance eligibility and benefits for our patients. We want to make sure each patient coming to our office has coverage and that we are participating with their particular insurance plan. Unfortunately, due to the constant changes and updates in insurance policies and plans it is impossible to always have the most up to date information. I understand that any remaining fees unpaid by my Insurance carrier are my responsibility and hereby agree to pay promptly in full. I also agree that any insurance payments received directly by me will be forwarded to this office upon receipt. Any legal fees incurred in the collection of unpaid balances will be at my expense.

MEDICARE PATIENTS are advised that Medicare will pay 80% of their allowable fees after the calendar year deductible has been met. The patient by law is responsible for the remaining 20% only if your secondary insurance carrier does not pay it or you do not have a secondary insurance.

If we are providers for your insurance company, you are responsible for any deductible and/or co-payment. By signing this I agree to the above terms and acknowledge that I have read this policy.

Signature: ____ **Date:** ________________________