Consent to Medical Treatment:

Apollo Pain Management (APM)S maintains personnel and facilities in order to assist my physicians in providing me with medical care, and I authorize APM providers and personnel to perform on me the care ordered by my physicians. I consent to receive services by telemedicine (using Interactive audio, video, or data communications to carry out consultations, evaluations, screenings, diagnosis, treatment, monitoring or other communications benefiting a patient) if appropriate for my condition, and I understand the risks, benefits and alternatives of doing so, I choose to receive services even if my insurance plan may not cover or continue to cover specific service, including the specific services rendered during the admission. I understand that I have the right to be informed by my providers of the nature and purpose of any proposed operation or procedure and any available alternative methods of treatment together with an explanation of the risks associated with each of them. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to the recognized standards of medical practice, and I acknowledge that APM and its personnel are not responsible for providing me this information. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of examinations and or treatments provided by APM.

Consent to View History of Scripts

I, the undersigned, give consent to Apollo Pain Management to view my prescription history from my pharmacies.

Consent to Recording or Filming:

I authorize APM, the attending physician, or other APM authorized persons to record, photograph or film me for treatment, quality Improvement or education purposes. Such recording, filming or photographs will be released only as permitted by law or authorized by me.

Assignment of Insurance Benefits, Patient Financial Responsibility and Credit Report Authorizations:

I guarantee payment of all charges made for or on account of the patient. I assign my right and my insurance benefits payments or other payment sources directly to APM and/or the physicians providing services in conjunction with APM. This assignment includes, but is not limited to, radiology reading, pathology services, emergency room visits or EKG readings. I understand I will receive separate bills for certain APM and physician services. I understand I am financially responsible to APM and physicians for charges not covered by this insurance assignment, I further understand APM can obtain my credit report for collection purposes and I am responsible for any collections, attorney fees and costs. I have provided all Medicare information and insurance cards to APM. I agree that in the event benefits paid under this assignment or any other amounts paid by me/us or my/our behalf exceeds the amount due the APM, my physicians, or those entitles for services in connection with this treatment, and such excess amount may be applied to any other indebtedness that I, my spouse, or any child for whom I am financially responsible, may have with the APM or any other facility or entity related to APM.

Authorization to Disclose Information and Privacy Act:

I authorize APM, and its affiliates to use or disclose my protected health information for the purposes of treatment, payment or healthcare operations. This consent shall cover any of my protected health information that APM may maintain or receive. I authorize the release of medical and related information about my treatment to the Professional Standards Review Organization responsible for reviewing the medical care

furnished to me. This authorization will expire six years from the date shown below; however, I reserve the right to revoke this authorization at any time by contacting the Corporate Privacy Officer at (828)221-0121. I understand I have the right to review the Notice of Privacy Practices before signing this consent. I further understand that the Notice of Privacy Practices provides a more complete explanation of the uses and disclosures of my protected health Information.

Authorization to Release Medical Information:

I authorize the APM and my physicians to disclose any medical information related to my services or treatment to my insurance company, governmental or charitable agencies and their agents, my employer and professional review organizations with whom I may have insurance coverage or who may be assisting in the payment of my bill and my medical care. I also authorize the APM and my physicians to release any medical information to any licensed physician or medical facility to which I may be referred or transferred for further medical care. In addition, I authorize the APM and my physicians to release any medical information necessary to prove the APM's damages in any legal proceeding brought about to enforce any unpaid balance on any of my accounts. This authorization will expire two (2) years from the date shown below, and I understand that I or my legal representative may revoke this authorization at any time, unless legal action has already been taken, or in In the event of my death, the release of medical information is necessary to verify any charges incurred by me.

Authorization to Release Medicare and Medicaid Information:

I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX 01 the Social Security Act is correct. I understand that health care services paid for under Medicare, Medicaid and Maternal and Child Health programs are subject to review by professional organizations, which may recommend denial of payment if my medical condition does not warrant continued APM care. I authorize the Financial Counseling Wellness staff of the APM to assist me in the processing of any benefits application, including Medical Assistance, Aid to Families with Dependent Children, or Special Assistance, initiated for the patient within six months of the date of this authorization. The Financial Counselor may have access to and copy any records or information to which I would be entitled. I authorize and direct the County Department 01 Social Services to provide such information to the Financial Counselor orally via telephone. I authorize and consent to referral to the County for benefits by use of any appropriate referral form. The doctrine of informed consent has been explained to me, I acknowledge that this consent is voluntary and that it may be revoked by me at any time except to the extent that action has already been taken in reliance on it. Unless otherwise revoked, this consent shall be valid for one year from the date of authorization, or until final determination of any benefits application as described above, whichever is later.

For Underinsured Patients or Uninsured Patients:

I authorize APM and its affiliates, to use or disclose my protected healthcare information for the purpose of helping me find to find a healthcare provider and/or locate a payment source for my visit.

Release of Responsibility/liability For Valuables:

I understand that APM has a policy for safekeeping of patient valuables requiring all money, credit cards and/or Items of value including jewelry to be given to a family member to hold or leave at home. If I choose not to deposit such items of value with my family member, I absolve APM from responsibility for their loss, damage or disappearance.

Payment Guarantee:

Patient and/or responsible party/parties agree to pay all charges for services rendered by APM and my physicians or other providers during treatment related to services provided by APM. This guaranty includes charges not covered by my insurance regardless of the reason insurance coverage is denied. I agree to pay the reason able cost of the attorney services in addition to the unpaid charges. I consent and authorize APM and its agents or subcontractors to contact outside sources including for the purpose related to my account, including evaluating and assessing my credit worthiness, my charity eligibility and the viability of collecting any amounts due for treatments I receive, whether at this time or on subsequent visits. I understand and agree that APM may assign my accounts as it deems necessary for the purposes of collecting any amounts I owe, including to collection agencies and attorneys. I consent and authorize APM and third party agents of APM to contact me at any telephone associated with me, including a wireless number, and to use pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account.

I affirm that my signature on this form indicates that I have disclosed any and all current Insurance coverage/s that may pay for this visit. Further, any failure on my part to Identify my insurance/s may result in additional charges for which I win be responsible. My signature also indicates that if I have no insurance coverage I will cooperate and participate in any efforts to help me qualify for any applicable coverage. Failure to do so may render me ineligible for any financial assistance discounts.

I have read the request and authorization in its entirety and agree to be bound by all the terms and conditions herein.

Witness my (our) hand(s) and seal(s) below.

_____ _____

Patient Responsible Party(ies)

_____ _____

Physician Relationship to Patient

****

I have been provided access to APM Notice of Privacy Practices

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Patient (or authorized representative)

Patient unable/unwilling to sign_____

Reason_____

APM Representative_____Date/Time_____

APOLLO PAIN MANAGEMENT
LIVE BETTER

Financial Policy

Medical and Surgical Consent: I, the undersigned, consent to the treatment and procedures which may be performed during this and any further service, and which may include but are not limited to any medical/surgical treatment procedures. I have the right to refuse any treatment and to be informed of the possible medical consequences of refusal. My signature on this document indicates my general consent to be treated. My physician may request that I sign a more specific form relative to any procedure that may be performed.

Release of Information: The physician(s) may disclose any or all parts of these medical records to my insurance carriers(s) and any organizations(s) contractually responsible for purposes of satisfying all charges billed by the physician(s). This includes but is not limited to all claim filings, appeals, and correspondence regarding the charges billed.

Financial Responsibility: I, the undersigned, herby understand and acknowledge that is the policy of this office that payment is made at each visit and I am responsible for payment of all services rendered in my behalf.

Financial Balance Policy: if you have established a balance that is 45 days or older and have not made arrangements to pay it, you will be discharged 30 days from the date the practice notifies you in writing. You must pay any balance owed before you are a patient of the practice again. If the balance is not paid within 30 days, the account will either be turned over to collections and reported to the credit bureaus, or your credit card that you have on file with our office will be billed for the balance.

Scheduling and NO SHOW Policy: If you are more than five minutes late for your scheduled appointment time, you will be rescheduled to the next available slot. This includes time for filling out the necessary paperwork for your appointment. Example: Your appointment time is 10:00. You arrive at 10:00 and don't have your paperwork completed, handed in and in the queue until 10:06. In this scenario, you will be rescheduled.

You will be given reminder calls about your appointment and are asked to be here 15-30 minutes prior to your appointment to fill out your paperwork so that the schedule does not get behind. The clock that we go by is at our front desk station. We are endeavoring to stay on schedule and abiding by this policy.

OFFICE VISITS: Missed office appointments are difficult to reschedule. If you are unable to keep your appointment, please notify the office 24 hours in advance or prior to the start of business on your appointment day and leave a message. Failure to do so will result in the appointment being marked a NO SHOW and you will be billed a **$50.00 cancellation fee**.

PROCEDURES: Due to allocation of additional resources, missed procedures are even more difficult to schedule. If you are unable to keep your appointment, please notify the office 24 hours in advance or prior to the start of business on your appointment day and leave a message. Failure to do so will result in the appointment being marked a NO SHOW and you will be billed a **$100.00 cancellation fee**.

If you are sick, please call the office and talk with the medical assistant to determine whether or not this appointment will be rescheduled without a charge. If you do not pay this charge, you will be subject to our Financial Balance Policy described above. Inclement weather falls under our inclement weather policy and no charges will be assessed.

Authorization for Medical Payments: I hereby authorize payment of medical benefits to any physician or supplier for services rendered.

Insurance Matters: I understand the following concerning insurance:

- We will file your insurance claim; however, we **MUST** have a copy of your insurance card in order to file. At the time of service, you will be responsible for any and all copay, deductibles and co-insurance amounts.

- All insurance changes must be given to us at the time of service. If your insurance changes and we are not notified in writing, you will be responsible for all charges and we will be unable to bill your insurance for any services before the change in notification.
- IN Network Insurance Office Policy: If we are contracted with your insurance company, you will only be responsible for your copays and co-insurance as outlined on your EOB (Explanation of Benefits)
- OUT of Network Insurance Office Policy: If we are not in contract with your insurance company, we will file the insurance on your behalf and accept assignment of the payments. Any balance will be patient responsibility. We are not obligated to write off amounts your insurance company recommends to us.
- Self-Pay Policy: Payment is mandatory at time of visit. You will not be permitted to carry a balance and if a balance remains you will not be able to come back for another visit until satisfactory arrangements have been made.
- As a courtesy, we will file your secondary insurance provided that all insurance information is given at the time of service. If no payment is received from the secondary carrier within 45 days of filing, the unpaid balance becomes patient responsibility. In the event of duplicate payment by the insurance and/or patient, refunds will be sent to the appropriate party as soon as possible.
- All patient balances become due and payable immediately upon your benefits determination or our receipt of the payment or denial notice from your insurance carrier.
- For those patients who are members of an insurance plan that requires a referral, please verify with our front desk staff that current authorization has been received prior to your visit. If we do not have a completed authorization, you will be responsible for your visit.
- The patient, not your office or the insurance company, is responsible for all charges incurred in regarding to all medical/surgical care. We advise you to know your insurance plan and you covered benefits. You will be billed directly for all non-covered services and supplies.

Medicare and/or Medigap Patient: I hereby request that payment of authorized Medicare and/or Medigap Benefits be made on my behalf to Apollo Pain Management (APM) for any services rendered to me. I authorize any holder of medical information about me to release to the health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits payable for related services.

Returned Checks: A service charge of $35.00 will be applied to your account for all returned checks. Once a returned check has been received, all future payments must be made with cash, money order or cashier's check.

_____ Date: _____

Patient Signature (or signature of Responsible Party)

_____ Date: _____

Witness

Talk to your health care provider about how to treat your pain. Create a safe and effective treatment plan that is right for you.

Alternatives to Opioids: Medications

ADVANTAGES:

- Can control and alleviate mild to moderate pain with few side effects.
- Can reduce exposure to opioids and dependency.

DISADVANTAGES:

- May not be covered by insurance.
- May not be effective for severe pain.

Florida HEALTH

NON-OPIOID MEDICATIONS	DESCRIPTIONS, ADDITIONAL ADVANTAGES & *DISADVANTAGES*
Acetaminophen (Tylenol)	Relieves mild–moderate pain, and treats headache, muscle aches, arthritis, backache, toothaches, colds and fevers. *Overdoses can cause liver damage.*
Non-steroidal Anti-inflammatory Drugs (NSAIDs): Aspirin, Ibuprofen (Advil, Motrin), Naproxen (Aleve, Naprosyn)	Relieve mild–moderate pain, and reduce swelling and inflammation. *Risk of stomach problems increases for people who take NSAIDs regularly. Can increase risk of bleeding.*
Nerve Pain Medications: Gabapentin (Neuraptine), Pregabalin (Lyrica)	Relieve mild–moderate nerve pain (shooting and burning pain). *Can cause drowsiness, dizziness, loss of coordination, tiredness and blurred vision.*
Antidepressants: Effexor XR, Cymbalta, Savella	Relieve mild–moderate chronic pain, nerve pain (shooting and burning pain) and headaches. *Depending on medication, side effects can include: drowsiness, dizziness, tiredness, constipation, weight loss or gain.*
Medicated Creams, Foams, Gels, Lotions, Ointments, Sprays and Patches: Anesthetics (Lidocaine), NSAIDs, Muscle Relaxers, Capsaicin, Compound Topicals	Can be safer to relieve mild-moderate pain because medication is applied where the pain is. Anesthetics relieve nerve pain (shooting and burning pain) by numbing an area; NSAIDs relieve the pain of osteoarthritis, sprains, strains and overuse injuries; muscle relaxers reduce pain by causing muscles to become less tense or stiff; and capsaicin relieves musculoskeletal and neuropathic pain. Compounded topicals prepared by a pharmacist can be customized to meet a patient's specific needs. *Skin irritation is the most common side effect. Capsaicin can cause warmth, stinging or burning on the skin.*
Interventional Pain Management	Includes anesthetic or steroid injections around nerves, tendons, joints or muscles; spinal cord stimulation; drug delivery systems; or permanent or temporary nerve blocks. Medicates specific areas of the body. Can provide short-term and long-term relief from pain. *Certain medical conditions and allergies can cause complications.*
Non-opioid Anesthesia	Opioids can be replaced with safer medications that block pain during and after surgery. A health care provider or an anesthesiologist can provide options and discuss side effects.

Florida Department of Health, Office of Communications, 09-20-19

Alternatives to Opioids: Therapies

ADVANTAGES:

- **Can control and alleviate mild to moderate pain with few side effects.**
- **Can reduce exposure to opioids and dependency.**
- **Treatment targets the area of pain—not systemic.**
- **Providers are licensed and regulated by the State of Florida.* (appsmqa.doh.state.fl.us/MQASearchServices)**

DISADVANTAGES:

- **May not be covered by insurance.**
- **Relief from pain may not be immediate.**
- **May not be effective for severe pain.**

Sources: American College of Surgeons, Centers for Disease Control and Prevention, National Institutes of Health, the Food and Drug Administration, Harvard Health and Wexner Medical Center (Ohio State University)

THERAPIES	DESCRIPTIONS, ADDITIONAL ADVANTAGES & *DISADVANTAGES*
Self-care	**Cold and heat:** Ice relieves pain and reduces inflammation and swelling of intense injuries; heat reduces muscle pain and stiffness. Can provide short-term and long-term relief from pain. *Too much heat can increase swelling and inflammation.* **Exercise and movement:** Regular exercise and physical activity can relieve pain. Simply walking has benefits. Mind-body practices like yoga and tai chi incorporate breath control, meditation and movements to stretch and strengthen muscles. *Maintaining daily exercise and overcoming barriers to exercise can be a challenge.*
Complementary Therapies	**Acupuncture:** Acupuncturists* insert thin needles into the body to stimulate specific points to relieve pain and promote healing. Can help ease some types of chronic pain: low-back, neck and knee pain, and osteoarthritis pain. Can reduce the frequency of tension headaches. *Bleeding, bruising and soreness may occur at insertion sites.* **Chiropractic:** Chiropractic physicians* practice a hands-on approach to treat pain including manual, mechanical, electrical and natural methods, and nutrition guidance. Can help with pain management and improve general health. *Aching or soreness in the spinal joints or muscles sometimes happens—usually within the first few hours after treatment.* **Osteopathic Manipulative Treatment (OMT):** Osteopathic physicians* use OMT—a hands-on technique applied to muscles, joints and other tissues—to treat pain. Clinically-proven to relieve low-back pain. *Soreness or stiffness in the first few days after treatment is possible.* **Massage therapy:** Massage therapists* manually manipulate muscle, connective tissue, tendons and ligaments. Can relieve pain by relaxing painful muscles, tendons and joints. Can relieve stress and anxiety—possibly slowing pain messages to and from the brain. *At certain points during a massage, there may be some discomfort—especially during deep tissue massage.* **Transcutaneous electrical nerve stimulation (TENS):** TENS is the application of electrical current through electrodes placed on the skin with varying frequencies. Studies have shown that TENS is effective for a variety of painful conditions. The intensity of TENS is described as a strong but comfortable sensation. *Allergic reactions to adhesive pads are possible.*
Rehabilitation Therapies	**Occupational therapy:** Occupational therapists* treat pain through the therapeutic use of everyday activities. Can relieve pain associated with dressing, bathing, eating and working. Therapy includes activities that increase coordination, balance, flexibility and range of motion. *Therapy interventions and recommendations will not help if the patient does not practice as instructed.* **Physical therapy:** Physical therapists* treat pain by restoring, enhancing and maintaining physical and functional abilities. *Therapy interventions and recommendations will not help if the patient does not practice as instructed.*
Behavioral and Mental Health Therapies	**Psychiatrists*, clinical social workers*, marriage and family therapists* and mental health counselors*** provide therapies that identify and treat mental disorders or substance abuse problems that may be roadblocks to pain management. *When used to manage pain, these therapies can take time.*

APOLLO PAIN MANAGEMENT
LIVE BETTER

NEW PATIENT – HPI and PMH
(This form must be completed prior to being seen)

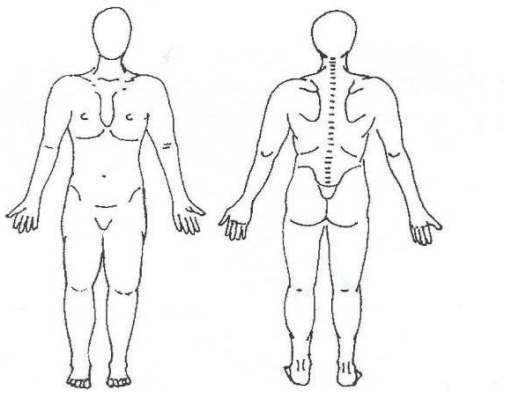
Name:_____DOB:_____Date:_____

Referring Physician_____Primary Physician_____

How did you hear about us? _____

Where is the location of your pain?

Please shade the painful areas on the diagram:



Pain is localized to (*GREATEST pain*): neck mid-back low-back Rt shoulder Lt shoulder Both shoulders
Rt arm Lt arm Both arms Rt hip Lt hip Both hips Rt knee Lt knee Both knees
Rt leg Lt leg Both legs Other: _____

Pain radiates to: Rt shoulder Lt shoulder Both shoulders
Rt arm Lt arm Both arms above elbow below elbow hand
Rt hip Lt hip Both hips Rt leg Lt leg Both legs above knee below knee ankle foot toes
Other: _____

Severity of pain is: On average – *0 1 2 3 4 5 6 7 8 9 10*
Worst it gets – *0 1 2 3 4 5 6 7 8 9 10*
Where **0** is *no pain*, and **10** is the *worst pain imaginable*

Onset of the pain was (*How long ago did it begin?*): _____ weeks months years

The pain occurred *(Under what circumstances did your pain begin?)*: Please circle one
after a fall after car accident after motorcycle accident after surgery for _____ after an illness _____
after work accident with gradual onset, no known cause Other: _____

The pain is described as *(Please circle all that apply)*:
Constant Intermittent Waxing and waning
Aching burning dull deep electrical sharp shooting vague
Other: _____

The pain is made worse *by (please circle all that apply):* everything

activity bending backward bending forward climbing stair cold driving
exercise heat lifting light touch looking around
looking up looking down lying down movement position change
sitting sitting to standing standing turning over twisting walking

Other: _____

The pain is improved by *(please circle all that apply):* nothing

activity bath/shower exercise heat ice lying down
massage medications meditation position change relaxation
sitting standing walking

Other: _____

Non-pharmacological approaches include (*What else have you tried?*): And did it help?

□ Acupuncture	some	little	none	made worse
□ Chiropractics	some	little	none	made worse
□ Massage	some	little	none	made worse
□ Physical Therapy	some	little	none	made worse
□ TENS unit	some	little	none	made worse
□ Home exercise	some	little	none	made worse

Prior Imaging / Diagnostic Studies (within the last TWO YEARS):

	Date (approximate)	Result (if known)
_____ X-ray	_____	_____
_____ CT Scan	_____	_____
_____ MRI	_____	_____
_____ Bone Scan	_____	_____
_____ EMG	_____	_____

Prior PAIN MEDICATIONS you have tried: Did it help? Side Effects:

□ Acetaminophen / Tylenol	some	little	none	drowsy	constipation	nausea	_____
□ Ibuprofen / Motrin	some	little	none	drowsy	constipation	nausea	_____
□ Naproxen / Alleve	some	little	none	drowsy	constipation	nausea	_____
□ Meloxicam / Mobic	some	little	none	drowsy	constipation	nausea	_____
□ Celecoxib / Celebrex	some	little	none	drowsy	constipation	nausea	_____
□ Cyclobenzaprine / Flexeril	some	little	none	drowsy	constipation	nausea	_____
□ Methocarbamol / Robaxin	some	little	none	drowsy	constipation	nausea	_____
□ Metaxalone / Skelaxin	some	little	none	drowsy	constipation	nausea	_____
□ Tizanidine / Zanaflex	some	little	none	drowsy	constipation	nausea	_____
□ Gabapentin / Neurontin	some	little	none	drowsy	constipation	nausea	_____
□ Pregabalin / Lyrica	some	little	none	drowsy	constipation	nausea	_____
□ Milnacipran / Savella	some	little	none	drowsy	constipation	nausea	_____
□ Duloxetine / Cymbalta	some	little	none	drowsy	constipation	nausea	_____
□ Codeine / Tylenol#3	some	little	none	drowsy	constipation	nausea	_____
□ Tramadol / Ultram	some	little	none	drowsy	constipation	nausea	_____
□ Morphine / MS Contin	some	little	none	drowsy	constipation	nausea	_____
□ Hydrocodone / Vicodin / Norco	some	little	none	drowsy	constipation	nausea	_____
□ Oxycodone / OxyContin / Xtampza	some	little	none	drowsy	constipation	nausea	_____
□ Oxycodone w Tylenol / Percocet	some	little	none	drowsy	constipation	nausea	_____
□ Other: _____	some	little	none	drowsy	constipation	nausea	_____

Prior Pain Procedures:

Have you ever been treated at another pain management center or program? _____Yes _____No

If yes:

- What was the doctor's name? _____
- What was the name of the practice? _____
- Where is it located? _____

Have you ever had any Pain Procedures / Injections in the past? _____Yes _____No

If yes, please select the treatments you have received, and what was the result (Did it help?):

□ Trigger Point Injections	some	little	none	made worse
□ Medial Branch Block / Facet Injection	some	little	none	made worse
□ RFA / Ablation	some	little	none	made worse
□ Epidural Steroid Injection	some	little	none	made worse
□ Spinal Cord Stimulator	some	little	none	made worse
□ Peripheral Nerve Stimulator	some	little	none	made worse
□ Pain Pump	some	little	none	made worse
□ Other: _____	some	little	none	made worse

Do you take any **blood thinning** medications? _____Yes _____ No

If yes, what?_____

MEDICATIONS

List all medications that you are currently taking now

Medication	Dose (mg)	How often? (# times/day)	What is this medication for?	Date started	Prescribing Doctor

MEDICAL HISTORY

(Please circle all that apply)

Cardiovascular: Hypertension Heart Attack Coronary Artery Disease Heart Failure Blood Thinners Venous Insufficiency Arterial Insufficiency Rhythm Disturb / Atrial Fib Pacemaker / Defibrillator
Respiratory: Asthma Emphysema Broncitis COPD TB Sleep Apnea Smoker Chronic Pneumonia Home Oxygen (___ L)
Gastrointestinal: Colitis Irritable Bowel Syndrome Gastritis Reflux/GERD Hiatal Hernia Pancreatitis Ulcer Liver Dis Hepatitis A,B,C Cirrhosis Crohn's Dis Gallbladder
Genitourinary: Renal Insufficiency Dialysis Prostatitis Enlarged Prostate Chronic Urinary Tract Infections Bladder Problems
Endocrine: Diabetes Hypothyroid Hyperthyroid Grave's Dis Hashimoto's hypothyroid Obesity
Hematologic: Blood clots Anemia Bleeding Disorder
Immunologic: Multiple Sclerosis Lupus Sjogren's Dis Raynaud's Syndrome HIV Immune Deficiency Autoimmune Disorder
Musculoskel: Fibromyalgia Rheumatoid Arthritis Osteoarthritis Osteoporosis Neck Problems Back Problems Muscular Dystrophy
Neurologic: Memory Problems Movement Disorder Parkinson's Dis Seizures Epilepsy Stroke / TIA Migraine / Headache Neuropathy
Psychologic: Anxiety Depression Bipolar Disorder Panic Disorder Alcohol / Drug Abuse
Misc: Glaucoma Cataracts Hearing Loss Visual Loss / Blindness Chronic Skin Disorder Pregnancy

Cancer: Site: _____ Diagnosis Date: _____ Chemotherapy Radiation Therapy

ALLERGIES

(Pleases list any known drug, food, or environmental allergies and indicate the adverse effect)

Allergen	Adverse Effect
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SURGICAL HISTORY

(Please list all surgeries)

DATE	SURGERY	DOCTOR

SOCIAL HISTORY

Smoking habits:_____packs per day for _____years
Alcohol intake:_____Amount & Frequency_____
History of Drug Abuse: Yes No Details:_____

WORKERS COMP / PERSONAL INJURY CLAIMS

(Only answer the following questions if your injury is related to a Workers Compensation or Personal Injury claim)

Are you, or have you ever been, involved with any of the following?

Disability:
_____Not receiving or seeking disability
_____Not receiving but seeking or planning to seek disability
_____Receiving disability

Litigation/lawsuit(s):
_____No & not intending pain-related litigation/lawsuit
_____Currently in pain related litigation/lawsuit
_____Past litigation/lawsuit or legal involvements related to pain condition

Motor Vehicle Accidents:
___ Pain ***not*** related to motor vehicle accident
___ Pain related to motor vehicle accident and settlement pending
___ Pain related to motor vehicle accident but ***no*** settlement pending or necessary

Date of Injury: _____

Details of Injury:

_____

_____

_____

Do you have any other litigation or lawsuits ongoing, pending, planned, or under consideration?

___ Yes ___No (If so, please explain)

_____

_____

_____

Attorney Name: _____

Attorney Firm: _____

Address: _____

Phone: _____ Fax: _____

APOLLO PAIN MANAGEMENT
LIVE BETTER

MEDICAL RECORDS RELEASE FORM

Patient name: _____ **Date of Birth**: _____

Phone Number: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below for the purpose of rendering medical care. I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that, by signing this form, I am specifically authorizing the release of this information.

I further authorize Apollo Pain Management and its physicians and employees to disclose any medical information related to my services or treatment rendered by Apollo Pain Management to any licensed physician, medical facility, or provider of ancillary services, including but not limited to physical therapy, chiropractor or acupuncture services, engaged in providing medical services or treatments to me, or to which I may be referred or transferred for further medical care.

Name: Apollo Pain Management
Street: 720 Cortaro Drive **City:** Sun City Center **State:** FL **Zip:** 33573
Office: 833-320-7246 **Fax:** 833-282-8899 **Email:** referrals@apollopainman.com

I do give permission for these records to be faxed to the above entity.

Please forward:

-Most Previous Two Office Visits
-Imaging Reports (MRI, CT, X-ray)
-EMG Results
-Insurance Information
-Initial History and Physical
-Lab Reports
-List of Patient's Medications
-List of previous pain procedures, dates, and results
-Other (please specify)_____

Patient Signature: _____**Date:**_____

APOLLO PAIN MANAGEMENT
LIVE BETTER

PAIN MANAGEMENT AGREEMENT

The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This is to help both you and Apollo Pain Management to comply with the law regarding controlled pharmaceuticals (pain and nerve medicines).

You may or may not receive narcotic medications. If you do receive narcotics, the following agreement will apply:

- I will obtain all narcotics from ONE pharmacy of your choice. I must notify the Apollo Pain Management if I change pharmacies. The name of the pharmacy I use is:_____ and the phone number is:_____ .
- I understand this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and my doctor undertakes it to treat me based on this agreement. The prescribing physician has complete liberty to discuss fully all diagnostic treatment details with the pharmacist dispensing the medication for maintaining accountability.
- I understand if I violate this agreement, my doctor may stop prescribing medicines, discharge me from the practice, and may also inform my referring doctor, medical facilities, and other authorities. Also, a drug-dependence treatment program may be recommended.
- Medications are prescribed to decrease pain and improve function/ability to work, not simply to feel good. I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my life, and how well the medicine is helping to relieve the pain and increase my activities.
- I will not attempt to obtain, or accept, any controlled medicines, including Opioid pain medicines, or controlled stimulants from anyone, including another doctor.
- I understand the use of these medications can lead to tolerance, physical dependence and may result in possible addiction and/or death. Withdrawal symptoms will occur if I stop taking these medications without proper supervision. Therefore, I agree to take my medication only as prescribed.
- **I understand that taking more than the prescribed dose will result in me being without medication for a period of time and may possibly result in withdrawal symptoms.**
- **I understand the risks of pain medications and opiates with regards to non-compliance and interactions with other medications/substances including benzodiazepines/alcohol/illicit substances, and the dangers of such action including but not limited to RESPIRATORY SUPPRESSION and DEATH.**
- I will not misuse, abuse, divert, or be non-compliant with medications.
- I will not share, sell or trade my medication with anyone, for any reason.
- I will safeguard my pain medication from loss or theft. Lost or stolen medicines WILL NOT be replaced.
- I will not use any illegal controlled substances including marijuana, cocaine, etc.
- I will abstain from using any alcohol while taking opiate pain medications.

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- I agree to submit to random blood, urine or saliva tests as requested by my doctor to determine my compliance with treatment and to rule out illicit usage. Presence of unauthorized substances or absence of authorized substances may result in immediate dismissal from the practice. Refusal of drug screen is automatic dismissal.
- I understand that the Florida prescription drug Database (PDMP, E-FORCSE) will be accessed and reviewed to confirm that I have been receiving opiate medications from physicians ONLY within this practice, unless other circumstances required such medication to be written for me.
- I will bring all prescription medications prescribed for pain in their original bottles to every office visit.
- I understand that I may be called to the office for a count of my medication(s) at any time. I understand that I must present to the pain clinic on the same day called, during office hours, with all my prescribed pain medication(s).
- I agree that refills of my prescriptions for pain medicine will be made only at the time of a scheduled office visit (not a procedure day), during regular office hours. No refills will be available during evenings or weekends. **Running out of medications is not an emergency.** Prescriptions are NOT called in to the pharmacy. Renewals are contingent on keeping scheduled appointments. Do NOT call for prescriptions or expect renewals or refills after hours
- I understand for emergencies occurring after office hours, I will go to my local emergency room.
- I agree to NOT to use heavy machinery including driving while taking opiate, muscle relaxants, or other medications which effect driving.
- If you were to not call or not show up for your appointments, you will be rescheduled on the next available clinic day which may be days or weeks out and also could result in but not limited to running out of prescribed medications, which is not an emergency as listed above.
- I authorize Apollo Pain Management (APM) and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including DHEC, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.
- I authorize my doctor to provide a copy of this agreement to my pharmacy, and any other pharmacy contacted regarding my treatment, and further authorize these pharmacies to release information to APM regarding any and all controlled substances which I have received from that pharmacy, regardless of the prescribing physician, during the time I am a patient at APM.
- I agree to waive any applicable privilege or right to privacy or confidentiality with respect to these authorizations.

NO SHOW POLICIES

OFFICE VISITS: Missed office appointments are difficult to reschedule. If you are unable to keep your appointment, please notify the office 24 hours in advance or prior to the start of business on your appointment day and leave a message. Failure to do so will result in a **$50.00 cancellation charge**.

PROCEDURES: Due to allocation of additional resources, missed procedures are even more difficult to schedule. If you are unable to keep your appointment, please notify the office 24 hours in advance or prior to the start of business on your appointment day and leave a message. Failure to do so will result in a **$100.00 cancellation charge**.

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I agree to follow these guidelines which have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be provided to me.

Patient Signature: _____ Date: _____

Medical records and history were reviewed. The patient was interviewed and examined by me. I agree with the assessment and care plan and confirm the diagnosis(es) above.

Physician Signature: _____ Date: _____

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New Patient Demographics

Date:_____ Home Phone:_____

Social Security No:_____ Cell Phone:_____

Email:_____ Work Phone:_____

PATIENT:

Name (Last, First, MI):_____

Street Address:_____

City:_____State:_____Zip Code:_____

Gender: M / F **Age**:_____**Birthdate:**_____**Height**_____**Weight**_____

Race:_____ **Ethnicity:**_____

Marital Status: Single Married Widowed Separated Divorced

Spouse's Name:_____Birthdate:_____

Spouse's phone number:_____Spouse's SSN: _____

Employment:

Employed Disabled Retired Full-time Student Part-time Student

Patient Employer:_____

Business Address & Phone: _____

Insurance:

Do you have Medical Insurance? Yes/No

Primary Insurance Name:_____

ID#_____Group #_____Subscriber:_____

Secondary Insurance Name: _____

ID#_____Group #_____Subscriber:_____

Workers Compensation: Yes / No

Claim#_____Adjuster_____

Phone#_____Fax#_____Date of Injury: _____

Claims Mailing Address: _____

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Patient Portal Consent Form

APOLLO PAIN MANAGEMENT offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass- phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect, and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

Printed Name:_____

Signature:_____ Date:_____

Patient Name: _____ Date: ____/_____/_____

Please answer each question as honestly as possible by putting the corresponding number in the box to the right (ie, if "Seldom" write "1", if "Sometimes" write "2", etc). There are no right or wrong answers.

SCORE	COLOR	Initials of Reviewer

SOAPP®-R

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in your home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					
Has any relative had a problem with: **(Please circle Y/N for each item below)** Alcohol: Y/N Addiction: Y/N Mental Illness: Y/N					

Green = less than 9	***Yellow = 10-21***	***Red = 22 and over***

Please include any additional information you wish about the above answers. Thank you.

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Consent to Participate in Telemedicine Visit

Patient Name: _____ Date of Birth: _____

1. I understand that my health care provider provides telemedicine consultation as an option for my medical appointment.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.
8. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:
 That I have read or had this form read and/or had this form explained to me
 That I fully understand its contents including the risks and benefits of the procedure(s).
 That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____ _____
Patient's/parent/guardian signature Date Time

_____ _____ _____
Witness signature Date Time