

Premier Pain Specialists, LLC  
1228 SE 8<sup>th</sup> Terrace  
Cape Coral, Fl. 33990  
Phone: 239-945-1105 Fax: 239-945-4495

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Sex: M - F Marital Status: Single Married Divorced Widowed

Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Diagnosis? If no diagnosis, what is the problem? \_\_\_\_\_  
\_\_\_\_\_

How long has this been a problem? \_\_\_\_\_  
\_\_\_\_\_

Referral Source: Patient, Physician, Other,  
Referral Source Name, Contact Name, Address & Phone Number:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to Policy Holder: Self Spouse Other

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Received Privacy Policy

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Authorization to Release Protected Health Information

HIPAA Compliant Request for Information

Premier Pain Specialists, LLC

1228 SE 8<sup>th</sup> Terrace

Cape Coral, Fl. 33990

Phone: 239-945-1105 Fax: 239-945-4495

Patient Name: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I authorize the following to release my entire health record to Premier Pain Specialists, LLC

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I hereby authorize Premier Pain Specialists to release and/or obtain written or oral, any or all information including HIV/AIDS, alcohol/drug abuse, occupational and mental health related information included within the medical records for the purpose of evaluation, treatment, prognosis, etiology and insurance matters to/from other health care providers, insurance companies, government agencies and other sources on a as needed basis.

This authorization is good for one year from the date signed unless otherwise noted.

I may revoke this authorization at any time by mailing or personally delivering a signed. Written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment of my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian or Personal Representative (attach proper documentation)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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**CONSENT TO EXAMINATION AND TREATMENT AND STATEMENT OF FINANCIAL  
POLICY AND RESPONSIBILITY**

By my signature below I attest that I am capable of reading and comprehending this form without assistance, and have signed the form of my own free will. I agree that I have been made aware of the availability of assistance and / or an interpreter to help me in completing this form, and declined any aid.

By my signature below I hereby authorize the physicians of Premier Pain Specialists, LLC with the assistance of other health care providers and assistants selected by them, to provide medical care and treatment to me. I further agree to undergo any examinations, x-rays, blood tests and / or any other diagnostic modalities that the physician may determine to be important and / or relevant to my care.

By my signature below I authorize the doctor to treat or correct any unexpected conditions or problem found during the examination, diagnostic procedure, and/or care, treatment, therapy or remedy listed above. I agree that the doctor will explain my medical condition(s), symptom, or trauma, if known, and will explain any proposed examination, diagnostic procedure, and/or care, treatment, therapy or remedy. I **agree to ask for clarification if needed.**

By my signature below I agree that the doctor will explain other relevant and available alternatives, including associated risks, to the examination, diagnostic procedure, and/or treatment proposed. I agree that I will be provided with the opportunity to discuss relevant and available alternatives. I **agree to ask for clarification if needed.**

By my signature below I understand that there are certain risks inherent to the diagnosis and treatment of any disease, physical trauma, or condition. I agree that the doctor will discuss the risks of the specific examination, diagnostic procedure, and/or treatment proposed, including risks that are specific to me. I further agree that the doctor will explain the risks of **not** having the examination / diagnostic procedure / treatment proposed. I **agree to ask for clarification if needed.**

By my signature below I agree that I am submitting to the examination, diagnostic procedure, and/or treatment of my own free will. I further agree that I can ask questions and raise concerns with the doctor about my condition, the risks inherent to the examination, diagnostic procedure, and/or treatment, and my treatment options. I agree that my questions and concerns will be discussed and answered to my satisfaction. I further attest that I understand that I may ask questions concerning my examination or treatment, and that I **may stop treatment at any time for clarification of treatment options.**

By my signature below I attest that I have stated or noted my past medical history to the best of my ability, and further attest that I have **not taken any undisclosed medications or drugs prior to examination and/or treatment.**

By my signature below I agree that the doctor or any individual employed by the physician has not provided me a guarantee or assurance that the examination, diagnostic procedure, and/or care, treatment, therapy or remedy will cure or improve the condition(s) listed above. I further understand that the examination, diagnostic procedure, and/or care, treatment, therapy or remedy may make my condition worse.

By my signature below I understand that as part of my treatment, PREMIER PAIN SPECIALISTS, LLC may determine that I should visit a specialists or other physician. In such circumstances Premier Pain Specialists, LLC will disclose my protected health information determined to be necessary to the specialist or other physician.

By my signature below I agree that, as part of the examination, diagnostic procedure, and/or care, treatment, therapy or remedy provided, the doctor may obtain certain protected health information, including past medical history. I understand that this will include a review, if necessary, of past, current or future health records, including records of procedures such as physical examinations, x-rays, blood or urine tests. I understand that further information will be gleaned, as necessary, from direct and telephonic conversations with the doctor and/or the doctor's health care staff, or from my responses to any questionnaire submitted prior to the initiation of the proposed examination, diagnostic procedure, and/or care, treatment, therapy or remedy. I understand that the information sought may include, but is not necessarily limited to, the following:

- Documentation of past medical history
- Records of physical exams and procedures
- Laboratory, X-ray, MRI, and other test results
- Records of medication or drug usage
- Records of implanted or external medical devices
- Information related to diagnosis and treatment of a mental health condition
- Information about HIV / AIDS
- Information about hepatitis infection
- Information about sexually transmitted diseases
- Information about infectious diseases that must be reported to Public Health authorities

By my signature below I understand that Florida law generally requires that physicians carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. I further understand that Florida law imposes strict penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. I understand that the physician listed above has elected, pursuant to Florida law, not to carry medical malpractice insurance. I understand that this election is permitted under Florida law, subject to certain conditions, and understand that I have been provided with notice of this election pursuant to Florida law.

By my signature below **I understand and agree to pay all deductibles, co-payments, and fees due, less insurance payments.** As a courtesy to you, we will submit your claim to your insurance company. Any portion not covered by your insurance company such as your co-insurance and/or deductible amount is due and payable at the time of service. Additionally, some insurance companies do not cover supplies necessary for your treatment. You are responsible for these non-covered services.

Failure to make payment in full or failure to make arrangements for payment may result in your account being placed with a collection agency. Should it become necessary to send your account to the collection agency, collection costs may include, but are not limited to, collection agency fees, court costs, attorney fees, interest on unpaid balances and any other fees or costs associated with the collection of unpaid balance. A \$25.00 returned check fee will be added to your account for all returned checks.

**HMO Patients:** You are responsible for notifying your Primary Care Physician of your office visit. You must bring the authorization for the visit with you and present it prior to being seen by the physician. We will have to reschedule your visit if prior approval is not received.

**Forms:** We require a 24-48 hour notice for forms completion. There is a \$8.00 fee per form and payment must be received IN ADVANCE.

**Prescription Refills:** We require a 24-48 hour notice for refill requests. Requests will not be considered during non-working hours. Please have the medication name, strength, pharmacy name and phone number available when requesting refills. Please call your pharmacy to verify that the prescription is ready.

Due to the nature of our specialty, there may be times when an emergency patient visit causes our schedule to run behind. Many times patients are taken out of order due to nursing services. Please bear with us, every patient's care is important to us.

By my signature below the undersigned patient hereby assigns the rights and benefits of insurance under the applicable insurance policy for any service and/or charges provided by Premier Pain Specialists, LLC. I hereby direct the benefits be paid directly to the physician on my behalf for any services furnished to me by Premier Pain Specialists, LLC.

By my signature below I hereby certify that I have read and fully understand all of the words and information contained in this form, and reaffirm my consent to the examination, diagnostic procedure, and/or care, treatment, therapy or remedy proposed.

MISSED APPOINTMENT OR NO SHOW: You will be charged a \$30.00 fee for any missed appointment or no show if the office is not notified 24 hours prior to that scheduled appointment.

By my signature below, I permit a copy/fax of this form to serve as an original signature of authorization.

\_\_\_\_\_

Patient or Patient's Representative Signature \_\_\_\_\_  
Date

Print Patient's Name: \_\_\_\_\_

**If signed by Representative, state name of**

Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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I \_\_\_\_\_ agree to participate in a Program of Pain Management with the Physicians of Premier Pain Specialists, LLC. I may be provided with controlled substances, while actively participating in the Pain Management Program, only if I adhere to the following regulations.

1. I will receive controlled substances from the Premier Pain Specialists, LLC. staff only.
2. I will use the medications within the parameters given by the Premier Pain Specialists LLC staff.
3. I will not receive replacements for lost, stolen, or destroyed medications.
4. I will not seek controlled substances from the Premier Pain Specialists, LLC staff if I decide to discontinue participation in the Pain Treatment Program.
5. I will agree to participate in a drug detoxification program if prescribed by a member of the Premier Pain Specialists, LLC Staff.
6. Should violation of this agreement occur, I will consider thirty days adequate notice for termination of controlled substances.
7. Should notice of termination occur, I agree to obtain an alternate source of physician care within thirty days.

I will under no circumstances hold any member of the Premier Pain Specialists LLC staff liable for any sequelae of discontinuance of controlled substances provided thirty days notice of termination is given.

Signed \_\_\_\_\_

Date \_\_\_\_\_

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Name: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Describe the pain that brings you to the Pain Center; \_\_\_\_\_  
\_\_\_\_\_

How long have you had this pain? \_\_\_\_\_

Have you had any weight loss or gain in the past year? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes explain \_\_\_\_\_

**MEDICAL HISTORY:** Check any of the following conditions you have or have had in the past.

- |                          |                             |                     |                        |
|--------------------------|-----------------------------|---------------------|------------------------|
| ____ Diabetes            | ____ Asthma                 | ____ Cancer         | ____ Arthritis         |
| ____ High Blood Pressure | ____ Emphysema              | ____ Ulcer          | ____ Bleeding Problems |
| ____ Kidney Problems     | ____ Neurological Problems  | ____ Liver Problems | ____ Immune Problems   |
| ____ Heart Problems      | ____ OTHER (describe) _____ |                     |                        |

**SURGICAL HISTORY:** List any general surgeries you have had: \_\_\_\_\_  
\_\_\_\_\_

List any surgical procedures for pain relief: \_\_\_\_\_  
\_\_\_\_\_

MEDICATION ALLERGIES: \_\_\_\_\_  
\_\_\_\_\_

Please list all current **prescribed** medications:  
\_\_\_\_\_  
\_\_\_\_\_

Please list all pain medications taken in the past: \_\_\_\_\_  
\_\_\_\_\_

Are you taking over the counter medications? \_\_\_ YES \_\_\_ NO  
If Yes, Please list: \_\_\_\_\_  
\_\_\_\_\_

Are you taking ant Anticoagulants (Blood Thinner)? \_\_\_ YES \_\_\_ NO Aspirin Coumadin  
If yes, please list: \_\_\_\_\_

PATIENTS NAME \_\_\_\_\_ DATE \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If yes, how much \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If yes, How much and Type \_\_\_\_\_

MEDICAL HISTORY INFORMATION (Please check all that apply)

**CONSTITUTIONAL**

- Fever
- Chills

**EYES**

- Cataracts
- Glaucoma
- Changes in Vision
- Double Vision
- "Halos" around Lights
- Other: \_\_\_\_\_

**EARS, NOSE, MOUTH & THROAT**

- Difficulty Hearing
- Ear Pain &/Or Drainage
- Nose Bleeds
- Sores in the Mouth
- Frequent Sore Throats
- Other: \_\_\_\_\_

**CARDIOVASCULAR**

- High Blood Pressure
- High Cholesterol
- Heart Disease
- Heart Attack
- Angina
- Heart Failure
- Heart Valve Problem
- Heart Rhythm Problem
- Phlebitis
- Chest Pain or Tightness
- Jaw Pain
- Arm Pain
- Irregular Pulse
- Waking from Sleep with shortness of breath
- Other: \_\_\_\_\_

**RESPIRATORY**

- Bronchitis
- Asthma/Emphysema
- Cough
- Shortness of Breath
- Pain with Breathing
- Wheezing
- Coughing up Blood
- Night Sweats
- 

**GENITOURINARY**

- Kidney/Bladder Stones
- Ostomy
- Dialysis
- Pain on Urination
- Frequency of Urination
- Blood in Urine
- Breast lumps or discharge
- Incontinence/Bed Wetting
- Self Catheterization
- Foley Catheter

**MALE ONLY**

- Abnormal Urinary Stream
- Prostate Problems
- Penile Prosthesis
- Urinary Sphincters

**GYN (FEMALE ONLY)**

- Date of Last Menstrual Period \_\_\_\_\_
- Menopausal
  - # of Pregnancies \_\_\_\_\_
  - # of Children \_\_\_\_\_
  - Vaginal Discharge
- Date of Last Pap Test \_\_\_\_\_
- Menstrual Problems \_\_\_\_\_

**DERMATOLOGICAL**

- Breakdown
- Rash
- Infection
- Change in Mood
- Other: \_\_\_\_\_

**GASTROINTESTINAL**

- Ulcer/Gastritis
- Hepatitis
- Pancreatitis
- Diverticuli
- Ostomy (type) \_\_\_\_\_

**FEEDING/TUBE**

- Feeding/PEG Tube
- Heart Burn
- Abdominal Pain
- Loss of Appetite
- Weight Loss/Gain
- Nausea/Vomiting
- Vomiting Blood
- Diarrhea
- Constipation
- Rectal Bleeding
- Black Stools
- Difficulty Chewing/ Swallowing
- Regular Use of Laxatives

**MUSCULOSKELETAL**

- Arthritis (type) \_\_\_\_\_
- Joint Pain
- Swollen Joints
- Neck or Back Pain
- Muscle Weakness

**ENDOCRINE**

- Diabetes
- Thyroid Problems
- Excessive Thirst or Urinating
- Sensitivity to Heat or Cold
- Mood Swings
- Other: \_\_\_\_\_

**ALLERGIC**

- Hay Fever
- Bee Sting Reaction
- Hives
- Other: \_\_\_\_\_

**NEUROLOGIC**

- Stroke
- Seizures
- Fainting/Dizzy Spells
- Head Injury
- Headaches
- Balance Problems
- Memory Loss
- Other: \_\_\_\_\_

**CANCER**

- Cancer – Where \_\_\_\_\_
- Chemotherapy
- Radiation
- Surgery

**PSYCHOSOCIAL**

- Depression
- Substance Abuse
- Recent lifestyle changes (Divorce/Death/Loss of job)
- Sexual Concerns Related to Your Illness \_\_\_\_\_

**OTHER**

- Difficulty Sleeping
- Indicate Usual Bed Time \_\_\_\_\_
- Regular Use Sleeping Pills
- Back/Neck Problems
- HIV/AIDS
- Blood Transfusion
- Reaction to Blood Transfusion

Which of the following tests have you had to evaluate your pain problems?

TEST	CHECK DATE
X-ray	_____
CT Scan	_____
MRI	_____
EMG	_____
Myelogram	_____
Thermogram	_____
Other	_____

Which of the following treatment have you had for your pain problems?

TEST	CHECK DATE
Nerve Blocks	_____
TENS Units	_____
OT/PT	_____
Biofeedback	_____
Hypnosis	_____
Counseling	_____
Chiropractor	_____



**Assignment of Benefits**  
Premier Pain Specialists, L.L.C.  
P.O. Box 151460, Cape Coral, FL 33915-1460

I \_\_\_\_\_ with insurance benefits through \_\_\_\_\_ hereby authorize all entitled benefits under my governing Plan/Policy to be directly paid to the provider listed above for all services rendered. I understand my Plan is legally responsible to accept this HIPAA compliant agreement, provide all entitled benefits following all terms, conditions and requirements of the governing Plan, as well as all applicable state and federal governing laws. This authorization includes any and all rights permissible under my governing Health and Welfare Plan; applicable Social Security Act; Federal, City or State Government program; state and federal law. I understand this authorization also covers any other provider of service directly associated with services rendered and requested by the above provider, including but not limited to surgical related services, anesthesia, diagnostic testing, labs, pathology, radiology, implants, tissues, durable medical equipment or any other services as ordered by the provider listed above.

I hereby certify that all insurance information provided is true and accurate and that I am responsible for keeping it updated. I hereby authorize the Provider listed above to submit claims, on my behalf, to the insurance company responsible for administering entitled benefits for all services rendered in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full and in full compliance of applicable state and federal laws. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by my insurance company including any portion paid and not applied to in network benefits for any out of network services, non covered services, services determined by the insurer as not medically necessary, or any failure by my insurer to comply with all applicable laws.

I hereby irrevocably, designate, authorize and appoint Provider listed above as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments, rights and remedies due under my Health and Welfare plan/Policy to include all medical services rendered or to be rendered as ordered by the provider listed above. This power of attorney shall automatically terminate, without formal action being taken, as soon as the above listed healthcare provider has received payment in full, rights and remedies under applicable governing law for all medical care and services provided. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I hereby authorize my insurer to assign and transfer any and all entitled plan benefits and rights to Provider listed above and any appointed business associates working with them for the sole purpose of making sure all protected rights and entitled benefits under my specific health and welfare plan or governing policy are administered accurately, including the right under applicable law to receive all relevant documents or data, governing plan documents, remedies, disclosures, appeal, administrative reviews and litigation on my behalf. This is a direct assignment of my rights and benefits under the governing plan/policy. I understand this payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment where entitled benefits are not paid pursuant to applicable federal and /or state laws.

I hereby instruct and direct my Insurance Company to pay all entitled plan benefits as required by the governing Plan directly to any applicable Provider listed above and rendering services for all entitled benefits related to such services rendered following all terms, conditions and requirements of the governing Health and Welfare Plan. I understand under applicable governing law that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my protected rights pursuant to applicable state, federal or ERSIA law hereby instruct and direct my Insurance Company to provide specific SPD documentation stating such non-assign ability clause to myself and the applicable Provider, along with the regulatory guideline that allows for such non-assignability. Upon proof of specified non-assignability documentation, I then instruct that the insurer make out the check to me and mail it directly to the Provider and address listed on the submitted claim for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. I agree and understand that any funds received by my insurance company due for services rendered by any and all healthcare providers listed in this assignment of benefits will be immediately signed over and sent directly to such provider. Upon receipt of said check, I authorize Provider listed above to receive any such checks, endorse them for deposit only, and to deposit and apply all the proceeds toward payment due on my account. I authorize the release of any information pertinent to my case to any insurance company, adjuster, Plan Sponsor, governmental agency or attorney involved in this case or responsible for making sure all protected rights and entitled benefits are provided pursuant to the governing Plan, state and federal laws. I authorize all applicable Providers listed providing medical services or appointed business associates to be my personal representative, which allows them as my legally binding authorized representative to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information, appeals, remedies and protected disclosures from my Plan or insurance company, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my insurer and/or plan benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my stated plan benefits based on billed charges, within ninety (90) days of any and all appeals or request for information. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. I understand that all delinquent accounts bear interest or administrative fees at the legal rate. I also agree that any penalties or fines levied against my insurance company will be paid to Provider acting as my personal representative.

I authorize all providers included in this agreement to provide medical care reasonable and at the standard of care as required by state law. A photocopy of this Assignment shall be considered as effective and valid as the original.

\_\_\_\_\_  
Signature of Patient/Guarantor

\_\_\_\_\_  
Date



**Premier Pain Specialists, LLC**  
**1228 se 8<sup>th</sup> Terrace**  
**Cape Coral, FL 3990**  
**Ph: 239-945-1105 Fax: 239-945-4495**

NAME: \_\_\_\_\_

**Please fill out:**

**Please circle one:**

**Marital Status:     S     M     D**

**Race:**            **American Indian or Alaskan**  
                      **Asian**  
                      **Black or African American**  
                      **Native Hawaiian/Other**  
                      **White**  
                      **Refuse to report**

**Ethnicity:**        **Hispanic or Latino**  
                      **Non Hispanic or Latino**  
                      **Refuse to Report/Unreported**

**Nationality:** \_\_\_\_\_

**Language:** \_\_\_\_\_

**Dominant Hand:** \_\_\_\_\_

**Mothers Maiden Name:** \_\_\_\_\_