COASTAL
SPINE & PAIN CENTER
Treating Pain From Head to Toe

PATIENT INFORMATION

PLEASE PRINT CLEARLY

Email Address:

Date:

Patient Name: Date of Birth: Sex: Marital Status:

Address: City: State: Zip:

Home Phone #: Cell#: Social Security #:

Primary Language Spoken: Race:

Ethnicity (Please check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

State of License: Primary Care Physician:

Driver License Number: Referring Physician:

Employer's Name & Address: Employer's Phone #:

If Patient is Married Please Complete This Section:

Spouse's Name: Social Security Number: Date of Birth:

Spouse's Employer: Employer's Phone #:

Spouse's Employer's Address:

Does the patient have health insurance? ☐ Yes ☐ No

If your response was yes, please list the insurance company's names. Please have your insurance cards available to copy.

Primary Insurance Carrier:

Secondary Insurance Carrier(s):

Subscriber Name: Subscriber DOB:

Subscriber Gender: ☐ M ☐ F Subscriber SSN: Subscriber I.D. #:

Subscriber's relationship to patient (mother, father,grandmother, etc.):

Patient Signature: Date:

Witness Signature: Date:

Emergency Contact:

Phone #: Cell #: Relationship:

COASTAL SPINE & PAIN CENTER

FINANCIAL POLICY

As your physician, I am committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Coastal Spine & Pain Center. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED

We accept cash, personal checks, MasterCard and Visa. Returned checks are subject to a $40.00 service fee and you will lose your privilege to write checks in all our centers. Coastal Spine & Pain Center currently uses Check Velocity, a returned check company who will automatically debit your account for the amount of the returned check plus the applicable service fee.

HMO/PPO INSURANCE COVERAGE

CO-PAYMENT AND DEDUCTIBLE MUST BE PAID AT THE TIME OF SERVICE. I understand that it is my responsibility to provide Coastal Spine & Pain Center with a copy of my current insurance card and, if required by my insurance, to obtain a referral from my primary care physician. Coastal Spine & Pain Center is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a self-pay patient and I am financially responsible for the total amount of the services provided. I will notify Coastal Spine & Pain Center immediately upon any change to my insurance. We will file your insurance if we are under contract with your insurance company. I understand that all charges not covered by my insurance are my responsibility. If the insurance company fails to pay Coastal Spine & Pain Center in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Coastal Spine & Pain Center.

MEDICARE

Your deductible and 20% of the allowable charges are due at the time of service; however, since we are Medicare providers we will file your Medicare. I hereby authorize and assign all payments of authorized Medicare benefits for medical services and/or procedures rendered to patient, directly to Coastal Spine & Pain Center. I hereby authorize Coastal Spine & Pain Center to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by Medicare for which I have signed an Advance Beneficiary Notice ("ABN"). If we do not know the allowable charge for a specific service, you will be billed after payment is received from Medicare. Please bring your Medicare Explanation of Benefits to show that you have met your deductible for the year.

WORKER'S COMPENSATION

We will call your employer to authorize your visit prior to your appointment. We will file with your company's insurance.

AUTOMOBILE ACCIDENTS

We will file your insurance claim when you are involved in an automobile accident; however, it is your responsibility to provide us with your insurance information so that we can verify your coverage. You will be responsible for payment of your portion at the time you receive medical treatment.

LABORATORY BILLING PROCEDURE

I have been informed that all laboratory procedures done outside of the office (blood work, cultures, pap smears, urine drug screenings, etc.) will not be included in the charges for Coastal Spine & Pain Center. All lab tests performed by an outside laboratory are billed separately to either my insurance company or myself. I understand that all charges not covered by my insurance are my responsibility. I will direct any questions regarding a bill or statement from an outside laboratory to the lab. Coastal Spine & Pain Center will send my lab specimens to a laboratory that accepts my insurance. All lab screenings will be sent to Coastal Laboratories who is affiliated with Coastal Spine and Pain Center unless your insurance requires it to go to another lab (ie. Quest or LabCorp.)

NO SHOW POLICY (Please initial)

____ There will be a $50.00 charge if you fail to show for your scheduled office appointment. It is your responsibility to notify the office 24 hours in advance if you are unable to keep your office appointment.

____ There will be a $75.00 charge if you fail to show for your scheduled procedure appointment. It is your responsibility to notify the office 24 hours in advance if you are unable to keep your procedure appointment.

CONSENT FOR MEDICAL TREATMENT

I am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize care encompassing the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations performed. This form has been fully explained to me and I certify that I understand and accept its contents as noted.

CHILDREN OF DIVORCED PARENTS

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED, NO MATTER WHO IS RESPONSIBLE BY ORDER OF THE DIVORCE DECREE.

FORM COMPLETION FEE

Due to the large volume of forms that we are required to complete, our office reserves the right to charge up to $25.00 per page for the completion of forms. Dictated letters are dealt with on a case-by-case basis.

PRIVACY POLICY

I have received a copy of Coastal Spine & Pain Center's privacy policy and have been given the opportunity to have my questions, if any, answered.

FINANCIAL AGREEMENT

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (e.g. yearly physicals and mole removals).

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.**
Collection action will be taken for any charges, including those that insurance has not paid, older than 90 days. We realize that emergencies do arise that may affect timely payment of your account. If extreme circumstances occur, please contact us promptly for assistance in the management of your account.

I do hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to Physicians Group Services, P.A. d/b/a Coastal Spine & Pain Center. In the event I receive payment directly from my insurance company for services rendered by Coastal Spine & Pain Center, I agree to endorse any check received to Coastal Spine & Pain Center.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Date: _____

Patient Signature: _____

Printed Name of Patient: _____

Parent, Guardian or Legal Representative Signature: _____

Printed Name of Parent, Guardian or Legal Representative: _____

Relationship to Patient: _____

Legal Representative's Authority to Act for Patient (Power of Attorney, Healthcare Surrogate): _____

REVISED 12/2014

COASTAL SPINE & PAIN CENTER
Treating Pain From Head to Toe

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(*) SECTION REQUIRED FOR COMPLIANCY

*Patient Name:	*Birth Date:	Social Security No:
*Provider (Who is releasing information):		
Address 1:		
Address 2:		
City:	State:	Zip:

I hereby authorize my protected health information from the above provider to be released to:

*Recipient's Name (Who is receiving the information):		
Address 1:		
Address 2:		
City:	State:	Zip:
Phone:	Fax Number:	

*This authorization will expire upon the following: (Fill in the Date or Event, but not both.)

(If no expiration is specified, this authorization will expire 90 days from the date signed.)

*The following information may be disclosed (Choose one of the following):

☐ *** All Medical Records covering dates _____ through _____

☐ *** Entire Medical Record

☐ *** Specific Medical Records _____

☐ *** Other (Specify): _____

***I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. _____ (Initial) If not applicable, check here (☐)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see & obtain a copy of the information described on this form for a reasonable copy fee, if I ask for it.
6. I may retain a copy of this form after I sign it.

**Signature of Patient / Guardian / Legal Representative:	Date:
(If not signed by the Patient) Print Name:	Relationship to Patient:

Legal Paperwork is required if not signed by the patient.

HIPAA PRIVACY NOTICE

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

INTRODUCTION

We are required by law to maintain the privacy of protected health information ("PHI"). PHI includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. You can always request a copy of our most current privacy notice from our office.

PERMITTED USES AND DISCLOSURES

The following categories describe the different ways in which we may use and disclose your PHI without obtaining your authorization:

- Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.
- Payment means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, prior to providing health care services, we may need to provide to your HMO information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the HMO for the services rendered to you, we can provide the HMO with information regarding your care if necessary to obtain payment.
- Health care operations means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.
- We have an indirect treatment relationship with you, that is, we provide health care to you based on the orders of another health care provider. For example, if you have come to us for a diagnostic procedure, we can disclose the results of that test to the physician who ordered the procedure.

OTHER USES AND DISCLOSURES OF PHI

We may contact you to notify you of lab or test results, to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

We may disclose your PHI only to those people that you have authorized. We will only disclose the PHI directly relevant to their involvement in your care or payment. We may also use or disclose your PHI to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the PHI that is directly relevant to their involvement in your care. When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.

We will allow your family and friends to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, and similar forms of PHI with your authorization.

We may contact you as part of our marketing efforts as permitted by applicable law.

Except for the special situations listed below, we will not use or disclose your PHI for any other purpose unless you provide written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

SPECIAL SITUATIONS

- Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

- Worker's Compensation: We may release medical information about you for programs that provide benefits for work-related injuries or illness.

- Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following:
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of product, recalls, repairs or replacements;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- Health Oversight Activities: We may disclose medical information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. We may disclose PHI to persons under the Food and Drug Administration's jurisdiction to track products or to conduct post-marketing surveillance.

- Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- Law Enforcement. We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct on our premises;
  - In emergency circumstances to report a crime, the location of the crime or victims or the identity, description or location of the person who committed the crime.

- Coroners, Medical Examiners and Funeral Directors: We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

- National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counter- intelligence, or other national security activities authorized by law.

- Protective Services for the President and Others: We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

- Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

YOUR RIGHTS

1. Requesting Restrictions: You have the right to request restrictions on our uses and disclosures of PHI for treatment, payment and health care operations. However, we are not required to agree to your request. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Practice Office Manager at your treating location (904) 265-7755. Your request must describe in a clear and concise fashion:

a) the information you wish restricted;
b) whether you are requesting to limit our practice's use, disclosure or both; and
c) to whom you want the limits to apply.

2. Confidential Communications: You have the right to reasonably request to receive communications of PHI by alternative means or at alternative locations. However, you are required to provide our office with a daytime telephone number.

3. Inspection and Copies: You have the right to inspect and copy the PHI contained in your medical and billing records, except for:

i. psychotherapy notes, which are notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record;
ii. information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
iii. PHI involving laboratory tests when your access is required by law;
iv. if you are a prison inmate and obtaining such information would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you;
v. if we obtained or created PHI as part of a research study for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;
vi. your PHI is contained in records kept by a federal agency or contractor when your access is required by law; and
vii. if the PHI was obtained from someone other than us under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

We may also deny a request for access to PHI if:

- a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person;
- the PHI makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
- the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.

If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. Requesting an Amendment: You have the right to request an amendment (correction) to your PHI, but we may deny your request for correction, if we determine that the PHI or record that is the subject of the request:

i. was not created by us, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
ii. is not part of your medical or billing records;
iii. is not available for inspection as set forth above; or
iv. is accurate and complete.

To request an amendment, your request must be made in writing and submitted to the practice office manager at your treating location (904) 265-7755. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing.

In any event, any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

5. Accounting of Disclosures: You have the right to receive an accounting of disclosures of PHI made by us to individuals or entities other than to you, except for disclosures:

i. to carry out treatment, payment and health care operations as provided above;
ii. to persons involved in your care or for other notification purposes as provided by law;
iii. for national security or intelligence purposes as provided by law;
iv. to correctional institutions or law enforcement officials as provided by law; or
v. that occurred prior to April 14, 2003.

6. Copy of Privacy Notice: You have the right to request and receive a paper copy of this notice from us.

COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact the Practice Office Manager at your treating location (904) 265-7755. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of the Department of Health and Human Services.

CONTACT PERSON

If you have any questions or would like further information about this notice, please contact (904) 265-7755.

BY SIGNING THIS NOTICE, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Date: _____

Patient Signature: _____

Printed Name of Patient: _____

Parent, Guardian or Legal Representative Signature: _____

Printed Name of Parent, Guardian or Legal Representative: _____

Relationship to Patient: _____

Legal Representative's Authority to Act for Patient (Power of Attorney, Healthcare Surrogate): _____

COASTAL SPINE & PAIN CENTER

Informed Consent and Agreement for Treatment with Opioid Analgesic Medications

Patient Name _____ Date _____

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your pain management specialist to comply with the law regarding controlled pharmaceuticals. I understand that this Agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my pain management specialist undertakes to treat me based on this Agreement.

I have agreed to use opioid analgesics (morphine-like medications) as part of my treatment for acute/chronic pain. I understand that these drugs could be useful, but have a potential for misuse and are therefore closely controlled by the local, state and federal governments. Because my pain management specialist is prescribing such medication to help manage my pain, I agree to the following conditions. I am aware that failure to abide by any of these conditions will be considered a breach of this agreement, and at the sole discretion of my pain management specialist or the medication utilization review committee, may result in the termination of our physician/PA/NP-patient relationship. In this case, my provider will stop prescribing these pain- control medicines and will taper off the medication over a period of several days, as necessary, to lessen withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

1. I am responsible for my pain medications. I agree to take the medication only as prescribed and to contact my physician before making any changes.

    - I understand that increasing my dose without the close supervision of my pain management specialist could lead to drug overdose, causing severe sedation, respiratory depression and death.

    - I understand that decreasing or stopping my medication without the close supervision of my physician could lead to withdrawal. Withdrawal symptoms may include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh," abdominal cramps and diarrhea. These symptoms can occur 24 to 48 hours after the last dose and can last up to several weeks.

2. I will not request or accept a prescription for opioid pain medicines from any other physician or individual while I am receiving such medication from my pain management specialist. Prescriptions for controlled stimulants or anti-anxiety medicines need to be coordinated with your pain management specialist.

3. I understand the side effects that are related to opioid medication. Common side effects are nausea and vomiting (similar to motion sickness), drowsiness and constipation. Less common side effects are mental slowing, flushing, sweating, itching.. urinary difficulty, jerkiness, change in personality, sleep changes, potential for increased pain, risks to unborn children, changes in appetite, coordination, sexual desire and performance. Most side effects would occur at the beginning of my treatment and often go away within a few days without treatment. It is my responsibility to notify my pain management specialist of any side effects that continue or are severe (such as sedation or confusion). I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work. I am also responsible for notifying my pain management specialist immediately if I need to visit another physician or emergency room due to pain.

4. (FOR FEMALE PATIENTS ONLY) I also understand that if I became pregnant, or if I am suspicious that I am pregnant, I will notify the doctor and staff of the office immediately. I further accept that any medication may cause harm to my embryo/fetus/baby and hold Physicians Group Services, P.A. d/b/a Coastal Spine & Pain Center, its shareholders, officers, directors, employees, contractors and agents harmless for injuries to the embryo/fetus/baby.

5. I understand that the opioid medication is strictly for my own use. I will not share, sell or trade my pain medication with anyone. If children are in the house, a childproof top is mandatory.

6. I understand I must contact my pain management specialist before taking benzodiazepines (drugs like Valium, Xanax or Ativan), sedatives (drugs like Soma or Fiorinal) and antihistamines (drugs like

Benadryl). I understand that the combination use of the above drugs and opioids, as well as alcohol and opioids, may produce profound sedation, respiratory depression, blood pressure drop and even death. I cannot consume alcohol or use recreational/illegal drugs (including marijuana, cocaine, heroin, etc.) while on opioid analgesic medications. If consumed, the consequence will be termination from the program. I understand that opioid prescriptions will not be mailed. During the time that my dose is being adjusted, I will be expected to return to the Coastal Spine & Pain Center no less frequently than one time a month. After I have been placed on a stable dose, I will return to the Coastal Spine & Pain Center whenever instructed by my pain management specialist.

7. I am responsible for my opioid prescriptions. I understand that refill prescriptions:

    - Can only be written for a one-month supply and will *be filled* at *the same pharmacy* (as designated below). I will update my record of pharmacy should it change.

      Pharmacy Name: _____ Phone #: _____
      Pharmacy Address: _____

    - Shall be made *during regular office hours* 8 *AM* - 5 *PM,* Monday through Friday, and can be picked up only in person. Refills will not be made at night, on holidays or on weekends. Prescriptions will not be mailed.

    - Refills shall not be made if I "run out early", "lose a prescription" or spill or misplace my medication.

    - I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

    - I am responsible for keeping track of the amount of medication remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. Replacement prescriptions will be given at the discretion of my physician. Lost or stolen medicines will likely not be replaced.

    - Shall not be made as an "emergency," such as on Friday afternoon because I suddenly realize I will "run out tomorrow." I will call at least one week ahead to schedule pick-up for my prescriptions.

8. While physical dependence is to be expected after long-term use of opioids, signs of addiction (and psychological dependence) shall be interpreted as a need for weaning and detoxification. I agree, if this is the case, that I may need to be admitted for detoxification to appropriate facility

    - Physical dependence is common to many drugs, such as blood pressure medications, anti-seizure medications and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal.

    - Addiction is a psychological and behavioral syndrome that is recognized when the patient abuses the drug to obtain mental numbness or euphoria, when the patient shows a drug craving behavior or "doctor shopping." when the drug is quickly escalated without correlation to pain relief and/or when the patient shows a manipulative attitude toward the physician in order to obtain the drug. If the patient exhibits such behavior, the drug will be tapered. Such a patient is not a candidate for the opioid trial and he or she may be discharged from Coastal Spine & Pain Center.

    - Tolerance is a pharmacological property of certain drugs and is defined as a need for higher doses to maintain the same drug-related effect.

COASTAL SPINE & PAIN CENTER

Informed Consent and Agreement for Treatment with Opioid Analgesic Medications

9. I understand that the goals of my pain physician's treatment plan may include time-contingent use of opioids. If it appears to the pain management specialist that there is no improvement to my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the pain management specialist.

10. I agree to submit to urine, saliva and/or blood screens at anytime as determined by my pain management specialist to detect the use of both prescribed and non-prescribed medication. I may also be requested to bring my medication in at any time for the pain management specialist to inspect.

11. I further understand that if I do not follow any of the above conditions or provisions, I may (at my physician's discretion) no longer receive any type of opioid medication.

    - Controlled medication therapy may be discontinued if patients: (i) develop tolerance which cannot be managed; or (ii) have side effects, which cannot be controlled.

    - Discharge from Coastal Spine & Pain Center will occur if: (i) patients become addictive or abusive of other medications and substances (this includes alcohol), (ii) increase their medications without prior approval from my pain management specialist, (iii) obtain non-authorized controlled medications from other practitioners; (iv) fill prescriptions at multiple pharmacies; (v) sell, give away or otherwise divert the medications from their intended use; alter prescriptions; or (vi) other serious concerns arise. Coastal Spine & Pain Center always cooperates with authorities if illegal activities occur.

12. I also understand that if I have a problem or question with any of the terms of this Agreement, I must make an appointment to discuss this with the pain management specialist and receive clarification before a problem or crisis situation arises.

13. I authorize the release of any information and medical records by the pain management specialist, his or her designee, and my pharmacy to other healthcare providers, pharmacist, my family, my employer, my insurance company or other reimbursing agencies. I also authorize the pain management specialist, his or her designee, and my pharmacy to contact any legal authority, or regulatory agency to obtain or provide information about my care or actions if the pain management specialist feels it is necessary and to cooperate fully with any city, state or federal law enforcement agency, including the Florida Board of Pharmacy and Drug Enforcement Administration, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my pain management specialist to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

14. I understand that no agreement can anticipate all events in medical treatment which may arise and that me and my heirs, will hold harmless Physicians Group Services, P.A. d/b/a Coastal Spine & Pain Center, its shareholders, officers, directors, employees, contractors and agents for all resultant problems. This Agreement supersedes and replaces all previous agreements.

By signing below, I certify that I have read the above Information, I have received a copy of the contract and all my questions regarding the treatment of pain with opioid analgesic medications have been answered to my satisfaction. I hereby give my consent to participate in opioid medication therapy.

Patient signature: _____ Date: _____

Physician: _____ Date _____

COASTAL
SPINE & PAIN CENTER
Treating Pain From Head to Toe

NOTICE OF EMERGENCY MEDICAL CONDITION

The undersigned licensed medical provider, hereby affirms:

1. The below injured patient, has in the opinion of this medical provider, suffered an **Emergency Medical Condition**, as a result of the patient's injuries sustained in an automobile accident that occurred on _____ (fill in date of accident).
2. The basis for the finding of an **Emergency Medical Condition** is that the patient has sustained acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: a) serious jeopardy to patient health; b) serious impairment to bodily functions; or c) serious dysfunction of a bodily organ or part.

I hereby attest that I am a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner licensed under chapter 464, and that the above facts are true and correct.

_____ _____ _____
Name (PRINT or TYPE) Signature of medical provider Date

The undersigned injured person or legal guardian of such person affirms:

1. The symptoms I reported to the medical provider are true and accurate
2. I understand the medical provider has determined I sustained an Emergency Medical Condition as a result of the injuries I suffered in the care accident.
3. The medical provider has explained to my satisfaction the need for future medical attention and the harmful consequences to my health which may occur if I do not receive future treatment.

Injured patient receiving this diagnosis or legal guardian of said injured patient:

_____ _____ _____
Name (PRINT or TYPE) Signature of injured patient/guardian Date

COASTAL
SPINE & PAIN CENTER
Treating Pain From Head to Toe

INITIAL OFFICE VISIT PATIENT INFORMATION SHEET

Name: _____ Age: _____ Sex: _____

Referred By: _____ Today's Date: _____

Current Problems

List your chief complaint(s) and/or symptom(s):

1. _____
2. _____
3. _____
4. _____

History of Present Illness

Date of Initial Symptoms:_____

If you answered the accident/personal injury section please skip, otherwise describe in your words:

_____

_____

_____

_____

_____

_____

On the Job/Personal Injury History

Are you being evaluated for pain resulting from a work or personal injury? ☐Yes ☐ No If no, skip to the next section

Date of Accident: _____

Description of accident – (please briefly describe how your injury occurred) _____

_____

_____

When did you first seek care? ☐Immediately ☐Same Day ☐Next Day ☐Other _____

Where did you seek care? ☐Emergency Room ☐Doctor's Office ☐Other_____

What treatment did you initially receive? _____

_____

Place an X next to the number that best describes your pain at its **worst during the last month:**

0	1	2	3	4	5	6	7	8	9	10

Place an X next to the number that best describes your pain on **average during the last month:**

0	1	2	3	4	5	6	7	8	9	10

Pain Description (check all applicable): ☐Constant ☐ Intermittent ☐Sharp ☐ Burning ☐ Shooting ☐ Achy ☐Knife-like

☐Electric ☐ Twisting ☐ Pressure ☐ Lancinating ☐ Buzzing ☐Gnawing ☐Toothache ☐Pressure ☐Deep ☐Heavy

Prior Treatment

Have you been treated by another physician for this? Yes ☐ No ☐ If yes, please list physician(s) name(s):

_____

Please describe previous treatment for the condition that brings you to our office: _____

_____

_____

_____

_____

_____

Have you had any of the following types of therapy? (check all that apply)

☐ Physical Therapy	☐ Epidural Injections
☐ Massage Therapy	☐ Facet Injections
☐ Chiropractic	☐ Other Spinal Injections
☐ Acupuncture	☐ Braces/Supports
☐ Trigger Point Injections	☐ TENS Unit

Activity Limitations

How does your condition affect your daily activities? (Including leisure)_____

_____

_____

_____

Previous Work – Up/Diagnostic Studies

Have you ever had any of the following diagnostic test/work-ups or studies? (check all that apply) If yes: please give the approximate month and year of the study:

☐ X-Rays:	☐ EMG/NCV:
☐ Myelogram:	☐ CAT-SCAN:
☐ EEG:	☐ Bone Scan:
☐ MRI:	☐ Discogram:
☐ Recent Blood Work:	☐ Other(describe):

Past Medical History

List any medical problems past and present which require(d) medical treatment:_____

_____

_____

_____

_____

Have you ever had any surgery? Yes☐ No ☐ If yes, list surgery type and date: _____

_____

_____

Medications

List ALL the medications you are CURRENTLY TAKING:

Name	Dose(mg)	Times per day currently taking
Pain Medications		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Medication other than pain (blood pressure, diabetes, etc.)		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you taking Plavix/clopidogrel, warfarin, Coumadin, or Effient/prasurgel? Please **write** YES or NO: _____

Are you allergic to shellfish, crabs, iodine, or radiographic dye? Please **write** YES or NO: _____

Are you **allergic** to any medications? Please list if you are:

Medication Allergic to:	**Allergic Reaction**
_____	_____
_____	_____
_____	_____
_____	_____

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

How often do you have mood swings? _____

How often do you smoke a cigarette within an hour after you wake up? _____

How often have you taken medication other than the way that it was prescribed? _____

How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? _____

How often, in your lifetime, have you had legal problems or been arrested? _____

Family History

Are there any members of your family with the same or similar problems or conditions as yours?
Yes ☐ No☐ If yes, please explain:

_____

_____

Personal/Social History

Do you use Tobacco? Yes ☐ No☐ If yes, how Much:_____

Do you use alcohol? Yes☐ No ☐ If yes, amount:_____

Do you have a history of substance abuse (including alcohol)? Yes☐ No ☐ _____

Are you receiving disability benefits from any source? Yes ☐ No ☐ If yes, explain below:

_____

Are you now working? ☐Yes ☐No If yes: ☐Full Time ☐Part Time

What type of work do you perform? _____

_____ Have you had to limit your work because of your condition? ☐Yes ☐ No

Please describe these limitations:_____

_____ If not employed, when were you last employed? ____/____/____. What type of work was that?

_____

Review of Systems (Please check all that apply to you):

General:	Fever☐ Chills☐ Weight change☐ Weakness☐ Fatigue☐
Ophthalmology:	Blind spots☐ Pain from light☐ Drainage from eye☐ Double vision☐ Blurred vision☐
Respiratory:	Cough☐ Sputum☐ Wheezing☐ Asthma☐ Shortness of breath☐
Cardiology:	High blood pressure☐ Swelling of ankles☐ Murmurs☐ Irregular heartbeat☐ Chest pain☐
Dermatology:	Itching☐ Rash☐ Dry skin☐ Skin color changes☐
Endocrinology:	Diabetes☐ Hyper or Hypo Thyroid☐ Hot/Cold intolerance☐ Frequent urination☐ Thirst☐
Gastrointestinal:	Heartburn☐ Constipation☐ Nausea☐ Vomiting☐ Bloody stools☐ Incontinence of stool☐
Genitourinary:	Incontinence of Urine☐ Bloody urine☐ Burning with urination☐ Kidney Disease☐ Sexual Dysfunction☐
Musculoskeletal:	Pain in: Low back☐ Mid back☐ Upper back☐ Neck☐ Shoulder☐ Arm☐ Elbow☐ Wrist☐ Hand☐ Hip☐ Leg☐ Knee☐ Ankle☐ Heel☐ Foot☐ Weakness☐ Loss of range of motion☐ Muscle pain☐ Spasms☐ Stiffness☐
Neurology:	Numbness☐ Pins and Needles☐ Seizures☐ Blackouts☐ Dizziness☐ Vertigo☐ Impaired concentration☐ Memory loss☐ Headaches☐ Light/Noise sensitivity☐
Psychology:	Depression☐ Anxiety☐ Panic attacks☐ Difficulty sleeping☐ History of Drug/Alcohol Abuse☐
Hematology:	Swollen glands☐ Bleeding problems☐ Bruising☐ Infection☐ Liver Disease☐

_____ **Date**

Ferdinand Formoso, D.O. / Kenneth Powell, D.O. / Alan Miller, M.D.
John Hunt, M.D. / Patrick Burns, D.O. / Manuel Lopez, M.D. / Scott Scimpff, M.D.
Lee Irwin, M.D. / Eli Loch, D.O. / Haitao Zhang, M.D. / Robert Nastasi, M.D.
Christopher Manees, M.D. / Michael Greene, D.O.