



7964 Summerlin Lake Dr., Fort Myers, FL 33907 • Scheduling: 239-333-1177 • Fax: 239-939-4733

Full Name _____
Address _____
City _____ State _____ Zip _____

Re Appointment scheduled for _____, at _____, with _____
Please arrive 15 minutes prior to scheduled time for registration process.

Dear _____:

It is our pleasure to welcome you to Pain Management Consultants of Southwest Florida, PL.

In order to assure that your first visit with us goes smoothly, we have enclosed forms to be completed prior to your appointment. These forms are necessary to assist in your care. Mailing this packet to you in advance affords you the opportunity of filling it out at home at your convenience rather than doing so in the office where all the information needed may not be as accessible. This will save you time in the office, streamline the process and avoid the inconvenience of filling out these forms at the last minute. **To expedite the registration process, we kindly ask that you bring the completed forms to our office at least one day prior to your scheduled visit. This will insure that all information is entered in our computer system prior to your visit and will expedite your registration process and afford our staff the necessary time to request additional records as needed. We understand that this may be an inconvenience, however, it is our goal to insure that you receive the highest level of care. For your convenience, our office has an after-hours mail drop to the right or our front door.** If you are unable to return the packet prior to the day of your visit, kindly arrive 30 minutes prior to your scheduled appointment.

When you arrive for your initial visit and are being checked in, a member of our staff will ask for your insurance card(s) and Driver's License to scan, take your photo and have you electronically sign our HIPPA Privacy Compliance Notice. This information is collected to protect you as the patient from fraudulent activity.

Please be sure to bring the completed packet to our office at least one day prior to your scheduled appointment along with any recent (within the last 18 months) MRI, CT Scan (Cat Scan), X-ray or Physical Therapy reports. If you do not have copies, of your reports, please contact the rendering physician or facility and have them faxed to our office at 1-877-343-6571 prior to your appointment.

Again, we welcome you to our practice. If you have access to a computer, please visit our website at www.flpaincenters.com to find out how Pain Management Consultants of Southwest Florida, PL can help you. Our aim is excellence in patient care and to assist our patients in any way we can.

Sincerely,
Scheduling Staff for Pain Management Consultants

Enclosures
Form: 04/14/2018



PATIENT DEMOGRAPHIC INFORMATION

First Name	Middle Name	Last Name	E-mail Address
SSN: _____ DOB: _____ Drivers License #: _____			
Address		City, State	Zip Code
Northern Address		City, State	Zip Code
Patient Cell Phone: _____		Preferred Contact Phone # _____	
Patient Occupation: _____		Employer Phone: _____	
Employer Address: _____			

EMERGENCY CONTACT INFORMATION

Spouse Name: _____ Spouse DOB: _____

Spouse Cell Phone: _____ Spouse Work Phone: _____

Spouse Employer & Address: _____

Other Emergency Contact & Relationship: _____

HEALTH INSURANCE INFORMATION

Primary Insurance Name: _____

Insurance Subscriber _____ Relation to Subscriber: _____

Policy Number: _____ Group # _____

Claims Mailing Address: _____

Phone Number: _____

Secondary Insurance name: _____

Insurance Subscriber _____ Relation to Subscriber: _____

Policy Number: _____ Group # _____

Claims Mailing Address: _____

Phone Number: _____



PLEASE BRING THE FOLLOWING TO YOUR APPOINTMENT ON: _____

- ALL PRESCRIPTION MEDICATION IN THEIR ORIGINAL CONTAINERS • INSURANCE CARD • ID CARD
- IMAGING FILMS/REPORTS (MRIs, X-RAYS, CT SCANS, PHYSICAL THERAPY REPORTS ETC.)

PATIENT HEALTH HISTORY - _____, Chart # _____

For us to obtain a complete medical history, please fill out every item as this information is very important.

Full Name: _____ DOB: _____ Male _____ Female _____

Social Security Number: _____

Primary Physician: _____ Primary MD Phone Number: _____

Pharmacy name & address: _____ Pharmacy Phone Number: _____

Your Insurance Company's preferred Lab & Phone Number: _____

Is This a Work Comp Case: No Yes Date of Injury: _____

Recent Auto Accident: NO Yes (IF YES, MUST COMPLETE AUTO DISCLOSURE FORM) Date of Accident: _____

Past Injuries/falls – Please list and provide dates: _____

Current Medications – Are you taking ANY medications now including prescriptions, over-the-counter or herbal medication

NO YES If yes, please list below and include dosages. Bring all medications with you in their original bottles.

MEDICATION NAME	DOSAGE	HOW OFTEN TAKEN

Medication Allergies – Are you allergic to ANY medications? No Yes (If yes, please list:)

MEDICATION	TYPE OF REACTION

Please check if you are allergic to the following: IODINE SHELLFISH LATEX

Surgeries – Have you had Bone, Joint, or Muscle surgeries? NO YES (If yes, please list:)

TYPE OF SURGERY/PROCEDURE	DATE OF SURGERY/PROCEDURE



Please list any specialists that have previously evaluated you for your pain:

Neurologist: _____ Pain Physician _____
 Neurosurgeon: _____ Psychiatrist: _____
 Orthopedic Surgeon _____ Rheumatologist: _____
 Osteopathic Physician: _____ Rehab/Physiatrist: _____

TESTS: If you have had any of the following, please describe where, when and the results of your tests.
Please bring a copy of the films/reports with you.

TEST	YES	NO	DATE	WHERE WAS IT DONE/FINDINGS
X-Rays				
CT/MRI				
EMG/NCS (Nerve Conduction Studies)				
Myelogram				
Discogram				

TREATMENTS: If you have had any of the following, please list when, where and if it was helpful.
Please bring a copy of the reports with you.

Treatment	When	Where did you have the treatment	Results of the treatment(s)/was the treatment helpful?
Acupuncture			
Alternative/Herbal			
Massage therapy			
Braces/splints/assistive devices			
Chiropractor			
Heat/Ice therapy			
Injection therapy			
Nerve blocks			
Over the counter meds			
Prescription meds			
Occupational therapy			
Physical therapy			
TENS Unit			
Traction			
Biofeedback			
Counseling			
Other			

_____, Chart # _____

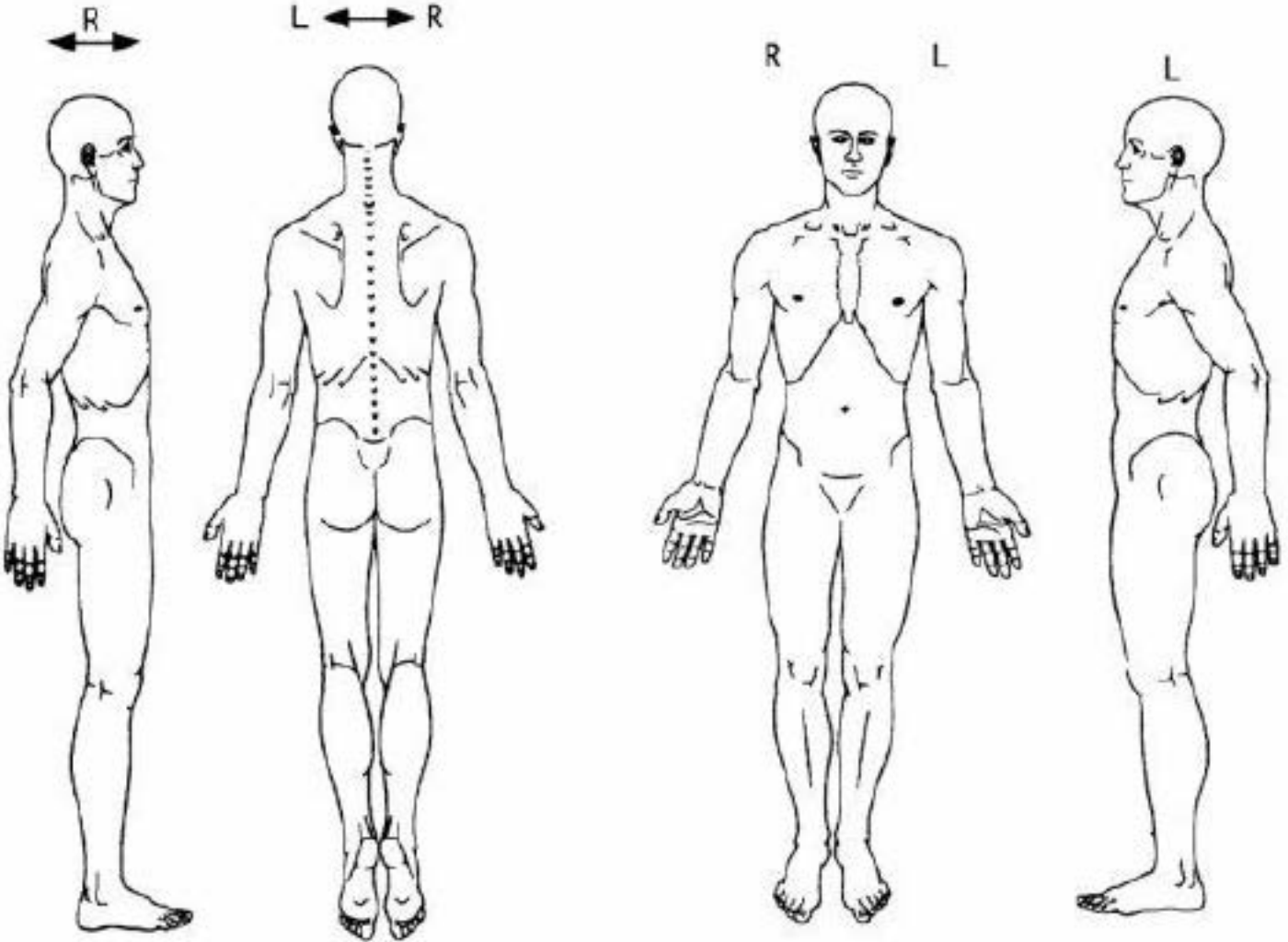


What is the MAIN reason you are here today to see the Physician:

Please circle the types of pain you are having: Burning Stabbing Aching Sharp

How long have you experienced this pain? _____ Hours _____ Days _____ Months _____ Years

Please mark the body below in the location(s) you are having pain:



Patient/Legal Guardian Signature

Date

Admitted by:-----

_____, Chart # _____

Patient Health History Page 3 of 3

Form: 04/14/2018



AUTHORIZATION FOR USE/DISCLOSURES OF PROTECTED HEALTH INFORMATION

Patient Name: _____, Chart # _____:

Description of information to be used/disclosed:

Release of medical information and/or billing information

Person(s) or class of persons authorized to use/discole the information:

Pain Management Consultant of Southwest Florida, PL

****Family member or friend to whom the information may be used or disclosed:

Purpose for the use or disclosure:

Continuation of treatment and Release of Medical Information and or Billing Information

The information used or disclosed pursuant to this authorization:

_____ May / _____ May not / include information related to HIV/AIDS.

_____ May / _____ May not / include information related to mental health

_____ May / _____ May not / include information related to substance abuse or alcoholism

Expiration: This authorization (check x) applicable box

DOES NOT EXPIRE

Expires on _____ / _____ / _____

Expires on the occurrence of (describe expiration event):

Important Notice: You have the right to revoke this authorization. Your revocation must be in writing to:
Pain Management Consultants of Southwest Florida, P.L.
7964 Summerlin Lakes Dr., Fort Myers, FL 33907

We will not condition the provision of health care services on whether you sign this authorization, unless your authorization is needed to provide information relating to health care-related research, or the health care is needed to provide health information to a third party.

The information used or disclosed pursuant to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by applicable law or regulations.

You have a right to a copy of the signed authorization.

Signature Date

_____, Chart # _____



CONTROLLED SUBSTANCE AGREEMENT

_____, Chart # _____

To be prescribed opioid medications or other controlled substances, you must agree to the following statements:

- I understand that the goal of using these medications is to reduce the intensity of my pain, but that total pain relief is unlikely.
- I understand that the use of opioid medications is associated with a number of risks, some of which are outlined below in Part I of this document.
- I understand that I have a responsibility to protect myself and others from harm, and that taking the medications outside the manner in which they are prescribed can lead to dependence/abuse/death. I will not operate automobile or other dangerous equipment if there is any question as to whether my judgment, reflexes or coordination are impaired by my medications.
- I will not use any illegal drugs (such as cocaine, speed, PCP, etc.)
- I will not share or trade my medications with anyone else.
- I will not sell my medications.
- I will not obtain prescriptions for controlled substances (opioids, sedatives, sleeping pills, etc.) from another doctor or clinic.
- I will discontinue all pain medications or other controlled substances prescribed by another physician or clinic unless specifically told to do otherwise by Drs Acosta, Mahaney, Micovic, Shuster, Replogle, Martinez, or Greschler.
- I will keep my medication in a safe place, away from children, friends or pets. I understand that accidental ingestion of these medications by anyone else could be fatal.
- I understand that it is my responsibility to take my medications as prescribed. If I run out of my medications early, I realize that I will be without my medications until the next scheduled visit and I will most likely go through withdrawal, which can be very unpleasant.
- I agree to obtain all my medications from the same pharmacy.
- If I need to change my pharmacy, I agree to notify this office and have my old pharmacy forward my records to the new pharmacy.
- I agree to have my pharmacy confirm all my current and past prescription fills with this office.

_____, Chart # _____

Controlled Substance Agreement/Consent

Page 1 of 2



LABORATORY DRUG SCREENING CONSENT

I, _____, request that payment of authorized benefits is made on my behalf to the laboratory LabCorp, Quest Diagnostics or Lee Memorial Health System. I authorize any holder of medical or other information about me to be released to the insurance company, LabCorp, Quest Diagnostics or Lee Memorial Health System, HCFA, and their agent's information to determine these benefits or any benefits for related services. I understand that I am financially responsible for all services performed by the above mentioned laboratory, whether or not they are paid by insurance. I hereby authorize LabCorp, Quest Diagnostics, or Lee Memorial Health System to release the minimum necessary private health information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I the undersigned, authorize LabCorp, Quest Diagnostics or Lee Memorial Health System or any agents thereof, to notify me by telephone, answering machine, mail, etc., regarding billing and collection information.

PATIENT CONSENT AND AGREEMENT FOR OFF-LABEL PAIN TREATMENT

REASON FOR THIS CONSENT AND AGREEMENT: All prescription drugs in the United States have a label approved by the United States Food and Drug Administration. This label provides an indication and dosing for the drug, but neither patient nor physician is legally bound to follow them. Pain treatment is virtually impossible unless the physician prescribes one or more medications that are not intended for a specific indication or dosage not listed on the drug label.

CONSENT AND AGREEMENT: The undersigned acknowledges that pain control cannot e achieved without off-label use of one or more drugs. The undersigned furthermore accepts all risks and complications that may occur from off-label use, since the benefit of pain control cannot otherwise be achieved. The undersigned agrees to waive all liability against the physician and clinic that provide pain treatment.

SPECIFIC OFF-LABEL USES: Any and all off-label use of drugs are covered by this consent including, but not limited to the following;

1. The uses of antidepressants, anti-epileptics, muscle relaxants, tranquilizers, and nutraceuticals for pain relief.
2. The administration of sustained release preparations of morphine and oxycodone used more frequently than every 12 hours.
3. Maximal dosage of opioids is to be determined by therapeutic effect rather than any arbitrary published maximal dosing level.
4. Topical use of morphine, methadone, naloxone, carisoprodol, and ketamine.

I, the undersigned, agree to the above and release the physician and clinic of all liability for off-label use of drugs.

PERMISSION TO PHOTOGRAPH

I agree to allow Pain Management Consultants of Southwest Florida, P.L. to digitally reproduce my image into my file as a means of identification. I understand that this is for my personal protection so that others may not impersonate me.

By signing this consent form, I declare that I have read the above consents: Laboratory Drug Screening, Off-Label Pain Treatment and Permission to Photograph. Furthermore, by signing below, I consent to the items listed on this form.

Patient Signature

Date

_____, Chart # _____



PATIENT INFORMATION AND FINANCIAL RESPONSIBILITY POLICY

WELCOME to our practice. Our ultimate goal is to treat the source of your pain when possible to minimize its impact on your life and help you return to a more functional and productive lifestyle. The following statement is to educate you with information relevant to our office policies, your treatment and financial responsibility. We ask that all patients read and sign our Policy Statement prior to seeing a medical care provider. If you have any questions or concerns about our policies, please do not hesitate to ask our business office personnel.

TREATMENT PLAN: Your Physician will discuss your treatment plan in detail. Patients are encouraged to participate in the progress of their treatment. Increasing your knowledge of your diagnosis and the treatment received will aid in learning how to cope with your pain and improve your day to day activities. A clinical chart is maintained with Physician dictation describing your diagnosis, treatment plan, the progress with treatment, dates of and fees for our services. Copies of Physician's dictation are available for a small fee.

PRESCRIPTION ISSUES: All medication refill issues will be addressed at scheduled appointments. Medications will not be dispensed between appointments. Patients experiencing reactions to medications and/or questions regarding prescribed medications may leave a message on the Nurse's answering line. All messages received are reviewed by our Nursing staff and addressed with Physicians. Phone messages are returned during or by the end of regular clinic hours the day they are received.

APPOINTMENTS: It is important that you arrive on time for your scheduled appointment. Failure to arrive on time may result in your appointment being rescheduled and a fee assessed. In the event of an emergency, we advise you to call 911 or go to the nearest emergency facility. Scheduling changes may be made by calling (239) 333-1177. If you are unable to meet your appointment, we ask that you call and provide us with 24 hours notice, failure to provide 24 hours notice, will result in assessed fees as outlined below.

- \$50.00 for failure to provide 24 hour notice resulting in a missed non/procedure appointment.
- \$50.00 for not arriving on time for a non/procedure appointment, resulting in a rescheduled appointment.
- \$75.00 for failure to provide 24 hour notice resulting in a missed procedure appointment.
- \$75.00 for not arriving on time for a scheduled procedure, resulting in a rescheduled procedure.
- Pain Management Consultants of Southwest Florida, P.A. reserves the right to adjust these fees from time to time.

FEES: We accept assignment with most major insurance companies and participating provider plans. However, you must understand that regardless of your medical insurance coverage, You are responsible for payment of your account and are expected to pay your copay and any patient level balance due at the time of each visit.

1. Fees for services, along with unpaid deductibles and co-payments, are due at the time of service and will be collected at check in. We do not accept post dated checks. Failure to pay your copayment at time of service will result in a \$25.00 fee being added to your account.
2. Your insurance policy is a contract between you, your insurance company and or your employer. We are not a party to that contract. Therefore, it is your ultimate responsibility to insure that your claims are paid. If your insurance company does not pay your balance in full within 30 days, we ask that you work with our billing staff by calling your insurance company to facilitate payment. Our staff will work with you to resolve any claim payment issues.

_____, Chart # _____

Patient Information/Financial Policy Agreement

Page 1 of 2



- 3. Returned checks will be subject to \$35.00 collection charge and may result in our office requiring payment by money order, cash or credit card for future visits.
- 4. Unpaid balances over 90 days may be subject to collections via Small Claims Court, attorney, and/or collection agency with applicable collection fees. All collection fees are the responsibility of the patient.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate with our Business Office any such problems so that we can assist you in the management of your account.

INSURANCE

Private/Government Insurance: As a courtesy, our billing office will file a claim with your private or government carrier. You are responsible for the following:

- Providing our office with accurate and correct insurance information and notifying our billing office of any changes to your insurance coverage prior to your visits. Failure to notify us in advance of any changes to your insurance coverage will require that we bill you for payment of our charges.
- If your insurance is unable to process and pay your claim due to missing information from you, you will be responsible for payment of the charges.

Workers Compensation: We will file an insurance claim with your employer’s workers compensation carrier. If your employer denies your claim, and you have provided us with health insurance information, we will file your claim to your health insurance carrier. Involvement of legal counsel will not mitigate your responsibility for your charges. You are ultimately responsible for payment of services provided to you.

Auto Insurance: We will file a claim to your auto insurance carrier. Once benefits have been exhausted, we will then bill your health insurance. If you do not have health insurance coverage, you will be responsible for unpaid balances and any future treatment. Involvement of legal counsel will not mitigate your responsibility for payment as we do not accept letters of protection from attorneys.

THANK YOU. We are committed to providing you with the highest quality health care and hope you find your visit beneficial and our staff friendly and compassionate.

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to Pain Management Consultants of Southwest Florida, P.L., the medical and/or surgical benefits I am entitled from my insurance company(s) and/or Medicare. This authorization is in effect for all future claims until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above Policies as outlined in this document. I understand that I am financially responsible for all charges incurred for my medical treatment including laboratory test charges and x-ray charges incurred on my behalf for care rendered. These charges will be in addition to charges for the care that the personnel of Pain Management Consultants of SW Florida, P.L., provide. I further understand I may receive separate bills for each of these services, and that I am financially responsible for any services not covered by third party payors, including but not limited to my health insurance and/or managed care plans. I have had the opportunity to ask and have my questions answered to my satisfaction.

PATIENT ACKNOWLEDGEMENT: I have been provided with a copy of this notice. Failure to read this notice does not negate my responsibilities as outlined above.

Patient/Legal Guardian Signature Date

-----, Chart # -----



April 14th, 2018

To Our Valued Patients,

The practice of Pain Management has been forced to undergo some changes over the past year. Due to the increasing problems of controlled substance abuse and diversion, the state of Florida has seen a tremendous increase in prescription-drug related deaths. Along with this increase, the rate of abuse has also increased 10-fold.

The State of Florida has passed a new law (Senate Bill 2722) to attempt to control prescription drug abuse. In conjunction with this law, the Florida Board of Medicine has implemented new guidelines to monitor pain management patients and clinics. These new laws and guidelines went into effect October 1, 2010. Our practice fully supports these guidelines and will abide by them. This is being done for the welfare of the citizens of our community and state.

Please be aware that these new guidelines include:

1. More frequent urine drug testing
2. Restrictions on the number of prescriptions that physicians may write
3. No phoning- in to pharmacies of controlled substances
4. A face-to-face encounter for every controlled substance prescription written
5. Psychological evaluations may be necessary for ongoing care in certain patients
6. Appointments for controlled substance prescriptions will be more frequent

It is imperative that these measures be implemented to insure that we physicians may continue to care for our patients. We understand your potential frustration with these guidelines. There are many more guidelines that this practice must follow to meet the requirements of the Department of Health.

If you have any questions, we will be happy to sit down and discuss them with you. We thank you in advance for your understanding.

Sincerely,

Gene D. Mahaney, MD

Gilberto Acosta, MD

Velimir Micovic, MD

Adam M. Shuster, DO

Timothy D. Replogle, MD

Michael D. Martinez, MD

David S. Greschler, MD

Form: 04/14/2018



*****COMPLETE THIS FORM IF YOU ARE BEING TREATED FOR AN AUTO ACCIDENT*****

**Standard Dis-closure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided**

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were actually rendered. This means that those services have already been provided

- 2. I have the right and the duty to confirm that the services have already been provided.
- 3. I was not solicited by any person to seek any services from the medical provider of the services described above.
- 4. The medical provider has explained the services to me for which payment is being claimed.
- 5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to \$500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name (PRINT or TYPE)	Signature	Date
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The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

- A. I have not solicited or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.
- B. The treatment or services rendered were explained to the insured person, or his or her guardian, sufficiently for that person to sign this form with informed consent.
- C. The accompanying statement or bill is properly completed in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to truthfully, accurately, and in a substantially complete manner.
- D. The coding of procedures on the accompanying statement or bill is proper. This means that no service has been up-coded, unbundled, or constitutes an invalid or not medically necessary diagnostic test as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable (Signature by his/ her own hand):

Name (PRINT or TYPE)	Signature	Date
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Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.



7964 Summerlin Lakes Dr., Fort Myers, FL 33907

Phone: 239-333-1177 Fax: 1-877-343-6571 www.flpaincenters.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
PLEASE FAX MEDICAL RECORDS TO: 1-877-343-6571

To:

I hereby authorize the above named Facility/Physician to release my medical records to Pain Management Consultants of SW Florida, P.L. I also give permission for the following to be disclosed: acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV); behavioral health services/psychiatric care; treatment for alcohol and/or drug abuse.

Please send the following specific information:

- 1) Office visit notes from the Patient's last two appointments
- 2) Diagnostic Reports
- 3) MRI/CT or X-Ray6 reports
- 4) Medication Flow Sheet
- 5) Other_____

The medical facility, its employees, officers, and physicians are released from legal responsibility or liability for the release of the medical record to the extent indicated and authorized herein. I understand that the medical record maintained by the doctor may contain medical and administrative information from other healthcare providers.

Patient Signature Date

Patient Name: _____, Patient's DOB: _____

PMC Chart # _____

If not signed by the Patient, Relationship to Patient