

COMPREHENSIVE PAIN CARE CENTER

DATE: _____ REFERRED BY: _____ PHONE: _____ FAX: _____

OFFICE CONTACT: _____ REFERRED TO: _____

PCP _____ PHONE: _____ FAX: _____

LAST NAME: _____ FIRST NAME: _____ PHONE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

SS# _____ DOB: _____ SEX: _____ MARITAL STATUS _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

PATIENT WORK STATUS: _____ PATIENT'S OCCUPATION: _____

PATIENT'S EMPLOYER: _____ ADDRESS: _____ PHONE: _____
FOR W/C

INSURANCE SUBSCRIBER _____ DOB: _____ SUBSCRIBER SS # _____

SUBSCRIBERS EMPLOYER _____ ADDRESS _____ PHONE _____

WORKERS COMPENATION	AUTO	PRIMARY INSURANCE	SECONDARY INSURANCE
CO NAME:	CO. NAME:	CO. NAME	CO. NAME:
ADDRESS FOR BILLING:	ADDRESS:	ADDRESS:	ADDRESS:
ADJ.	PHONE:	PHONE:	PHONE:
NCM:	CLAIM # ADJ.	POLICY/ID:	POLICY/ ID:
PHONE:	DOA:	GROUP:	EFF. DATE:
FAX:	PIP ____ % OF ____ MED PAY ____ % OF ____	EFF. DATE:	
CLAIM #	DED YES NO AMT. MET _____	DED. MET: YES NO	

INSURANCE CALL LOG: (CALL DATE/SPOKE TO/STATUS)

MEDICAL RECORDS/MRI REQUEST FROM: _____ DATE: _____
PATIENTS MUST BRING LIST OF MEDICATIONS, DOSES, AND FREQUENCY WITH THEM TO BE SEEN

REFERRAL COMPLETED _____ APPT. DATE/TIME _____

Please verify the information recorded above and sign below indicating all information is correct. If changes need to be made, please notify the front desk.

Signature

Date

Comprehensive Pain Care of South Florida, Inc

440 State Road 7, Suite 107
Royal Palm Beach, FL 33411
Tel (561) 795-8655 Fax (561) 795-8449

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____ **Social Security Number** _____

SECTION B: To The Patient- Please read the following statements carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Howell R. Goldfarb, M.D.
Address: 440 State Road 7, Suite 107, Royal Palm Beach, FL 33411
Telephone: 561 795-8655 **Fax:** 561 795-8449

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we look in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE

I _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy of Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment activities and healthcare operations.

Signature _____ Date _____

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PATIENT NAME: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

ASSIGNMENT OF INSURANCE BENEFITS

By my signature below, I am authorizing COMPREHENSIVE PAIN CARE OF SOUTH FLORIDA to release protected health information contained in my medical record to my insurance company or third party payer in order to process claims being submitted on my behalf by COMPREHENSIVE PAIN CARE OF SOUTH FLORIDA upon written request from the insurance company or third party payer. Only requested information required to process my claim or to determine coordination of benefits will be forwarded to my insurance company. I hereby irrevocably assign to COMPREHENSIVE PAIN CARE OF SOUTH FLORIDA all payments made by my insurance company or third party payer for medical services rendered to me. I understand I am financially responsible for all charges whether or not covered by my insurance company and I will make prompt payment of any balance remaining upon receipt of a billing statement from COMPREHENSIVE PAIN CARE OF SOUTH FLORIDA.

PATIENT SIGNATURE: _____

DATE: _____

WITNESS: _____

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By Florida Statute 893.13 it is a third degree felony, punishable by up to 5 years in prison and a \$5,000.00 fine if:

1. You do not tell a physician who prescribes you narcotic pain medication that you received narcotic pain medications from another physician since your last visit.
2. You possess or attempt to possess narcotic pain medication by misrepresentation, fraud, forgery, deception, or subterfuge.

By signing this document, I hereby swear under penalty of perjury that I have not been prescribed narcotic pain medication from another physician since my last visit to Comprehensive Pain Care and that I am in full compliance with Florida statute 893-13 as it is outline above.

Patient's Signature: _____

Date: _____

Witness' Signature: _____

COMPREHENSIVE PAIN CARE OF SOUTH FLORIDA
MEDICATION MANAGEMENT AGREEMENT

This agreement between _____, (“Patient”) and Comprehensive Pain Care of South Florida (“Provider”) is for the purpose of establishing between Provider and Patient on clear conditions an agreement between Patient and Provider for the prescription and use of pain controlling medications prescribed by the Provider for the Patient. Provider and Patient agree that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship.

The patient agrees to and accepts the following conditions for the management of pain medication prescribed or provided by the Provider for the Patient:

I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.

I realize that all of the medications have potential side effects and I will have the recommended laboratory studies required to keep the regimen as safe as possible.

I am responsible for my pain medications. I agree to take the medication only as prescribed by the Provider. I understand that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation and respiratory depression and death.

I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal. Withdrawal symptoms 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 24-48 hours after the last dose and can last up to 3 weeks.

I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my medication for a period of time. I agree to use _____ Pharmacy, located at _____, telephone number _____, for all my pain medication. If I change pharmacy for any reason, I agree to notify the Provider at the time I receive a prescription and advise my new pharmacy of my prior pharmacy’s address and telephone number.

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 and jerkiness. These 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 physician of any side effects that continue and/or are severe (i.e. sedation, confusion). I am responsible for notifying my pain physician immediately if I need to visit another physician or emergency room due to pain or if I become pregnant.

I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used my medication for at least four days.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell, or trade my medication for money, goods, or services.

I will not attempt to get pain medication from any other health care provider without telling them I am taking pain medication prescribed by the pain Provider. I understand it is against the law to do so. If my primary care physician is willing to prescribe my medications, the Provider will have to approve the arrangements to make sure there is no duplication. **I will discontinue all previously used pain medications, unless told to continue them.**

I understand I must contact my pain physician before taking other drugs. Medications like Valium or Ativan, sedatives such as Soma, Xanax, Fiorinal, antihistamines like Bendryl, and alcohol may produce profound sedation, respiratory depression, blood pressure drop, and even death when taken with opioids.

During the time my dose is being adjusted, I will be expected to return to the pain office at least once a month or whenever instructed by my pain physician.

I understand that opioid prescriptions will not be mailed. I will pick up my refill prescription at the office every month during scheduled medication maintenance office visits. If I am unable to obtain my prescriptions monthly, I will be responsible for finding a local physician who can take over the writing of my prescriptions with consultations from my pain physician.

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. Refill prescriptions will only be written during my monthly medication maintenance visits to the office. It is my responsibility to call at least two weeks in advance to schedule these appointments.

I understand medication refills will not be written if I “run out early”, “lose a prescription”, or “spill or misplace my medications”. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount 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.

Refills will not be made as an “emergency”, such as on Friday afternoon because I suddenly realize I will “run out tomorrow”. NO prescriptions will be filled on days when there is not a medication maintenance visit.

While physical dependence is expected after long-term use of opioids, signs of addiction (and psychological dependence) shall be interpreted as a need for weaning and detoxification. 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 response.

Addiction is a psychological and behavioral syndrome that is recognized when the patient abuses the drug to obtain mental numbness and euphoria; the patient shows a drug craving behavior or the patient “doctor shops”; the drug is quickly escalated without correlation to pain relief; and/or 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 and the patient will be considered not a candidate for the opioid trial. The patient will be discharged from the practice.

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

If it appears to the physician 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 my physician.

As a rule, prescriptions will be given in advance to accommodate for extended vacations or any other extended period away from home. Otherwise, prescriptions will be written once a month. A 3-day grace period may be given if the prescription ends on a weekend or holiday. Exceptions will not be made for distance traveled to fill prescriptions.

I agree to submit to urine and blood screens at any time as determined by my physician to detect the use of both prescribed and non-prescribed medications.

I authorize the release of any information and medical records by the Provider or his/her designee to other health care providers, my family, my employer, my insurance carrier, or other reimbursing agency. I also authorize any pharmacy to release information regarding my prescriptions. I understand any single violation to the above conditions may result in termination of my opioid medications. I will then be gradually taken off this medication and other therapies will be used or I may also be discharged from the practice.

I _____ have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give consent to participate in the opioid medication therapy.

Patient signature

Date

Witness signature

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PAYMENT REPSONISIBILITY AGREEMENT

I understand by obtaining services form Anesthesiology Consultants of the Palm Beaches (ACPB), DBA Comprehensive Pain Care of South Florida (CPC), I will be responsible for payment at the time of service for any co-payments, co-insurance, deductible or previous balances due upon request. If I have provided adequate insurance information, I understand the claim will be filed with my insurance company as a courtesy and any balances assigned to me by my insurance company will be payable upon request. If my insurance company denies all or part of my services due to termination of coverage, exhausted benefits, or information I have failed to provide to my insurance company for processing of my claim, I will become fully responsible for payment of said services.

I understand if I dispute charges billed to me by either Anesthesiology Consultants of the Palm Beaches or Comprehensive Pain Care of South Florida, I must do so by telephone call the business office at 1-561-795-8655 or in writing within 30 days of receipt of first billing statement received in order for consideration and investigation of the dispute. I understand I am responsible for being pro-active in the resolution process and must communicate with both my insurance company and the physician's office in order to assist with resolving the billed charges and I agree to make payment without delay.

I understand Anesthesiology Consultant of the Palm Beaches, DBA Comprehensive Pain Care of South Florida, can only determine benefits based on information received from my insurance company the day of my visit, however, my insurance does not guarantee payment based on verification of coverage until the claim is received and processed the their office. I will not hold Anesthesiology Consultants of the Palm Beaches or Comprehensive Pain Care of South Florida or it's representatives responsible for misinformation provided by my insurance at the time of my service. If I dispute the results of claims processing by my insurance company, I will settle my account with Anesthesiology Consultants of the Palm Beaches, DBA Comprehensive Pain Care of South Florida, and then contact my insurance company for correction or resolution of the disputed claim(s).

Signature of Patient or legal guardian

Date

Print name of patient

Signature of Witness

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**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I, _____, have received a copy of this office's Notice of Privacy Practices

NAME

SIGNATURE

DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refuses to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other _____