APEX Pain Care

1164 E. OAKLAND PARK BLVD
SUITE 201
OAKLAND PARK, FL 33334

Date: _____ / _____ / _____

Name _____
Address _____
City _____ **State** _____ **Zip Code** _____
Home Phone _____ **Cell** _____ **Work Phone** _____
Social Security # _____ **D.O.B** _____ **Age** _____
Sex _____ **Marital Status** _____
Name of Employer _____ **Occupation** _____
E-Mail Address _____ **Referred by** _____
Emergency Contact _____ **Phone #** _____
Primary Care Doctor _____ **Phone#** _____

How did you hear about our office? <u>Please Circle Answer</u>
Friend/Patient _____ Internet Yellow book Self-Referral
Physician _____ Radio Yellow Pages Other _____

<u>Insurance Information:</u>
*If you are a **<u>MEDICARE</u>** patient indicate what **<u>state</u>** you first received it from*: _____

Primary Carrier _____
Policy # _____ **Group #** _____

<u>Secondary Insurance</u>
Primary Carrier _____
Policy # _____ **Group #** _____

Patient Signature: _____ **Date:** _____

The following questions are designed to help your physician understand your current pain pattern and past treatment history. If you do not understand any of the following questions, please ask for assistance.

Where is your **PRIMARY** pain located? _____ right side/left
Where does the pain radiate to? _____
Is the pain Constant? Intermittent?
Is the pain Mild? Moderate? Severe?

Describe your pain:
Sharp/dull/throbbing/aching/burning/stabbing/cramping/tearing/other:

Is the pain constant chronic or acute interment?

What caused the pain to start? (Month/Year) _____

What treatment have you tried for the pain?_____

What makes the pain worse?_____

What makes the pain better?_____

Is there a **SECONDARY** part of your body where you have pain? **Yes / No**
Where is your pain located? _____ right side/left
Where does the pain radiate to? _____
Is the pain Constant? Intermittent?
Is the pain Mild? Moderate? Severe?

Describe your pain:
Sharp/dull/throbbing/aching/burning/stabbing/cramping/tearing/other:
Is the pain constant chronic or acute interment?
What caused the pain to start? (Month/Year) _____
What treatment have you tried for the pain_____
What makes the pain worse?_____
What makes the pain better?_____

Are you currently experiencing any of the following: Depression, loss of energy, sleeping problems, anxiousness, and loss of appetite, panic attacks, and sudden weight loss? None,
Other: _____

MEDICATION LIST

Starting with Pain Medications:

_____ _____

_____ _____

_____ _____

Any Medication Allergies?_____

List your usual Pharmacy name_____

Telephone number: _____

Are you taking blood thinner: Yes/ No

If yes, what are you taking? Coumadin, Lovenox, Aspirin, Plavix, Ticlid, Heparin, Pradaxa, Xarelto, Agrranox Other_____

How long have you been taking the medication? _____ Reason: _____

Which Doctor is monitoring this medication use? _____

Phone Number: _____

Have you had an MRI or X-ray, CT scan within the last 12 months? Yes No

What area of your body? _____ . If you don't have a written report, please provide the name and or phone number where you had it done. _____

Past Medical History (Please circle all that apply to your Health)

Cardiac: Hypertension, Heart Attack, Chest Pain, Heart Failure, Pacemaker, Irregular Rhythm, Other_____

Gastro-Intestinal: Hernia, Ulcers, Gastritis, Pancreatitis GERD, IBS, Diverticulitis, Colitis, Hepatitis, Other_____

Immune/Endocrine: Diabetes, Tuberculosis, Cancer, Thyroid, Arthritis, Fibromyalgia, Rheumatologic, Other _____

Respiratory: COPD, Asthma, Chronic Cough or Lung Disease, Emphysema,

Other_____

Neurological: Headaches, Seizures, stroke/TIA, Head Injury, Epilepsy, Sleeping problems, Other_____

ENT: Eye Disorders, Ear Disorders, Nasal Disorders, Throat Disorders, Other_____

Musculoskeletal: Abnormal Muscle function, Loss of joint function, Spine/Joint Pain, Arthritic Pain, Joint Replacement, Generalized aches/ Pain, Other_____

Hematological: Bleeding disorder, Inability to control bleeding from cuts, Phlebitis/Blood Clots, Transfusion Immune Problems/ HIV/AIDs, Other_____

Have you had Injections Cortisone done in the past? Yes / No

If yes, please circle from the options below:

Trigger Points Radio frequency Joint/ Bursa Botox Epidural Facet

Body Location: Cervical/ Lumbar/ Thoracic /Other_____

Was there Cortisone medication in the injection? Yes, No, Don't know

Did Injections Help? Yes/ No

Have you had any Surgery in the past? Yes/ No

If yes, please list below.

1)_____ **Date:**_____

2)_____ **Date:**_____

3)_____ **Date:**_____

Family History: (Please Complete)

Mother: Alive or Deceased

Age: _____ Reason: _____

Father Alive or Deceased

Age: _____ Reason: _____

Do you have Kids? Yes/ No

How many? ____ **Ages:** _____ _____ _____

Do you drink alcohol? Yes, No, Socially, Too much

Smoking History

Non Smoker

Current how many cigarettes a day do you smoke? _____

Past Smoker how long ago did you quit? _____

Recreational Drugs: Current, Past History, Never

Psychiatric History: Current/ Past Treating Physician:_____

Acknowledgement of Receipt of Notice

Apex Florida, LLC

1164 E Oakland Park Blvd, Ste 202,
Oakland Park, FL 33334

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy practice

Print name:_____ Telephone number:_____
Signature:_____ Date:_____

If not signed by the patient, please indicate:

Relationship(please circle):

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient:_____

For office use only:
Signed form received by: _____ Date:_____
Acknowledgement refused:_____
Reason for refusal:_____

Financial Policy

Updated 01/01/2014

Un-Paid Balance:

The patient or guarantor is responsible for any balance due to Apex Florida, LLC. If the balance is not paid in a timely manner, the account will be referred to a collection agency and assessed an additional fee of $30. If a collection account is not paid within 14 days, there will be an additional 100% fee attached to the outstanding balance due to attorney fees.

Primary insurance only covers a certain portion of the services the patient receives from our practice. Unless the patient has a Secondary Insurance/Supplemental which will cover what the primary does not.

***What could cause the patient to have a balance, if he/she has insurance coverage?**

-Not paying the co-pay at the time of service. (This is set by your insurance carrier, no insurance cover the co-pay)

– Not paying a co-insurance which is a set percentagefrom your insurance for procedures or visits. (The insurance carrier requires that the patient covers before the cover the rest)

-Deductible not met, some carriers will not cover any service unless deductible amount is fully met by patient.

I have read and fully understand this information and I agree to accept financial responsibility for the unpaid balance of all accounts in the event the following authorization is insufficient to liquidate the account.

I request that payment of authorized Medicare benefits be made on my behalf to Apex Florida, LLC for any services furnished me by this provider.

I hereby assign and transfer any insurance benefit due me for the professional services that I have received, to Apex Florida, LLC.

I authorize the release of any medical information necessary to process insurance claims.

_____ _____

Signature of Patient/Guarantor **Date**

APEX FLORIDA, LLC

Consent for Purpose of treatment, payment or Health Care Operations

I consent to the use or disclosure of my protected health information by Apex Florida, LLC, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Apex Florida, LLC.

I understand that diagnosis or treatment of my by Apex Florida, LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations, Apex Florida, LLC is not required to agree to the restrictions that I may request. However, if Apex Florida, LLC agrees to a restriction that I requested, the reliance on this consent.

My" protected health information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Apex Florida, LLC Notice of Privacy practices prior to signing this document.

Apex Florida, LLC Notice of Privacy has been provided to me.

The Notice of Privacy Practice for Apex Florida, LLC describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of health care.

A summary of the Notice of Privacy Practices for Apex Florida, LLC is also posted in waiting room.

This Notice of Privacy Practices also describes my rights and the duties of Apex Florida, LLC with respect to my protected health information.

Apex Florida, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practice.

I may obtain revised Notice of Privacy Practices by contacting Apex Florida, LLC 1164 E Oakland Park Blvd, St 202, Oakland Park, FL 33334

_____ _____

Name of patient or Representative(Please print) Date

_____ _____

Signature of Patient or Representative Employee Initial

APEX FLORIDA, LLC

OPIOID MAINTENANCE AGREEMENT

The long-term use of opioid therapy (narcotic analgesics) is somewhat controversial because of uncertainty regarding the extent to which this treatment actually improves the patient's quality of life. There is the potential risk of an addictive disorder. The extent of this risk is not certain. These drugs all have potential for abuse or diversion and accordingly, rather strict accountability is necessary when use is prolonged.

In addition to clinical monitoring to determine the benefits of this treatment, accountability is a necessity. For this reason the following policies are agreed to by treatment recipient as indicated by the signature below.

1. All narcotics must come from one physician or, during his or her absence, by the covering physician.
2. All narcotics must be obtained at the same pharmacy.
3. The prescribing physician has complete liberty to discuss fully all diagnostic and treatment details with the pharmacists at the dispensing pharmacy for purposes of maintaining accountability.
4. **Random urine and/or serum toxicology screens may be requested at any time.**
5. Prescriptions and bottles of narcotic tablets may be sought by other individuals with chemical dependency and should be closely safeguarded. In addition they may be hazardous or lethal if a person who is not tolerant to their effects, especially a child, should inadvertently take them. Early medications will not be given. If the patient uses a month's supply of medication in three weeks, the last week has to be endured with no medications. In an event that the medication is not controlling the pain and/or side effects occur, the patient is to bring in the medication to be disposed in our office so it may be documented in our records.
6. Medications will not be replaced if they are lost, fall into the toilet, are eaten by pets, left on a plane, or for any other reason. If your medication has been stolen and you complete a full police report regarding the theft, an exception may be made.
7. Prescriptions may be issued early, for example, if the treating physician is going to be out of town, or the patient is going to be out of town when a refill is due. However, these prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.
8. If the responsible legal authorities have questions concerning the patient's treatment as might occur, for example, if a patient were obtaining medications at several pharmacies, all records of narcotic administration.
9. It is understood that failure to adhere to these policies will result in permanent cessation of narcotic prescribing by this physician.

_____	_____
Physician Signature	Patient Signature
_____	_____
Print name	Print Name

Apex Florida, LLC

1164 E Oakland Park Blvd, Ste 202, Oakland Park, FL 33334 Tel: 954-678-1074 Fax: 954-938-2127

Authorization to Release or Obtain Medical Records

Date: _____

Patient Name: _____ Date of Birth _____

Address_____

I authorize the use/disclosure of health information about me as described below from:

AMERICAN PAIN EXPERTS/ APEX PAIN CARE 1164 E Oakland Park Blvd, St 202, Oakland Park, FL 33334

To: _____

- Complete Medical Record
- Abstract of Medical Record
- History & Physical (H&P)
- Discharge Summary
- Consultation/Operative Reports
- X-Ray and Imaging Reports
- Progress Notes
- Laboratory Test Results
- Immunization Records
- Other (please specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease Acquired Immunodeficiency Syndrome or human Immunodeficiency Virus. It may also include information about behavioral or mental health services and treatment of alcohol abuse.

This information is being provided to you from records whose confidentiality may be protected by State and/or Federal Law

I understand according to Florida Statures, there will be a charge for medical records copied and released to patients. There is no charge for copies to physicians form continuation of care.

This information may be disclosed to and used by the above facilities for purpose of:

- Further Medical Care
- Legal Investigation or Action
- Changing Physicians
- Insurance Eligibility/Benefits
- Personal
- Inspection/Copying of records
- Other (specify) _____

I understand I have the right to inspect and obtain a copy of my protected health information in the designated sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of an psychotherapy notes or any information compiled in anticipation of use or for any civil, criminal, or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988 (42 UCS Section 263 (a) and certain other records.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect may ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described above.

I understand that the information disclosed to pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.

I release the organization complying with this request of all responsibility for loss of confidentiality by access and/or copies of records released in compliance with this authorization.

I understand that I may revoke this authorization I writing at any time. To understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires with 90 days unless otherwise specified.

_____ _____

Signature of patient (if signed y person other than patient state relationship) Date

_____ _____

Name of Patient (Please Print) Social Security Number

Patient is: - Minor - Incompetent -Disabled -Deceased

Legal Authority: - Parent - Legal Guardian - Executor of Estate of Deceased - Power of Attorney -Authorized Legal Representative

_____ _____

Signature of Witness Date