


TAMPA PAIN RELIEF
Center
Patient Information

Patient Name: _____
Last First M.

Mailing Address (incl. city & zip): _____

Permanent Address (incl. city & zip): _____

Daytime Phone: _____ Ext. _____ Evening Phone: _____

Date of Birth: _____ SSN: _____ Marital Status: _____

Current Employer: _____ Occupation: _____

(If workers' comp, indicate employer where accident occurred)

Employer Address: _____

Date of Injury/Accident/Illness: _____

Closest friend or relative not living with you : _____

Address: _____

Daytime Phone: _____ Ext: _____ Evening Phone: _____

Insurance Information

Primary Insurance Company: _____

Subscriber's Relationship to Patient: SELF SPOUSE PARENT OTHER

Spouse Name: _____
Last First M.

Spouse's Employer: _____ Telephone # _____

Spouse SSN: _____ Spouse Date of Birth: _____

Secondary Insurance Company: _____

Third Insurance, if applicable: _____

Referral Information

(Please tell us how you were referred to our practice)

Referring Physician _____ Health Plan Provider List _____

Other Source _____ (W/C Adjuster, Case Manager, Website, Friend etc)

Please read the following authorization. Initial and sign below for our files.

_____ I understand that any appointment changes must be made at least 24 hours in advance or a \$30 fee will be applied.

Signature _____ Date _____

*** Please present this form and all insurance ID cards to the receptionist at this time. ***

Patient Name _____ **Date of Birth** _____ **Age** _____
Gender: *(Please circle)* Male / Female **Race:** *(Please circle)* White / Black / Hispanic / Asian / Other _____

Who referred you to us? _____ Who is your Family Doctor? _____
 Is your visit related to an injury? YES/NO If Yes, specify: AUTO Work Comp OTHER
 Have you been to any previous pain management? Yes or No *(circle one)*
 Name of Physician(s) _____

WORK STATUS: ___ Regular Duty ___ Light Duty, Restrictions _____
 ___ Off Work: last worked: _____
 ___ Disabled: since _____ by what doctor _____
 ___ Retired: since what year _____

Location of Pain: _____

In the diagram below, please shade the areas of your pain

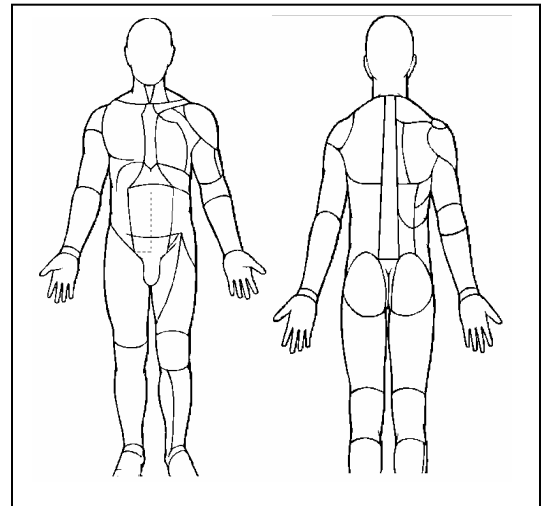
(Circle your answer)

Pain Scale: From 0 - 10 what is your pain level today?
 (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

What is your range of pain in the past month?
 (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

What treatments have you had for your pain? Check all that apply.

- | | | |
|---------------------------------------------------|--------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Favorable Results | <input type="checkbox"/> Poor Results |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Favorable Results | <input type="checkbox"/> Poor Results |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Favorable Results | <input type="checkbox"/> Poor Results |
| <input type="checkbox"/> Trigger Point Injections | <input type="checkbox"/> Favorable Results | <input type="checkbox"/> Poor Results |
| <input type="checkbox"/> TENS Unit | <input type="checkbox"/> Favorable Results | <input type="checkbox"/> Poor Results |
| <input type="checkbox"/> Nerve Blocks | <input type="checkbox"/> Favorable Results | <input type="checkbox"/> Poor Results |
| Type of Nerve Block _____ | | |



<input type="checkbox"/> Back or Neck Surgery	Type _____	When _____
<input type="checkbox"/> Spinal Cord Stimulator	Type _____	Date implanted _____
<input type="checkbox"/> Morphine Pump	Type _____	Date implanted _____
<input type="checkbox"/> Other: _____		

Allergies: _____

Patient History: (check each that apply)

- Tobacco:** ___ do not smoke ___ smoke ___ pack(s) per day
Alcohol: ___ do not drink ___ drink # of drinks per ___ day ___ week
Social History: ___ Married ___ Single ___ Divorced
Lives With: ___ Spouse ___ Children ___ Other ___ Alone
 ___ Blind ___ Glasses ___ Contacts ___ Hard of Hearing ___ Deaf ___ HIV+

Consent for Chronic Opioid Therapy

Tampa Pain Relief Center physicians and allied health professionals are prescribing Opioid medicine, sometimes called narcotic analgesics to me for pain management. This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including but not limited to, sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of Opioids. I will tell my physician about all other medicines and treatments that I am receiving.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: Using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for his/herself.

I am aware that certain other medicines such as nalbuphine (Nubain), pentazocaine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol), may reverse the action of the medicine I am using for pain control.

Taking any of these medications while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other physicians that I am taking an Opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has family or personal history of addiction. I agree to tell my physician my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that Opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help, and may cause unacceptable side effects. Tolerance or failure to respond well to Opioids may cause my physician to choose another form of treatment.

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 or family physician may check my blood to see if my testosterone level is normal.

FEMALES ONLY: If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric physician and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent on Opioids. I am aware that the use of Opioids is not generally 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.

Summary of Guidelines for prescribed Opiates:

Rodolfo Gari, M.D., Eaton I Yen, D.O.

4730 North Habana Ave., Ste 104 Tampa, Florida 33614 3450 East Fletcher Ave., Ste 220 Tampa, Florida 33613
Phone (813) 872-4492 Fax (813) 870-1502

1. The patient must provide copies of reports from previous and concurrent treating physicians
2. The patient must provide TRPC accurate patient address and phone number and keep us up to date of any changes in their personal information.
3. Tampa Pain Relief Center physicians and allied health professionals will be the only providers to prescribe controlled substances for pain.
4. The patient must provide us with the name and phone number of the pharmacy that the patient is using and keep us up to date with any changes.
5. The patient must be seen for regular office visits to receive a medication refill. Prescriptions will be written for a 30-day supply and will not be filled earlier than one (1) month.
6. The safety of the patient's medication is the patient's responsibility.
7. The patient is responsible for all prescriptions/medications given and must understand that if the prescriptions/medications are lost, misplaced or destroyed; the prescriptions/medications **cannot be replaced.**
8. **No refills will be made after hours, on weekends or on holidays.** The patient will need to notify the office for a refill at least three (3) days in advance.
9. Other classifications of medications may be prescribed to assist in pain management and limit opiate use.
10. Other therapies may be ordered to assist in pain management such as nerve blocks, TENS, physical or occupational therapy, psychological counseling as appropriate to the diagnosis.
11. The patient understands that no trustworthy patient-doctor relationship can be had with a patient that abuses illegal drugs. "Street Drugs" such as marijuana, cocaine, amphetamines, etc. are in and out of themselves dangerous. Mixed with some of the medicines often used in pain management, the combination could be lethal.
12. We will periodically check the patient's urine for compliance with therapy. The urine will be tested for the presence of the prescribed drugs as well as several other drugs, including illegal drugs.
13. The patient understands that if we find a urine sample that contains illegal substances, we may end the patient - doctor relationship.
14. The patient has the right to refuse such random or periodic urine testing. Tampa Pain Relief Center reserves the right to end the patient - doctor relationship on a patient that refuses to comply with our urine drug testing policy.

The patient authorizes any physician office, hospital or clinic to provide full details of medical history and treatment to TRPC for the use of continuity of care by completing a medical release form up to date.

Any breach of these guidelines may result in the patient being discharged from the practice of Tampa Pain relief Center.

I have read this form or have had this form read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with Opioid pain medications.

Patient signature

Date

Witness printed name and signature

Date



CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for **TAMPA PAIN RELIEF CENTER** to furnish medical care and treatment to myself, _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party _____ Date _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to **TAMPA PAIN RELIEF CENTER**. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Information Privacy: **TAMPA PAIN RELIEF CENTER** will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, and have copies available for distribution. The undersigned acknowledges receipt of this information.

Patient/Guardian/Responsible Party _____ Date _____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made due to policy termination, you will be responsible for the amount of money refunded to your insurance company. We reserve the right to assess a finance charge of 18% annually for balances carried over an extended period of time.

Benefits and eligibility are verified prior to your visit as a courtesy and as a result, we are not responsible for incorrect information provided by your insurance company as it relates to copay or benefit plan limitations. Your policy must be in effect at the time of service and subject to individual plan limitations and exclusions as mandated by your plan. An authorization is not a guarantee of payment.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to **TAMPA PAIN RELIEF CENTER**.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian/Responsible Party

Date

Center Representative/Witness

Date

Revised 03/08/05



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____

I authorize release of my health information records to **Tampa Pain Relief Center** to enable a comprehensive review of my medical care. I authorize the following physician offices, clinics, hospitals, other health care providers, pharmacies and legal offices to provide copies of my health information to:

TAMPA PAIN RELIEF CENTER

4730 N HABANA AVE. SUITE 104

TAMPA, FL 33614

OFFICE: 813-872-4492 FAX: 813-870-1502

(List of all facilities, clinics, and offices from which information will be requested)

PHYSICIAN OFFICES (please list all physicians you have seen in the past two years)

	Physician's Name	Address	Phone Number
1.			
2.			
3.			
4.			

PHARMACY (please provide an updated list of all pharmacies that you have used in the past two years)

	Pharmacy Name	Address	Phone Number
1.			
2.			
3.			
4.			

HOSPITAL AND OTHER FACILITIES (for surgeries/procedures, MRI/CT SCANS and any LAB and X-RAY reports)

	Facility Name	Address	Phone Number
1.			
2.			
3.			
4.			

Restrictions:

_____ There are NO restrictions on the information that can be released.

_____ The following information CAN NOT be released:

DURATION:

This authorization shall be effective immediately. I understand this authorization to release medical records will become invalid when I am no longer a patient of **Tampa Pain Relief Center**. I understand I have the right to revoke this authorization, at any time by sending written notification to the Privacy/Compliance Officer at the above listed address.

Signature of patient or personal representative

Date

(PLEASE PRINT) Name of patient or personal representative : _____

(PLEASE PRINT) If personal representative, describe authority: _____

(A COPY OF THE SIGNED AUTHORIZATION MUST BE PROVIDED TO THE PATIENT)

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Pain Disability Index Sheet

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).

No Disability 0 __. 1 __. 2 __. 3 __. 4 __. 5 __. 6 __. 7 __. 8 __. 9 __. 10 __. Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.

No Disability 0 __. 1 __. 2 __. 3 __. 4 __. 5 __. 6 __. 7 __. 8 __. 9 __. 10 __. Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No Disability 0 __. 1 __. 2 __. 3 __. 4 __. 5 __. 6 __. 7 __. 8 __. 9 __. 10 __. Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

No Disability 0 __. 1 __. 2 __. 3 __. 4 __. 5 __. 6 __. 7 __. 8 __. 9 __. 10 __. Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

No Disability 0 __. 1 __. 2 __. 3 __. 4 __. 5 __. 6 __. 7 __. 8 __. 9 __. 10 __. Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)

No Disability 0 __. 1 __. 2 __. 3 __. 4 __. 5 __. 6 __. 7 __. 8 __. 9 __. 10 __. Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.

No Disability 0 __. 1 __. 2 __. 3 __. 4 __. 5 __. 6 __. 7 __. 8 __. 9 __. 10 __. Worst Disability



Signature _____

Please Print _____

Date _____