



South Lake Pain Institute

Welcome to South Lake Pain Institute

We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

You will need to bring your insurance card and a photo ID with you for each appointment. Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your insurance card, your appointment will need to be rescheduled. You will be asked to fill out new registration forms annually so we may update your information.

All co-pays and past due balances are expected at time of service, unless a prior agreement has been made with our billing department.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

*Please bring **ALL** medications prescribed by our physicians in this office. Also a **list of ALL** your current prescriptions, and a **list of ALL** over-the-counter medications with you at each visit.*

Our Office Policy for a missed appointment is:

- If it is an appointment for a new patient, the appointment **will not** be rescheduled without a **valid reason**.
- Two (2) no-show appointments will result in dismissal from the practice.
- **\$150.00** will be charged if you failed to cancel your appointment within twenty four (24) hours before your scheduled New Patient Appointment.

We understand that appointments sometime need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment.

Welcome to our practice and thank you for choosing **South Lake Pain Institute, Inc.** for all your **Pain Management** needs.



South Lake Pain Institute

NEW PATIENT DEMOGRAPHIC FORM

Name:		DOB:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security #:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
Race:	Ethnicity:		Language:	
Address:				
Home Phone:	Work Phone:	Cell No:	Email:	
Occupation:	Employer:		Phone:	
Is this a work related injury: <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this injury related to a car accident ?: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Referring Physician:	Address:		Phone:	
Pharmacy:	Address:		Phone:	
Emergency Contact (Name)		Relationship to patient:		
Home Phone:		Work Phone	Cell No	
Primary Care Physician, (if different from above):				
Primary Insurance Information:		Member ID number:	Effective Date:	
<i>If your insurance policy/ policies are under another subscriber, please give their information:</i> Subscriber Name: Relationship: DOB: SS#:				
Secondary Insurance Information, if applicable:		Member ID number:	Effective Date:	
Tertiary Insurance Information, if applicable:		Member ID number:	Effective Date:	

Signature _____

Date _____

• 2440 Hooks Street Clermont, Florida 34711 • P (352) 394.0833 • F (352) 394.0367



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PLEASE SHADE YOUR AREA OF PAIN

Name: _____ DOB: _____ Date: _____

FOR OFFICE USE ONLY

Weight: _____

Height: _____

BP: _____

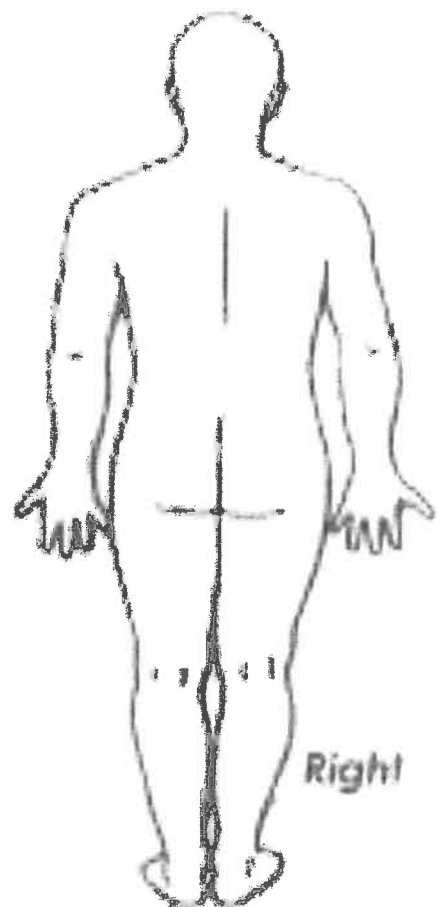
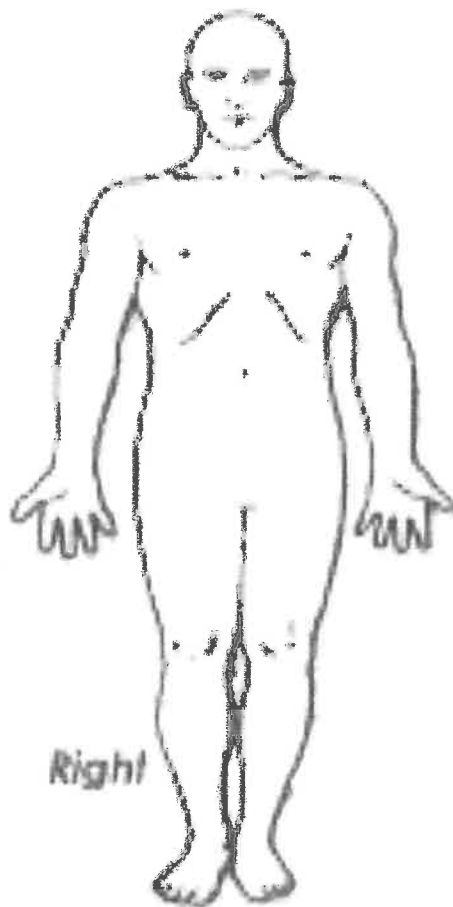
HR: _____

Temp: _____

Resp: _____

Ref Doc: _____

PCP _____



Please list all past and current treating Physicians

Physician Name

Phone Number

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NEW PATIENT CONSULTATION

Date: _____ Referring Physician: _____

Name: _____

DOB: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

HISTORY OF PRESENT PAIN PROBLEM

When did your pain start? _____

Location of your pain: _____

Description of your pain: _____

What event led to your present problem? _____

☐ Cancer ☐ Operation ☐ Car Accident ☐ Work Related Injury ☐ Other Injury _____

Circle the words that describe your pain:

<input type="checkbox"/> Aching	<input type="checkbox"/> Tender	<input type="checkbox"/> Throbbing
<input type="checkbox"/> Burning	<input type="checkbox"/> Shooting	<input type="checkbox"/> Sharp
<input type="checkbox"/> Numb	<input type="checkbox"/> Lacinating	

Is your pain (circle one)? Continuous ☐ Intermittent (Comes and Goes) ☐

If your pain is intermittent, how long does the pain last? _____

What makes your pain better? (Circle all that apply) _____

Sitting ☐ Standing ☐ Lying Flat ☐ Walking ☐ Twisting ☐ Coughing ☐ Sneezing ☐ Other: _____

What makes your pain worst? (Circle all that apply) _____

Sitting ☐ Standing ☐ Lying Flat ☐ Walking ☐ Twisting ☐ Coughing ☐ Sneezing ☐ Other: _____

Rate your pain by circling the number that best describes your pain:

Agonizing											None
10	9	8	7	6	5	4	3	2	1	0	

Does your pain interfere with your sleep? ☐ Yes ☐ No

How many work days did you miss in the last month due to pain? _____

Do you have any? (Circle all that apply)?

☐ Numbness ☐ Tingling ☐ Extremity Weakness ☐ Bowel / bladder incontinence

Are you more depressed? ☐ Yes ☐ No Are you more anxious? ☐ Yes ☐ No

Have you had Physical Therapy or Chiropractic Care? (Check all that apply)

☐ Physical Therapy ☐ Chiropractic Care ☐ Other _____

Please list When, Where and for How Long?

When: _____ Where: _____ How Long: _____

What test have been performed? (Check all that apply)

☐ X rays ☐ CT Scans ☐ MRI ☐ EMG / NCS ☐ Bone Scan ☐ Other

Please list When and Where

When: _____ Where: _____



South Lake Pain Institute

ALLERGIES TO MEDICATION:

What reaction do you have when you take? Symptoms / Side Effect

Please list **ALL** medications you are taking (Please include **ALL** the following information).

Name	Dosage (Strength)	Frequency

List **ALL** previous **PAIN** medications you have tried:

MEDICAL PROBLEMS: Please list **ALL** ongoing or previous medical problems

PAST SURGICAL HISTORY:

Type of Operation	Date

FAMILY HISTORY: Please list **ALL** medical problems in immediate family and their relationship to you.

SOCIAL HISTORY: (You must answer ALL of the following)

Do you smoke? ☐ No ☐ Yes How much? _____ How long? _____
Have you ever smoked? ☐ No ☐ Yes When did you quit? _____
Do you drink? ☐ No ☐ Yes How much per day? _____ Type of drink? _____
Have you tried any illicit drugs? ☐ No ☐ Yes What drugs? _____ How often? _____
Do you have a history of: Drug Abuse? ☐ No ☐ Yes Alcohol Abuse? ☐ No ☐ Yes
Are there any substance abuse issues in the household? ☐ No ☐ Yes
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Highest level of education completed (Check one):
☐ High School ☐ Technical ☐ Vocational ☐ College ☐ Highest Degree: _____
Employment Status (Check One): Occupation: _____
☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Disabled
Have you ever been involved in a lawsuit? ☐ No ☐ Yes Reason: _____
Do you see a Psychiatrist or Psychologist? ☐ No ☐ Yes (If yes, please give name below)
Name of Physician: _____ Phone: _____

Patient's Signature: _____ Date: _____



South Lake Pain Institute

FOR AUTO CASES ONLY

Name:		DOB:	
Date of accident / Injury:	Location in the vehicle: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Front <input type="checkbox"/> Back		
Type of Vehicle Involved:	Type of Other Vehicle involved:		
Were you wearing a seatbelt? <input type="checkbox"/> Yes <input type="checkbox"/> No	# of days after accident did the pain start?	Were you taken to ER? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Did you go by: <input type="checkbox"/> Ambulance <input type="checkbox"/> Self <input type="checkbox"/> Other	
What tests were performed in the hospital? <input type="checkbox"/> X-rays <input type="checkbox"/> MRI <input type="checkbox"/> T Scan <input type="checkbox"/> Other *If other, please explain:			
What medications were given at the hospital?	Any referrals given at the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		Other Treating Physicians:
Did you lose consciousness? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain immediate after accident? <input type="checkbox"/> Yes <input type="checkbox"/> No *If yes, Where?	Any lacerations: <input type="checkbox"/> Yes <input type="checkbox"/> No *If yes, Where?	
Do you have headaches: <input type="checkbox"/> Yes <input type="checkbox"/> No *How many times per week? *How long do they last?	Pre-existing status: History of pain prior to accident? <input type="checkbox"/> Yes <input type="checkbox"/> No History of treatment prior to accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Previous MVA? <input type="checkbox"/> Yes <input type="checkbox"/> No Previous Work Related Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Previous Slip and Fall Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Previous Other Injury? Yes / No Details of Accident:	Previous treatments <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Massage <input type="checkbox"/> Ice <input type="checkbox"/> Heat <input type="checkbox"/> Medications <input type="checkbox"/> EMG <input type="checkbox"/> NCS <input type="checkbox"/> Procedures <input type="checkbox"/> Surgery		
Signature:		Date:	



South Lake Pain Institute

PLEASE READ AND SIGN

Authorization to Treat: I hereby grant permission to the physicians and staff to perform any necessary procedures to treat the medical conditions for which I am seeking assistance. I understand that, except in an emergency situation, the staff will discuss with me my treatment options and that I will have the opportunity to accept or refuse specific treatments at that time.

Assignment of Benefits: I certify that the information I have given is correct. I hereby authorize payment to *South Lake Pain Institute, Inc.* of the benefits payable to my physician(s). In applying for payment under Title XVIII of the Social Security Act, I request payment of authorized benefits be made on my behalf to those who accept this assignment. I further understand that I am responsible for any charges not covered or payable by this assignment. Even though *South Lake Pain Institute, Inc.* accepts assignment of insurance company payments, insurance carriers occasionally send payments checks to the patient for services rendered by the physician. I agree to forward such payments I receive to *South Lake Pain Institute, Inc.* as soon as I receive them.

Charges for Services: The charges for *South Lake Pain Institute, Inc.* are for the physician's professional fees and services. These charges do not include hospital facility fees. The facility fees will be billed separately by the facility.

Payment for Services: As a courtesy to you, we will file claims with your insurance company. Monthly statements are mailed to patients if they are responsible for some portion of the bill. Patients who have no insurance coverage, or a copay or deductible are aware that payment is due at the time of the service. Please call our office with any questions regarding your account.

Patient Responsibility for Payment: I understand that my insurance coverage is a contract between my insurance carrier and me, NOT between the insurance carrier and *South Lake Pain Institute, Inc.* Ultimately, all fees are my responsibility. Should timely payments not be made on my account, I understand that a **10%** (ten percent) late payment fee may apply if my account should exceed **60** (sixty) days past due. I understand that all copays and previous balances must be paid prior to seen provider. If balances are not paid, appointment may be rescheduled. *South Lake Pain Institute, Inc.* reserves the right to refuse treatment and/or services to me until my account is brought current.

I authorize *South Lake Pain Institute, Inc.* to retain the services of an attorney or collection agency to assist with the collection. Any expenses incurred by *South Lake Pain Institute, Inc.* for such action shall become an additional liability for which I assume responsibility. I understand that if my insurance requires a referral that is my responsibility to have a referral at time of visit from the Primary Care Physician (PCP) or current treating physician. I understand, that I am required to notify the office if I am not able to keep my scheduled appointment.

I understand that I will be charged **\$75.00** for a follow up office visit, **\$300.00** for procedures, and **\$150.00** for New Patient appointments if I fail to cancel / re-schedule within **24** (twenty four) hours. I understand that I will be charged **\$35.00** as an additional fee for any returned checks. I understand that I will be charged for copies of all medical records. The fee for copies is **\$1.00** per page up to **25** pages and **\$0.25** per page thereafter. These fees are to be paid prior to records being sent. I am required to give the office at least **30** (thirty) days' notice if requesting records. I understand that there is also a fee for medical forms. The cost of these forms will be discussed after reviewed.

Patient Name _____
DOB: _____

Patient Signature: _____
Date: _____

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South Lake Pain Institute

PATIENT'S CONSENT FOR PROVIDER TO DISCLOSE PHI TO AUTHORIZED PERSONS

1. Authorization to Disclose PHI (Protected Health Information):

I hereby authorize, *South Lake Pain Institute, Inc.* to disclose any or all of my medical and protected health information (PHI) to the persons indicated below:

Name

Relationship, if any:

Specify Records Needed, IF NOT ALL: _____

2. Purpose of Disclosure:

The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or to know the status of my health.

3. Expiration of Authorization:

This authorization shall continue until I revoke this authorization in writing, which I may do at any time by sending a letter addressed to the Privacy Officer to any office where I am treated by Provider.

4. Conditioning of Treatment:

Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this consent.

5. Re-disclosure by Recipient:

I understand that once Provider disclose my PHI to the persons listed herein, my Provider has no control as to whether those persons may re-disclose my PHI, which may no longer be protected by Federal or State Law

6. Acknowledge of Reading and Agreement:

Patient SS#

Patient DOB

Date

Printed Patient Name / Representative

Patient Signature / Representative

If a Representative Signs, state the Representative Authority: _____

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South Lake Pain Institute

Authorization for the Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive maybe re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations authorized to use or disclose the information:

2. Persons/organizations authorized to receive the information:

South Lake Pain Institute, Inc. **352-394-0833 Phone**
2440 Hooks Street **352-394-0367 Fax**
Clermont, FL 34711

3. Specific Description of information that may be used/disclosed:

ITEMS 4-6 ONLY APPLY IF THE PRACTICE IS REQUESTING THE INFORMATION FOR ITS OWN USES AND DISCLOSURES.

4. *The information will be used/disclosed for the following purposes:* *Continuing care*

5. *I understand that this Authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign or my revocation of this Authorization will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.*

6. *The person/organization authorized to use/disclose the information will receive compensation for doing so.*
Yes _____ No **X**

7. I understand that I may inspect or copy the information used or disclosed.

8. I understand that I may revoke this Authorization at any time by notifying the person/organization providing the information in writing, except to the extent that:
(a) Action has been taken in reliance on this authorization; or
(b) If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest acclain under the policy.

9. This authorization expires on _____.

Patient SSN _____ Patient DOB _____ Date _____

Printed name of patient/ patient's representative _____ Relationship _____

Signature of patient /patient's representative _____



South Lake Pain Institute

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES PURSUANT TO 45 C.F.R. § 164.520

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking for it.

Contact Person

You may contact our Privacy Officer at the following phone number for any questions:

Jorge Colon (352)-394-0833

Effective Date

The effective date of this revised Notice of Privacy Practices is 08/21/2017.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received from the Group a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this Group's privacy practices and my rights regarding privacy of my protected health information.

PATIENT SIGNATURE

DATE



South Lake Pain Institute

ADVANCE HEALTH CARE DIRECTIVE

What are Advance Directives?

"Advance directives" are legal documents that allow you to plan and make your own end of life wishes known in the event that you are unable to communicate. Two types of Advance Directives are: A Living Will and a Designation of Health Care Surrogate Form, which is sometimes known as a Durable Power of Attorney for Health care. Both can be changed anytime, and you'll want to update them periodically.

What is a living will (LW)?

A (LW) describes your wishes regarding medical care, and guides your family and healthcare team through the medical treatment you wish to receive if you are unable to communicate your wishes. According to the state's (LW) law, this document is considered legal as soon as you sign it and a witness signs it, if that is required. A (LW) goes into effect when you are no longer able to make your own decisions.

What is a Medical Power of Attorney (POA)?

A medical (POA) allows you to select the person you trust to make decisions about your medical care if you are temporarily or permanently unable to communicate and make decisions for yourself. This includes not only decisions at the end of your life, but also in other medical situations. This document is also known as a "healthcare proxy," "appointment of healthcare agent" or "durable power of attorney for healthcare." This document goes into effect when your physician declares that you are unable to make your own medical decisions. The person you select can also be known as a healthcare agent, surrogate, and attorney-in-fact or healthcare proxy.

Do you have an Advance Directives?

☐ Yes ☐ No If yes, which ones? _____

If no, would you like to have one? ☐ Yes ☐ No

Would you like to have more information? ☐ Yes ☐ No

If yes, Please feel free to speak with Front Desk to schedule an appointment.

Name: _____ Date: _____

Appointment Date, if requested: _____