To help us understand your issue(s), please complete **ALL Questions** on **ALL** of the attached forms.

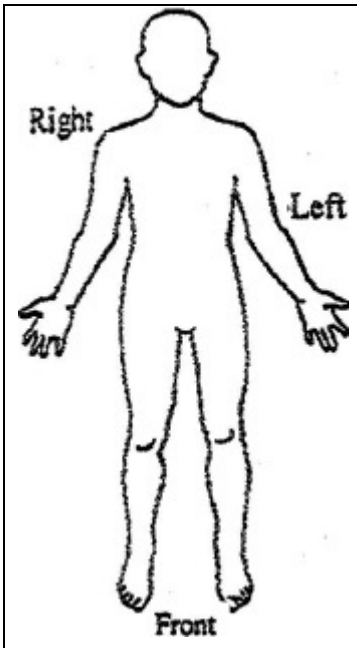
First Name: _____ Last Name: _____
Email: _____
Phone: (_____) _____Allergies:_____
Primary Care Physician: _____ Prev. Pain Physician: _____
D.O. B _____ who referred you to us? _____ Height: _____ Weight: ____
Address: _____ City: _____Zip code: _____

Which part of your body hurts the most? _____How long have you had this pain? _____

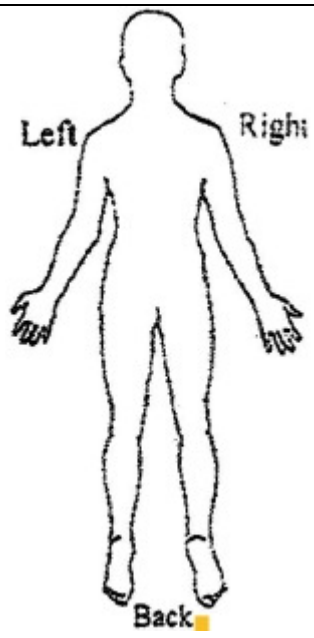
*On a Pain scale of 0 to 10, **circle** the number that describes your level of pain:*

No Pain = 0 1 2 3 4 5 6 7 8 9 10 = Worst imaginable Pain.

Shade in areas below where you have pain and check ALL the words that describe your pain.



□ Aching Pain	□ Stinging Pain
□ Soreness	□ Unbearable
□ Shooting Pain	□ Burning Pain
□ Cramping	□ Stabbing Pain
□ Tingling	□ Numbness
□ Radiating	□ Excruciating
□ Hotness	□ Coldness
□ Tightness	□ Heaviness
□ Dullness	□ Sharpness
□ Constant Pain	□ Brief Pain



Pain caused from: Accident – Yes or No; Illness – Yes or No; Unknown Cause- Yes or No

If accident or illness explain and give dates: _____
_____
_____
_____
_____

First and Follow up visits are Only a Consultation
Medications may not be prescribed at this visit.
It is strictly up to the Doctor and the office.

Fees are as follows for cash paying patients:

First Visit: **$300.00** and Follow Up Visits: **$170.00**

Please make sure to **bring an extra $40.00 every follow up visit** for **RANDOM** urine test. Fifteen minutes late for appointment **$20.00** fee. If you fail background or urine test at your initial visit you will only be refunded 50% of your visit.

$25-$50 fax/copying per third party Firm's request.
(Legal, personal injury law firms, social security law firms, disability, etc…)

You will be seen by **appointment time**. You may arrive **no** more than **15** minutes early. **No smoking in parking area.**

Our office may communicate with you by mail and or voicemail.
I agree to accept provided electronic copy.
I read and fully agree with the office policy.

Name: _____ Sign: _____Date: _____

Rules and Policy of the Office

1. **No Smoking in front of the building**.
2. You should **not** arrive more than **15 minutes** before your appointment.
3. Signing in more than 15 minutes late, may jeopardize your appointment or pay a **$20 Late Fee.**
4. Call **48 hours in advance** of your scheduled appointment to cancel if needed. Under 48 hour notice, you will be charged a **$20.00 cancellation fee**, which must be paid **in addition** to your normal office visit fee, before you will be seen by the doctor.
All future appointments will be cancelled until the fee is paid.
You must call between the hours of 8:30 am and 5:00 pm M – T and **speak to our staff.** This is enforced for the consideration of all other patients who are currently in the waiting room and improvement of our total patient care.
5. Cell phone in the office or waiting room disrupts our doctor.
6. No loitering or waiting in the parking lot. Nobody waits/sits in the parking lot, ***we will reschedule your appointment, if your relative/friend waits or sits in the parking lot.***
7. Food or drink may contaminate our healthcare clinic
8. You are in a healthcare and **smoke free** environment.
9. Your Primary Care Physician approves insurance and medical accessories. If you are here, **you are on a Medical Maintenance Program only.** At the current time, **we only accept Medicare B insurance.**

These rules and policy copy will be kept in your chart.
I completely agree to follow these rules and policy.

Please Sign: _____Witness:_____ Date: _____

HIPPA AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Recipient: A Pain And Wellness Center
8800 49th St. N # 101
Pinellas Park, FL 33782
Fax 727-361-1477
Phone: 727 548-1111

I _____ DOB: _____ authorize the Pain and Wellness Center to request any and all medical records, X-Rays, MRIs, or any diagnostic testing results from any and all medical providers involved in patient's care, past or present.

Please forward any and all documents requested to the attention of the requesting provider at the above fax or address.

Patients Signature: _____ Date: _____

If individual is unable to sign this Authorization, please complete the information below:

Guardian/Representative: _____ Legal Relationship _____ Date: _____

New Health Care Consumer Questionnaire

Patient (Last) Name _____ First_____ DOB ___/____/_____ Date: _____

In order to best serve your medical needs, we ask that you complete the following questionnaire as completely as possible. The Health Care Consumer (HCC) – Health Care Provider (HCP) relationship is a privileged relationship built on trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false information may seriously and adversely affect your health.

Patient's Social Security Number _____- ____ - _____ *Gender:* □ *Male* ___ □ *Female* ___

If the person completing this form is NOT the patient, please write your name, your relationship to the patient and why you are completing the form for this patient.
{Name: _____ Relationship: _____ Reason (completing form) _____}

Reason for Visit: _____

Patient's Personal Contact Information (Address and Phone)
Address: _____ City: _____ State: ___ Zip _____
Home Phone _____ Cell Phone: _____ Work Phone: _____

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

Insurance Information (Insurance Company, Policy Number, Contact Number)

Name: _____ Contact # _____
Policy # _____ Fax (if known) _____

Additional or Secondary Insurance Company

Name: _____ Contact # _____
Policy # _____ Fax (if known) _____

Have you completed a Living Will or designated Durable Power of Attorney for Health care? □ Yes □ No

Do you have any religious or cultural beliefs that may impact your health care? □ Yes □ No
If yes, please describe _____

□ You Do □ You Do Not understand English well. The language you prefer _____

Level of education completed
□ < 6^{th} grade □ 6^{th} – 8^{th} grade □ 9^{th} grade □12^{th} grade □1-4 yrs college □>4 yr college

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New Health Care Consumer Questionnaire (continued 1)

Names and Phone Numbers for Health care Providers (HCPs) from whom you are currently receiving care (or have seen within the past 12 months) AND ANY Health Care Providers from whom you are obtaining prescriptions.

_____ Contact # _____

_____ Contact # _____

Please list **all** the medications you are taking. Include over the counter medications, herbs &Vitamins

Medication Name	Dose	Last taken	Medication Name	Dose	Last Taken
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please list and describe allergic reactions you have had to food, medications, or insect stings.

Check if you are allergic to: __Shellfish _____ __IV Contrast Dye _____ __ Penicillin's ____

Please list Food, Medication or Insect Allergies	Reaction
_____	_____
_____	_____

Please list your occupations. Include the length of time you performed in that role, and describe your work responsibilities in that occupation. (Include military experience).

Occupation	Start Date	Stop Date	Responsibilities
_____	_____	_____	_____
_____	_____	_____	_____

Patient's signature _____ **Witness Signature:** _____

New Health Care Consumer Questionnaire (Continued 2)

Have you ever been exposed to known cancer causing agents or inhalation hazards? ☐ Yes ☐ No
Examples: asbestos, paints, aniline, dyes, chemicals, silica, etc…
If yes, please list types of exposure, time period exposed, and health problems experienced at time of exposure

Chemical agent	Start Date	Stop Date	Health problems resulting from exposure
_____	_____	_____	_____
_____	_____	_____	_____

Please describe your hobbies;

_____

Travel destinations OUTSIDE the United States	Dates spent at this destination
_____	_____
_____	_____

Travel destinations INSIDE the United States	Dates spent at this destination
_____	_____
_____	_____

Do you exercise? □ Yes □ No If Yes, describe how long and how often you exercise on average each week

In the past 12 months, have you fallen? □ Yes □ No If yes, how many times? _____
If yes, have you ever broken bones, or sustained an injury, as a result of falling? □ Yes □ No

Do you have a history of smoking? __ Yes __No if yes, _____ # packs per day X __ for # years
Have you ever chewed tobacco? __ Yes __ No
Have you ever smoked pipes/ cigars? __Yes __ No If yes, how many cigars or bowls __per day or wk.
Have you quit? If so, when. __ Yes __ No _____
Have you considered quitting? __ Yes __ No If yes, have you set a date to quit? __ Yes __ No
Have you tried quitting? __ Yes __ No If yes, what is the longest time period you quit smoking? ___

Do you have a history of alcohol use? __ Yes __ No If yes, specify _____ # drinks per __ Day __ Wk
1 "drink" is equal to 12 oz. can of beer; 1.5 oz. liquor (80 proof) or 5 oz. wine

Have you ever experienced a blackout or loss of consciousness due to alcohol intake? __ Yes __ No
Have you ever needed to drink to prevent yourself from shaking, sweating, and becoming irritable? __Yes __No
Have you ever been arrested or ticketed for DUI (Driving Under the Influence)? __ Yes __ No
Have you been involved in any motor vehicle accidents in the past 12 months? __ Yes __ No

Do you use drugs for recreational purposes? __ Yes __ No
If yes, check all that apply __ Amphetamines __ Cocaine __ Marijuana __ Heroin __ Inhalants __ LSD

Method of delivery you chose __ Ingestion __ Injection __ Inhalation

Patient's signature_____ **Witness signature:** _____

New Health Care Consumer Questionnaire (Continued 3)

How much would you use _____

How long did you use drugs _____

Have you quit? __ Yes __ No If yes, when _____

Have you ever taken drugs to prevent shaking, sweating and becoming irritable? __ Yes __ No

Have you ever had a problem with addiction to prescription pain medication or benzodiazepines? __Yes __ No

Have you EVER been diagnosed with sexually transmitted disease (like syphilis, gonorrhea, or HIV) or exposed to a sexually transmitted disease during childbirth? __ Yes __ No
Do you have any tattoos or body piercings? __ Yes __ No
Have you received any transfusions of blood or blood products? __ Yes __ No

Can you perform your own hygiene, dressing, cooking and shopping needs independently? __ Yes ___ No
Do you feel safe in your relationship? __ Yes __ No
Have you ever been in a relationship where you were threatened, hurt or afraid? __ Yes __ No

Have you ever had the following exams?

Cardiac Stress Test	__ Yes __ No	_____
ECHO	__ Yes __ No	_____
Chest X-Ray	__ Yes __ No	_____
CT "CAT" Scan of chest	__ Yes __ No	_____
Pulmonary function test	__ Yes __ No	_____
EEG	__ Yes __ No	_____
Bone density test	__ Yes __ No	_____

Have you had any of the following vaccinations? Check all that apply, and specify when last received.

__ Yes __ No Tetanus _____
__ Yes __ No BCG or TB _____
__ Yes __ No Varicella _____
__ Yes __ No HPV (Gardasil) _____

Patient's signature: _____ Witness signature: _____

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New Health Care Consumer Questionnaire (Continued 4)
Past Medical History Please check all that apply

Adrenal Dysfunction	__Yes	__No	Irregular Heart Rhythm	__Yes	__No
Alzheimer	__Yes	__No	Kyphosis	__Yes	__No
Amyotrophic Lateral Sclerosis	__Yes	__No	Liver Dysfunction	__Yes	__No
Anorexia or Bulimia	__Yes	__No	Kidney Failure, or Dysfunction	__Yes	__No
Anxiety Disorder	__Yes	__No	Malignancy if yes, describe below	__Yes	__No
Arteriovenous Malformations (AVMs)	__Yes	__No	_____	N/A	N/A
Arthritis	__Yes	__No	_____	N/A	N/A
Asthma	__Yes	__No	Mania	__Yes	__No
Autoimmune Disorder	__Yes	__No	Muscular Dystrophy	__Yes	__No
Bipolar Disorder	__Yes	__No	Myocardial Infarction (heart attack)	__Yes	__No
Bleeding Disorder	__Yes	__No	Narcolepsy	__Yes	__No
Cataracts	__Yes	__No	Obstructive Sleep Apnea	__Yes	__No
Cerebrovascular Accident (Stroke)	__Yes	__No	Organ Transplant If yes, describe	__Yes	__No
Chemotherapy if yes, state when	__Yes	__No	_____	N/A	N/A
_____	N/A	N/A	Osteoporosis	__Yes	__No
Claudication	__Yes	__No	Pancreatitis	__Yes	__No
Clotting Disorder	__Yes	__No	Periodic Limb Movement Disorder	__Yes	__No
Congenital Heart Defects	__Yes	__No	Peripheral Artery Disease	__Yes	__No
Coronary Artery Disease	__Yes	__No	Personality Disorder	__Yes	__No
COPD	__Yes	__No	Pituitary Dysfunction	__Yes	__No
Cystic Fibrosis	__Yes	__No	Polycystic Ovarian Syndrome	__Yes	__No
Depression	__Yes	__No	Pulmonary Artery Hypertension	__Yes	__No
Diabetes	__Yes	__No	Pulmonary Fibrosis	__Yes	__No
Dialysis	__Yes	__No	Radiation Therapy If yes, explain	__Yes	__No
Eclampsia or Pre-eclampsia	__Yes	__No	_____	N/A	N/A
Endocarditis	__Yes	__No	Recurrent infections	__Yes	__No
Endometriosis	__Yes	__No	Restless leg syndrome	__Yes	__No
End stage renal disease	__Yes	__No	Sarcoidosis	__Yes	__No
Erectile Dysfunction	__Yes	__No	Schizophrenia	__Yes	__No
Esophageal Dysfunction	__Yes	__No	Scleroderma	__Yes	__No
Fibromyalgia	__Yes	__No	Scoliosis	__Yes	__No
Gallstones	__Yes	__No	Seizure disorder	__Yes	__No
Gastritis or Gastric Ulcers	__Yes	__No	Sickle Cell	__Yes	__No
GERD (reflux problems)	__Yes	__No	Sjogren	__Yes	__No
Glaucoma	__Yes	__No	Skin Disorders (Psoriasis, Acne)	__Yes	__No
Heart or Valve Defects	__Yes	__No	Thalassemia	__Yes	__No
Hemochromatosis	__Yes	__No	Thrombocytopenia	__Yes	__No
Hemorrhoids	__Yes	__No	Thrombophilia	__Yes	__No
Hepatitis	__Yes	__No	Transfusions	__Yes	__No
HIV or AIDS	__Yes	__No	Tuberculosis	__Yes	__No
Hypertension	__Yes	__No	If yes, have you been treated?	__Yes	__No
Hyperthyroidism	__Yes	__No	Urinary retention or urgency	__Yes	__No
Hypotension	__Yes	__No	Vasculitis	__Yes	__No
Hypothyroidism	__Yes	__No	Visual defects	__Yes	__No
Inflammatory Bowel Disease	__Yes	__No	Vocal cord dysfunction/paralysis	__Yes	__No

Patient's signature: _____ **Witness Signature**: _____

New Health Care Consumer Questionnaire (Continued 5)

Review of Systems In the last 6 months, have you experienced any of the following symptoms?

Constitutional			**Genitourinary**		
Weight Loss or Gain	__Yes	__No	Blood in your urine	__Yes	__No
Appetite changes (increased or decrease)	__Yes	__No	Menstrual changes	__Yes	__No
Fatigue, profound and impairs daily function	__Yes	__No	Urinating that is painful or difficult	__Yes	__No
Fever	__Yes	__No	Erection problems	__Yes	__No
Eyes			**Musculoskeletal**		
Eye pain or drainage	__Yes	__No	Broken bones	__Yes	__No
Visual changes	__Yes	__No	Joint pain or swelling	__Yes	__No
Dry, irritated eyes	__Yes	__No	Muscle aches	__Yes	__No
ENT/Mouth			Muscle weakness	__Yes	__No
Ear pain or drainage	__Yes	__No	Back pain	__Yes	__No
Frequent sinus infections	__Yes	__No	**Skin/Breasts**		
Hearing changes or loss	__Yes	__No	Masses or lumps	__Yes	__No
Nosebleeds	__Yes	__No	Nipple discharge	__Yes	__No
Dizziness	__Yes	__No	Rashes or non healing ulcers	__Yes	__No
Respiratory			**Neurologic**		
Blood in your sputum	__Yes	__No	Seizures	__Yes	__No
Chess tightness	__Yes	__No	Coughing or choking with swallowing	__Yes	__No
Cough lasts > 1month, productive or not	__Yes	__No	Excessive daytime sleepiness	__Yes	__No
Shortness of breath	__Yes	__No	Extremely pain/ burning sensations	__Yes	__No
Wheezing	__Yes	__No	Hallucinations	__Yes	__No
Chest pain with inhalation or coughing	__Yes	__No	Numbness or tingling	__Yes	__No
Cardiovascular			Difficulty falling/staying asleep	__Yes	__No
Chest pain or heaviness	__Yes	__No	**Endocrinologic**		
Palpitations	__Yes	__No	Hair loss		
Fainting or near fainting spells	__Yes	__No	Frequent urination	__Yes	__No
Swelling of feet or legs	__Yes	__No	Increased thirst	__Yes	__No
Shortness of breath lying flat in bed	__Yes	__No	Heat or cold intolerance	__Yes	__No
Gastrointestinal			**Heme/ Lymph**		
Abdominal pain	__Yes	__No	Bleeding from gum or nose	__Yes	__No
Blood in your stool	__Yes	__No	Unexplained bruising	__Yes	__No
Constipation	__Yes	__No	Night sweats	__Yes	__No
Diarrhea or food intolerance	__Yes	__No	Swollen, painful lymph nodes	__Yes	__No
Heartburn or indigestion	__Yes	__No	**Allergy / Immune**		
Vomiting or nausea lasting > 1 day	__Yes	__No	Watery eyes	__Yes	__No
Swallowing difficulty	__Yes	__No	Runny nose	__Yes	__No
Psych			Food intolerance	__Yes	__No
Anxiety without clear explanation	__Yes	__No	Frequent skin sores	__Yes	__No
Sadness lasting for days/weeks	__Yes	__No			
Hearing voices	__Yes	__No			
Thoughts of hurting yourself	__Yes	__No			
Thought of hurting others	__Yes	__No			
Fear of people, places or things	__Yes	__No			

Patient's signature: _____ **Witness Signature**: _____

New Health Care Consumer Questionnaire (Continued 6 ENDS)
PLEASE list all surgical procedures you have had. Include surgeon and date of procedure.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Family Medical History Please list all known medical problems in your immediate family.
(Specify M = Mother, F = Father, B = Brother, S= Sister, So = Son, D = Daughter, GM/GF = Grand M/F)

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Additional information that you feel may be helpful for your healthcare provider to know:

_____
_____
_____
_____
_____
_____
_____

Health care provider notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient's signature: _____ **Witness Signature**: _____

Name: _____ Date: _____

DRUG USE QUESTIONAIRE (DAST – 20)

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 24 months.

Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question. In the statements, "drug abuse" refers to
(1) the use of prescribed or over the counter drugs in excess of the directions and
(2) any non-medical use of drugs.

Please answer every question and/or the most right questions
<u>These questions refer to the past twenty four (24) months</u> Circle your Responses

1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Have you abused prescription drugs?	Yes	No
3	Do you abuse more than one drug at a time?	Yes	No
4	Can you get through the week without using prescription drugs?	Yes	No
5	Are you always able to stop using prescription drugs when you want to?	Yes	No
6	Have you had blackouts or "flashbacks" as a result of drug use?	Yes	No
7	Do you ever feel bad or guilty about your drug use?	Yes	No
8	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
9	Have you neglected your family because of your use of drugs?	Yes	No
10	Have you been in trouble at work or school because of drug abuse?	Yes	No
11	Have you lost your job because of drug abuse?	Yes	No
12	Have you gotten into fights when under the influence of drugs?	Yes	No
13	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
14	Have you been arrested for possession of illegal drugs?	Yes	No
15	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
16	Have You had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc…)?	Yes	No
17	Have you been involved in a treatment program specifically related to drug use?	Yes	No
18	Have you ever been arrested for Selling or Trafficking **ANY** Narcotic or Illegal medication?	Yes	No
19	Have you ever Dr. Shopped?	Yes	No

By signing below, I indicate that all information is correct and true to my knowledge.

Patient's signature: _____ **Witness signature**: _____

Pain treatment Agreement

I understand that I have a right to comprehensive pain management. I understand that failure to follow any of these agreed statements might result in The Pain and Wellness Center (the office) and /or physician not providing ongoing pain management care for me.

I, _____, voluntary agree to undergo pain management. My diagnosis is: _____.

I agree to use the prescribed medicine for managing pain only and no other use permitted or recommended.

I understand that The Pain and Wellness Center believes in the following Pain Patients Bill of Rights."

You have the right to:

Have your pain prevented or controlled adequately.
Have your pain and medication history taken.
Have your pain questions answered.
Know what medication, treatment or anesthesia will be given.
Know the risks, benefits and side effects of treatment.
Know what alternative pain treatments may be available to you.
Ask for changes in treatments if your pain persists.
Receive compassionate and sympathetic care.
Receive pain medication on a timely basis.
Refuse treatment without prejudice from your provider/physician.
Include your family in decision-making

Termination cause

A. The provider/physician may terminate this agreement at any time if he/she has cause to believe that I am not complying with the terms of this agreement, or to believe that I have made a misrepresentation or false statement concerning my pain or my compliance with the terms of this agreement.

B. I understand that I may terminate this agreement at any time.

If the agreement is terminated, I will not be a patient of the physician and/or at The Pain Mgmt Corp/A pain and Wellness Center. and would strongly consider treatment for chemical dependency if clinically indicated.

Patient's Signature: _____ **Witness Signature**: _____

Date: _____

Narcotic/Controlled Substance Agreement

8800 49th ST N, #101, Pinellas Park, FL 33781
Tel: 727-548-1111 Fax: 727-361-1477

I, _____, agree to the following conditions regarding opioid use.

1. **(Note for female,)** if I become pregnant there are narcotic risks to the unborn child, which include narcotic addiction and the possibility of the baby experiencing narcotic withdrawal at birth. I am obligated to inform my physician about my pregnancy as soon as possible. _____ Initial

2. I understand that the possible complications of chronic narcotic therapy include, but not limited to: chemical dependency (addiction), impaired judgment, confusion, allergic reaction, constipation, difficulty in urination, drowsiness, dizziness, nausea, itching, slowed respiration, breathing problems, and reduced sexual function. If I take more than what I am prescribed, a dangerous situation and or fatal complication could result, such as coma, organ damage, or even death. I understand that if I run out of medication too soon or if my medication is stopped suddenly I could have narcotic withdrawal symptoms, which may be very uncomfortable or dangerous. _____ Initial

3. I will obtain prescriptions for opioid and other controlled medication(s) from only one physician, i.e. **The Pain and Wellness Center**. If it is found that I receive a prescription for narcotic medication from a source other than A Pain and Wellness Center I understand I will be discharged from their care and all prescriptions will **immediately** be discontinued. _____ Initials

4. I will have my prescriptions filled at only one pharmacy, if possible. _____ Initials

5. I will take the medication(s) only as prescribed and will notify my physician if I do not. I agree to **random urine** and blood tests to assess my compliance. _____ Initials

6. I understand that the eventual goal is to taper off the narcotic medication(s) as tolerated. I agree to meet regularly with my physician to assess my progress. I understand if I reschedule too many times I can be discharged or charged **$20.00** for everyday I rescheduled w/o a 48hr notice. _____Initials

7. **Random urine drug tests** may be performed to monitor prescribed pain medication.

8. Lost, stolen, or misplaced opoids controlled substance **WILL NOT BE REPLACED**. Refills will not be given early for any reason. PRESCRIPTIONS WILL ONLY BE GIVEN DURING REGULAR OFFICE HOURS AND WILL NOT BE GIVEN OR REFILLED BY THE PHYSICIAN DURING WEEKENDS OR EVENINGS. _____Initials

9. I understand a psychological evaluation regarding addiction and drug dependency may be necessary at any time the treating physician sees fit. _____Initials

10. I certify that I am NOT currently abusing illicit or prescription drugs. _____Initials

11. I am NOT currently using any illegal street drug(s) and will not do so while being treated at this facility. Failure to comply with this rule could be cause for my immediate termination from this treatment._____ Initials

Narcotic/Controlled Substance Agreement

8800 49th ST N,#101 Pinellas Park, FL 33781
Tel: 727-548-1111 Fax: 727-361-1477

12. **I will not share, sell, or trade my medication** with anyone. If I do I will be discharged. ____Initials

13. If I deviate from the above guidelines or if the medication loses its effectiveness in increasing my functional ability, I understand that the physician may taper off or discontinue the narcotic. _____Initials

14. I give **The Pain and Wellness Center**, Permission to contact other physicians and pharmacies to confirm compliance. _____Initials

15. I understand this document and my personal medical information may be disclosed to law enforcement in the event of violation or breach of this agreement. A Pain and Wellness Center will co-operate with law enforcement in the event of a violation of this agreement. _____ Initials

A Pain and Wellness Center may terminate this agreement at any time they have caused to believe that I am not complying with the terms of this agreement or believe I made a misrepresentation of false statement concerning my pain, medical, social, or arrest history. A Pain and Wellness Center may also terminate this agreement if reasonable suspicion of doctor shopping or drug diversion exists and may provide my entire medical records to the appropriate law enforcement officials.

My signature at the bottom indicates my understanding and agreement with the above guidelines, And all information provided is true and correct to my knowledge.

Patient's signature: _____ Date: _____

Witness signature: _____ Date: _____

Florida legislature law 893.13

States that it is a felony for a person to go to more than one doctor to obtain narcotic medication, before a refill is allowed for the first prescription. This is considered Dr. Shopping so by signing this below you confirm that it has been at least 28 days since you have received any narcotic medication from any doctor and starting today you agree to only obtain medication from A Pain and Wellness Center.

Print Name: _____Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

THE PAIN MGMT CORP/A PAIN AND WELLNESS CENTER

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have been provided a copy of the Notice of Privacy Practices Regarding my Protected Health Information by A Pain and Wellness Center.

_____ _____

Patient Signature Date

Pain & Wellness Center
8800 49th St. N Ste. 101
Pinellas Park, FL 33782
727-548-1111 F: 727-361-1477

I _____D/O/B:_____ am aware that if I have Medicaid Insurance I am going outside the Medicaid System and I am responsible for the full cash payment at A Pain & Wellness Center. If I choose to use my Medicaid Insurance I will look for a practice that is in the Medicaid system and I will sign a release form to transfer my chart/notes.

X_____ X_____
PATIENT SIGNATURE DATE

X_____ X_____
(WITNESS SIGNATURE) DATE

Patients copy

Pain and Wellness clinic or The Pain Mgmt Corp

Notice of Privacy Practices

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

The Pain mgmt. Corp (the "Clinic") is required by federal and Florida law to maintain a record of the care and services you receive at the Clinic. We understand that this information about you and your health is personal, and we are committed to protecting the privacy and security of your health information.

This Notice of Privacy Practices ("the Notice") describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, as well as other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" or "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. This Notice applies to your entire PHI maintained by the Clinic, whether the PHI is created by your treating physician, by your referring physician, by a nurse, or by others working at or with the Clinic.

The Clinic is required by law to abide by the terms of this Notice. In this regard, we are required by law to: - make sure that your PHI is kept private. – give you this Notice of our legal duties and privacy practices with respect to your PHI; and follow the terms of this Notice as currently in effect.

Revision of Notice of Privacy Practices

We reserve the right to change the terms of this Notice at any time, and we reserve the right to make the changed Notice effective for all health information that we maintain at the time of the revision. If we revise the terms of this Notice, we will post a revised notice at our office. We will also make paper copies of the revised Notice available upon request.

How to contact the Clinic

If you would like further information about your PHI, our contact number is 727 548-1111 or at 8800 49th street n, #101, Pinellas Park, FL 33782

This Notice is effective as of April 14, 2003

Your rights regarding your PHI

You have the following rights with respect to your PHI

Right to request restrictions: You may request that we restrict or limit the PHI we use or disclose about you for treatment, payment, or health care operations, or you may request a limit on the PHI we disclose to others who are involved in your care (i.e. a non-Clinic physician, a laboratory) or in the payment for your care. We are not required to agree to your request; but if we do, we will honor it. Even if we agree to your request, your restrictions might not be applied in certain situations. Your request must be in writing and submitted to 8800 49th St. north, suite 101, Pinellas Park, FL 33782.

Right to request confidential Communications: You have the right to receive communications from us in a confidential manner, and you may request that we communicate with you about your PHI in a certain way or at certain location. Your request must be in writing and must be specify how or where to be contacted.

Right to inspect and copy: You may review and obtain a copy of your PHI in a designated record set, certain exceptions may apply. Your request must in be writing. We charge a reasonable fee to cover our cost associated with your request. We reserve the right to withhold the requested PHI until payment is completed.

Right to Amend: You may ask us to amend your PHI if information is incorrect or incomplete. We may deny your request for certain specific reasons. Your request and supporting explanation must be in writing.

Right to accounting of Disclosures: You have the right to request a written list of certain disclosures of your PHI. We are not required to account for disclosures made for treatment, payment or healthcare operations, disclosures that you authorized, and certain other specific disclosure types. Your request must state specific time period. This period may not be longer than six years. Your request must be in writing. We charge a reasonable fee to cover our associated cost.

Right to a Copy of this Notice: You, as our patient, may request a copy of this Notice at any time.

Complaints: You have the right to complain to us and to the Secretary of the U.S Department of Health and Human Services, if you are sure that your privacy rights have been violated. Submit written complaints to 8800 49th St. N, #101, Pinellas Park, FL 33782.

HOW WE MAY USE AND DISCLOSE YOUR PHI

The following categories describe different ways that we use and disclose PHI. Your PHI may be used and disclosed by physicians, by nurses, technicians, or team members, by our office staff, and by others outside of our office that are involved in your care and treatment. When required, we will obtain your authorization before disclosing any of your PHI. And we will use reasonable efforts to share only minimally necessary PHI with others.

Treatment: we may use and disclose your PHI to provide, coordinate, and manage your health care and any related services. For example:

- Your PHI may be provided to a physician to whom you have been referred, to other physicians who may be treating you, or to a hospital that is involved in
- your care, to ensure that the physician or hospital has the necessary information to diagnose or treat you.
- We may disclose your PHI from time to time to another physician or healthcare provider who, at the request of your attending physician, becomes involved in your care by providing assistance with your health care diagnosis or plan of treatment.
- We may disclose your PHI to a pharmacy when calling in a prescription or verifying a prescription or treatment.

Payment: Your PHI may be used and disclosed by the office to process your payment for services to you. For example:
- Before you receive scheduled services, we may share information with health plan, verifying eligibility, coverage by your plan, policy and pre-approval.
- After you receive services, we may share information with health plan to support claims for payment, to review services and activities.

Health Care Operations: We may use or disclose, as needed, your PHI in order to support the business activities and operations, including but not limited to, reviewing the quality of the care, quality assessment activities, employee review activities, training, licensing, and marketing activities, compliance with applicable laws, and conducting or arranging for other business activities. For example:
- We review the quality, efficiency and cost of care that we provide to you and our other patients in order to find more efficient and effective ways to provide services, to develop ways to assist our health care providers and staff in deciding what additional services to offer, and to evaluate new treatment.
- We may share your PHI with third party "business associates" who perform various activities for the Clinic. Whenever an arrangement between the Clinic and business associate involves the use of PHI, we will have a written contract that contains terms to protect your PHI.

Disclosure to Department of Health and Human Services: We may disclose your PHI when required by U.S. Dept. of Health and Human Services, the Florida Department of Health or Agency for Health Care Administration, or their agents, as part of an investigation or determination of our compliance with laws.

Health Oversight Activities: We may disclose your PHI to health oversight agencies for oversight activities authorized by law, including audits, investigations, inspections, licensure, and administrative and/or legal matters.

Abuse or Neglect: we may disclose your PHI, in accordance with applicable federal, state, and local laws, concerning abuse, neglect, or violence w.r.t. you.

Law Enforcement and legal Proceedings: As required by law, we may disclose your PHI for law enforcement purposes or other government functions. We may disclose your PHI in response to a court or administrative order or a subpoena, discovery request.

Coroners, Medical Examiners: we may disclose your PHI to a Coroner or Medical Examiner.

Research: We may disclose your PHI for research purposes. For example: Research comparing the health and recovery of all patients who received one medication to those who received another for the same condition.

Public Health and Safety: We may use or disclose your PHI to the reporting of disease, injury, vital events. We may use or disclosure your PHI to prevent or lessen a serious threat to the health or safety of another person or to the public.

Worker's Compensation: We may disclose your PHI to Worker's compensation or similar programs.

Notification of Family and Friends: We may disclose your PHI to family members, relatives, or other person you identify, when the PHI is directly relevant to that person's involvement with your care. We may disclose you PHI to notify a family member, or another person responsible for your vital care. If you are unable to agree or object to such a disclosure, we may disclose such PHI as necessary. We may disclose your PHI to disaster relief organizations to coordinate relief efforts.

Appointment Reminders: We may use or disclose your PHI, as necessary, to contact you to provide appointment reminders or to reschedule your appointment. We may leave messages about your appointment on your answering machine or voice mail.

Alternative Treatment Information: We may use or disclose your PHI to professionals who may use alternative treatment methods. We may use and disclose your PHI for other marketing activities, such as newsletters about our practice, discount services we offer, products and services beneficial to you. You can write request for these materials not be sent to you.

ANY OTHER USE OR DISCLOSURE OF PHI ABOUT YOU REQUIRES YOUR WRITTEN AUTHORIZATION
We will not use or disclose your health information for any other purpose without your written authorization. Once you give written information, you may cancel your authorization in writing at any time. We process all written request and written authorization within 14 days of receiving.