Appointment Date:_____ Arrival Time:_____

Doctor:_____ Location:_____

WITHOUT YOUR PHOTO ID YOU WILL NOT BE TREATED. IF YOUR ID IS NOT A VALID FLORIDA STATE LICENSE OR IDENTIFICATION CARD YOU WILL ONLY BE ELIGIBLE FOR INJECTIONS.

IF YOU ARE UNABLE TO COMPLETE THIS PAPERWORK YOU MUST BRING SOMEONE WITH YOU TO YOUR APPOINTMENT THAT CAN ASSIST YOU WITH THIS PACKET.

NO SHOW POLICY – To assure that all of our patients have access to care when needed by maximizing the utilization of available appointments, you (the patient) are required to cancel your scheduled appointment with appropriate prior notice (24 hours.) Failure to cancel your appointment without 24-hour notice is considered a "No Show." If you have two "No Show" occurrences, a $50.00 penalty fee will be charged to your account. You will be required to pay this fee prior to being seen for another appointment.

Print Patient Name: _____ Date of Birth: _____

Patient Signature:_____Today's Date:_____

IF YOU HAVE AN HMO OR AN INSURANCE PLAN THAT REQUIRES AUTHORIZATION FOR PROCEDURES – You will ***NOT*** receive any injections at your first visit. Your insurance requires authorization and in order to obtain that authorization proper documentation of the initial visit must be done.

IF YOU DO NOT HAVE AN HMO – **Your initial appointment is a consultation only**. If you were referred for an injection it will be scheduled at a later date.

SOME INSURANCES – Will only cover injections if they are performed in a surgery center. If this is the case your injection will be scheduled for a later date during your initial appointment.

VERY IMPORTANT!

WHEN YOU RECEIVE THIS PACKET IT IS VERY IMPORTANT THAT YOU CALL OUR OFFICE AND LET US KNOW YOU HAVE YOUR PAPERWORK. IF YOUR NEW PT PACKET IS NOT COMPLETED AT THE TIME OF YOUR APPOINTMENT, YOUR APPOINTMENT WILL BE RESCHEDULED.

BOCA RATON	PALM BEACH GARDENS	OKEECHOBEE	Port St. Lucie	STUART	TRADITION
950 Glades Road, Suite 5A	4510 Donald Ross Rd.	208 NE 19TH Drive	(US 1 LOCATION)	111 SE Osceola Street	10050 SW Innovation Way
Boca Raton, FL 33431	Donald Ross Village	Okeechobee, FL 34972	10244 us Highway 1	Stuart, FL 34994	Suite 104
Tel: 561-939-5500	Palm Beach Gardens, FL 33418	Tel: 863-357-7246	Port St. Lucie, FL 34952	Tel: 772-223-2115	Port St. Lucie, FL 34987
Fax: 561-939-0555	Tel: 561-253-3777	Fax: 863-357-7247	Tel: 772-337-7676	Fax: 772-223-9238	Tel: 772-345-5588
	Fax: 561-253-3779		Fax: 772-337-7876		Fax: 772-337-7876

POLICY 3.3

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information. Information to be used or disclosed (must be identified in a specific and meaningful fashion); and purpose of use and disclosure: MRI, CT, XRAY, and Lab reports; last H&P, evaluation, and office notes for the purposes of pain management evaluation and treatment; other:

- The name or other specific identification of the person(s), or class of persons, authorized to receive the requested use or disclosure (written records) **Please print name(s) of authorized individuals and relation to the patient:**
- _____

_____**(Initials)** I hereby authorize Resolute Pain Solutions to verbally disclose my health information to:

(Please print name(s) of authorized individuals and relation to the patient)

_____

_____**(Initials)** I hereby authorize Resolute Pain Solutions to verbally disclose my health information on my home answering machine/voicemail on phone/cell phone.

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however, that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

SPECIAL SITUATIONS THAT DO NOT REQUIRE YOUR INFORMATION CONSENT OR AUTHORIZATION

We will disclose health information about you without your permission when required to do so by federal, state or local law. The following disclosures are permitted by law without any oral or written permission from you, although this list is not intended to be all-inclusive:

Organ and Tissue Donation - If you are an organ donor, we may release health 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 health information about you as required by military command authorities.

Worker's Compensation - We may release health information about you for worker's compensation or similar programs if you have a work related injury. These programs provide benefits for work related injuries.

Acknowledgement of receipt of Resolute Anesthesia and Pain Solutions Patient Privacy Notice (HITECH compliant) and ACHA bill of rights.

Print Patient Name: _____Date of Birth: _____

Patient/Guardian/Parent Signature: _____ Today's Date:_____

Relationship:_____

Print Name:_____ Date of Birth:_____ Age:_____

Sex:_____ Height:_____ Weight:_____ Home Phone:_____Cell Phone:_____

Work Phone: _____ Email Address:_____

Primary Care Physician: _____ PCP Phone #_____

Referring Physician:_____ Pharmacy Name: _____

Pharmacy Phone:_____ Pharmacy Address:_____

PAIN QUESTIONNAIRE

1. How did you hear about us? ☐Physician_____☐Patient_____☐Internet ☐Advertisement
2. Do you live with anyone? (children in the home, caregiver, assisted living) Yes or No If Yes, Who? _____
3. Tell us, in your own words, **where** your pain is located? _____
4. **How** did your pain begin? _____
5. **When** did your pain first start?_____
6. **From a scale of 1-10** (1=no pain at all; 10= the worst pain of your life)
   What number would you give your pain today?_____
   What number best describes how your pain interfered with your enjoyment of life in the past week?_____
   What number best describes how your pain interfered with your general activity in the past week? _____
7. How is your appetite? ☐Normal ☐Decreased ☐Increased
8. Are you able to bathe? ☐Normal ☐Restricted ☐Sponge Bath Only
9. Are you able to use the toilet? ☐Yes ☐No ☐Bed Pan or Urinal
10. Can you get up from your bed or chair? ☐Yes ☐No ☐Yes, with great difficulty
11. Can you get yourself dressed for the day? ☐Yes ☐No ☐Yes with assistance from another person
12. Check all of the following activities that make your pain **BETTER**?
    ☐ Sitting ☐Standing ☐Walking ☐Knees flexed
    ☐ Lying Flat ☐Lying prone (belly down) ☐Bending/stooping
    ☐ During the morning ☐During the afternoon
13. Check all of the following activities that make your pain **WORSE**?
    ☐Sitting ☐Standing ☐Walking ☐Knees flexed
    ☐Lying Flat ☐Lying prone (belly down) ☐Bending/stooping
    ☐During the morning ☐During the afternoon
14. Is there any associated weakness or numbness with your pain? ☐Yes ☐No
    If yes, how many hours of sleep are you getting per night? _____
15. Have you ever had a history of drug or alcohol abuse? ☐Yes ☐No
16. Name of Narcotic/Alcohol Treatment Programs or NONE / NOT APPLICABLE _____
17. Have you ever thought of harming yourself or others? ☐ Yes ☐ No
18. Name of Mental Health Facility or Physician:_____

MEDICAL HISTORY

1. List all drug and non-drug substances that you are allergic to: _____

2. Check all of the following medical problems yourself, mother, father or siblings are currently or have ever been treated for.
   Y= you M=mother F=father S=sibling

Y M F S	Y M F S	Y M F S	Y M F S
☐ ☐ ☐ ☐Cataract	☐ ☐ ☐ ☐Diverticulitis	☐ ☐ ☐ ☐Seizures	☐ ☐ ☐ ☐Arrhythmia
☐ ☐ ☐ ☐Glaucoma	☐ ☐ ☐ ☐Hiatal Hernia	☐ ☐ ☐ ☐Stroke	☐ ☐ ☐ ☐Heart Disease
☐ ☐ ☐ ☐Ear/Nasal Problems	☐ ☐ ☐ ☐Stomach Ulcer	☐ ☐ ☐ ☐Alzheimer's Disease	☐ ☐ ☐ ☐Mitral Valve Prolapse
☐ ☐ ☐ ☐Hearing Problems	☐ ☐ ☐ ☐Prostate Problems	☐ ☐ ☐ ☐Parkinson's Disease	☐ ☐ ☐ ☐Aneurysm
☐ ☐ ☐ ☐Headache	☐ ☐ ☐ ☐Diabetes	☐ ☐ ☐ ☐Emphysema/COPD	☐ ☐ ☐ ☐Asthma
☐ ☐ ☐ ☐High Blood Pressure	☐ ☐ ☐ ☐Heart Attack/Angina	☐ ☐ ☐ ☐Liver Disease	☐ ☐ ☐ ☐Kidney Disease
☐ ☐ ☐ ☐Bowel Problems	☐ ☐ ☐ ☐Bladder Problems	☐ ☐ ☐ ☐Congestive Heart Failure	☐ ☐ ☐ ☐HIV/AIDS

3. Mother is: ☐Living and well ☐Living, health problems ☐Living, unknown health history ☐Deceased

4. Father is: ☐Living and well ☐Living, health problems ☐Living, unknown health history ☐Deceased

5. List all of your previous major surgeries and dates: A._____ B. _____

   C. _____ D. _____ E. _____ F. _____

6. List any hospitalizations and dates: A._____ B. _____

   C._____ D. _____ E. _____ F. _____

7. Check all of the symptoms you are currently experiencing?

☐ Weight loss	☐Painful urination	☐Anxiety/depression	☐Fever, night sweats, chills
☐Fainting	☐ Urinating frequently	☐Tendency to bleed	☐Change in bowel habits
☐Dizzy spells	☐Retention of urine	☐ Chest pain	☐ Peptic Ulcers
☐ Palpitations	☐ Muscle pain	☐ Shortness of breath	☐Nausea or vomiting
☐ Epilepsy (seizures)	☐ Muscle weakness	☐ Swelling of ankles	

8.Are you working? ☐Full time ☐Part time ☐Not working/limited ☐Workers' Comp ☐Litigation involvement ☐Retired

9.What type of work did you or do you perform? _____

10.Smoking History (circle answer) CURRENT SMOKER FORMER SMOKER NONSMOKER

If a current smoker, how many cigarettes do you smoke a day?_____ Do you use other tobacco products? ☐ Yes ☐No

11. Have you had a drink containing alcohol in the last year? ☐Yes ☐No If yes, how often do you have a drink containing alcohol?

_____

12. Could you be pregnant? ☐Yes ☐No

13. Do you have any of the following…… (Please check yes or no)

Family history of alcohol abuse?	☐ Yes	☐ No
Family history of illegal drug abuse?	☐ Yes	☐ No
Family history of prescription drug abuse?	☐ Yes	☐ No
Personal history of alcohol abuse?	☐ Yes	☐ No
Personal history of illegal drugs?	☐ Yes	☐ No
Personal history of prescription drug abuse?	☐ Yes	☐ No
History of preadolescent sexual abuse?	☐ Yes	☐ No
Personal History of ADD, OCD, Bipolar or Schizophrenia?	☐ Yes	☐ No
Personal History of Depression?	☐ Yes	☐ No

Please list all medications you are currently taking (include aspirin, ibuprofen, vitamin E, herbal remedies)

	Name of Drug	Dose (mg and times per day)	Reason
1.			
2.			
3.			
4.			
5.			
6.			

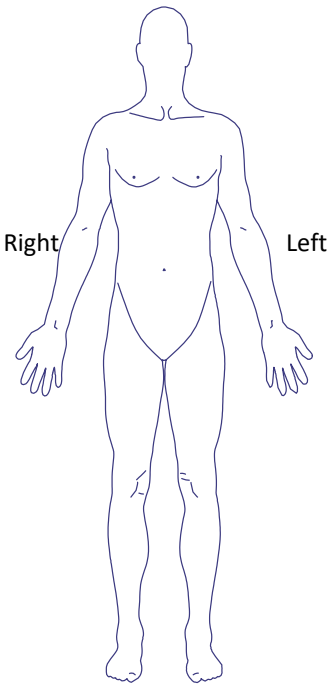
Please CIRCLE YES OR NO regarding the treatments you are currently or have previously received for your pain.

(If you answer yes, please tell us when, for how long and percentage of relief)

1. Physical Therapy	Yes No	When (month/year):_____	For How Long:_____weeks/months	% of relief_____%
2. Massage Therapy	Yes No	When (month/year):_____	For How Long:_____weeks/months	% of relief_____%
3. Chiropractor	Yes No	When (month/year):_____	For How Long:_____weeks/months	% of relief_____%
4. TENS Unit	Yes No	When (month/year):_____	For How Long:_____weeks/months	% of relief_____%
5. Epidural Injection	Yes No	When (month/year):_____	For How Long:_____weeks/months	% of relief_____%
6. Facet Injection	Yes No	When (month/year):_____	For How Long:_____weeks/months	% of relief_____%
7. Spine Surgery	Yes No	When (month/year):_____	For How Long:_____weeks/months	% of relief_____%
8. Pain Medication	Yes No	When (month/year):_____	For How Long:_____weeks/months	% of relief_____%
9. Hypnosis	Yes No	When (month/year):_____	For How Long:_____weeks/months	% of relief_____%
10. Biofeedback	Yes No	When (month/year):_____	For How Long:_____weeks/months	% of relief_____%
11. Home Exercise Program	Yes No	When (month/year):_____	For How Long:_____weeks/months	% of relief_____%
12. Hot/Cold Packs Yes No	13. Bed Rest Yes No		14. Herbal Medicine Yes No	Any Relief?_____

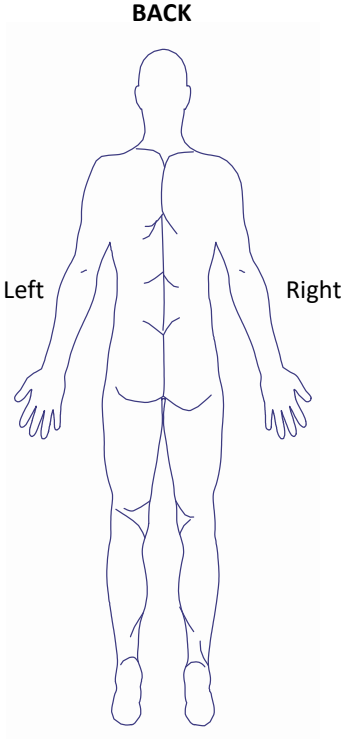
Please shade in the areas on the diagrams where your pain is located and circle the four words that best describe your pain.

FRONT



ACHING	NUMBING
ANNOYING	RADIATING
BRIEF	SEVERE
BURNING	SHARP
COLDNESS	SHOOTING
CONSTANT	SORENESS
CRAMPING	STABBING
DULL	STINGING
EXCRUCIATING	TIGHT
HEAVY	TINGLING
HOTNESS	TRANSIENT
INTENSE	UNBEARABLE

BACK



Print Patient Name: _____ Date of Birth:_____

Patient Signature:_____ Todays Date:_____

PAIN MANAGEMENT CONTROLLED SUBSTANCE ACKNOWLEDGEMENT AND AGREEMENT/ INTRACTIBLE PAIN & DIVERSION

The purpose of this agreement is to ensure that the patient has given accurate information upon which the doctor can rely in implementing a pain management program. It is also to prevent misunderstandings about certain medications you will be taking for pain management. This is to help both you and your physician comply with the law regarding controlled pharmaceuticals.

PLEASE READ AND INITIAL THE FOLLOWING:

_____ I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

_____ I understand that if I break this agreement, my doctor will stop prescribing these pain-control medications, I will be discharged from my doctor's care, and I may be criminally prosecuted. In this case, my doctor may taper off the medication over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment program may be recommended.

_____I will communicate fully with my doctor and staff about the character and intensity of my pain, the effects of the pain on my daily life, and how well my medicine is helping to relieve my pain

_____I will NOT use any illegal controlled substance, illicit drug or any other medication prescribed to anyone other than myself.

_____ I will not share, sell or trade my medication with anyone.

_____ I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti- anxiety medicines from any other doctor, unless coordinated with this office.

_____ I will safeguard my medicine from loss or theft. I understand that lost or stolen medication will not be replaced.

_____ I agree that refills of my medication will only be available during my regularly scheduled office visits. I understand that it is my responsibility to make and keep timely appointments. Prescriptions will not be phones in or picked up outside of these visits. Refills will not be available during evening, weekends or holidays.

_____ I authorize the doctor, facility and pharmacy to cooperate fully with any city, county, state or federal law enforcement agencies in the investigation of any possible misuse, sale or other diversion of my medications.

_____ I authorize my doctor to provide a copy of this agreement to my pharmacy, primary care provider and referring physician. I agree to waive any applicable privilege of right of privacy or confidentiality with respect to these authorizations.

_____ I agree that I will submit to blood, urine or saliva testing (at my own expense if applicable) if requested by my doctor to determine my compliance with my program of pain control medication.

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

_____ I will bring all unused pain medication to every office visit.

_____I understand that my pain medications have the potential to impair my judgement and caution should be used when driving or operation heavy machinery.

_____ I understand that alcohol may potentiate the effects and duration of my medications. I acknowledge that I have been advised to avoid alcohol consumption.

_____ I have fully been informed of the psychological dependence (addiction) of a controlled substance.

_____ I fully understand the behavioral effects of medications and agree to maintain appropriate behavior at all times with my clinicians and support staff. I will notify clinicians for assistance as needed for concerns regarding side effects. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the same effect of pain control, and i do know t6hat i will become physically dependent on the medication.

_____ I understand that it is a criminal offense in the state of Florida to acquire or obtain or attempt to acquire or obtain possession of a controlled substance by misrepresentation, fraud, forgery, deception or subterfuge. I understand that if I make any false statements in this agreement i will be subject to criminal prosecution.

_____ I understand that I may be called into the office for random urine drug screening and/or medication counts. I will be required to present myself to the office by the close of business on that day or I may be discharged from the practice.

Print Patient Name: _____ Date of Birth:_____

Patient Signature:_____ Todays Date:_____

1. Have you seen any other physicians regarding any condition that requires pain management or obtained a prescription for a controlled substance from another physician within the last year? ☐ YES ☐ NO
   ***If you answered yes you must list each and every physician and medication prescribed:
   _____

   Patient Signature:_____

2. I am not presently being treated or attempting to be treated by another physician for any condition that requires pain management.
   Patient Signature:_____

3. I am not exaggerating any of the symptoms of any condition that requires pain management.
   Patient Signature:_____

4. I understand that there are alternatives to narcotic drug therapy which include multi-disciplinary therapies such as physical therapy, TENS, physician directed home exercise, acupuncture and interventional treatment such as steroid injections.
   Patient Signature:_____

5. I have been completely honest with my doctor regarding any condition that requires pain management.
   Patient Signature:_____

6. I will not see any other physician regarding any condition that requires pain management unless I notify my doctor prior to visiting the other physicians.
   Patient Signature:_____

DIVERSION POLICY : WHAT IS DIVERSION? — "The act or an instance of diverting from a course, activity or use."

Diversion is against the law and Resolute Pain Solutions takes this very seriously. If diversion occurs, you will be immediately discharged from our practice without a refund.
Here are some examples of what diversion is when discussing controlled and non-controlled medications.

1. Having a friend, family member, neighbor, or co-worker give you or sell you medication because you missed your appointment with your doctor which is scheduled every 30 days.
2. Going to multiple doctors for the same medication without notifying all physicians.
3. Giving away or selling your medications.
4. Having a positive urine test result for medications when you have not seen a doctor for over 30 days.
5. Having a negative urine test result for medication prescribed within the last 30 days of visit.
6. A positive urine test result for an illicit drug is a mandatory discharge.

Patient abuse of medication is a serious problem. Please read this form carefully. You will be held to this agreement by your physician and by any law enforcement agency investigation for any possible abuse of the doctor/patient relationship with regard to pain management.

Print Patient Name: _____ Date of Birth:_____

Patient Signature:_____Today's Date:_____

I do hereby state that I have read this form completely, and that all of the information is true and accurate. I understand that any false statements given in conjunction with this agreement will subject me to criminal prosecution. I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this documentation has been given to me.

This agreement is entered into on this_____day of_____month _____year

Patient Signature:_____

Provider Signature: _____

Physician Signature: _____

Patient Information

Print Patient Name: _____ Date of Birth:_____

Address:_____

City: _____State: _____Zip: _____

Home Phone #: _____Cell Phone #:_____Work Phone #:_____

Occupation:_____

Age:_____ Sex:_____ Social Security #_____ Preferred Language:_____

Marital Status: ☐ Married ☐Single ☐ Divorced ☐ Other

Emergency Contact:_____Relationship:_____

Emergency Contact Phone #:_____ Alternate Phone #:_____

IS YOUR IN JURY RELATED TO

☐ Work Injury ☐Auto Accident If Yes, what is the Date of Injury :_____

Claim # Assigned to Injury Case:_____Do you have an Attorney? ☐Yes ☐ No

Attorney or Case Worker Name:_____

Attorney or Case Worker Phone #:_____Fax #:_____

_____ I consent to treatment necessary for the care of the patient indicated on this form. I hereby authorize payment of medical benefits directly to the attending physician for services rendered.

_____ Authorization is hereby granted to release information as necessary to process and complete my claim. I understand that I am financially responsible for my account.

Print Patient Name: _____ Date of Birth:_____

Patient/Guardian/Guarantor Signature: _____ Todays Date: _____

Annual MIPS Questionnaire General 2019

Patient Name: _____ Date: _____

1. Do you have little or no interest in doing things? ____ No

____ Yes, please check one: ____ Several Days ____ More than half the days ____ Everyday

2. Are you feeling down, depressed or hopeless? ____ No

____ Yes, please check one: ____ Several Days ____ More than half the days ____ Everyday

If you answered YES to question 1 or 2, then complete the following table. If you answered No to both question 1 and 2 then you DO NOT have to complete the table, skip to below.

	Not at all (O)	**Several days (1)**	**More than half the days (2)**	**Everyday (3)**
3. Do you have trouble falling or staying asleep or sleeping too much?				
4. Do you feel tired or have little energy?				
5. Do you have poor appetite or overeating?				
6. Do you feel bad about yourself, feel like a failure, or feel you have let yourself or your family down?				
7. Do you have trouble concentrating on things, such as reading the newspaper or watching television?				
8. Do you move or speak so slowly that other people could have noticed? Or the opposite? Are you fidgety or restless and move around more than usual?				
9. Do you have thoughts that you would be better off dead and/or have thoughts of hurting yourself in some way?				

Have you fallen in the last 365 days? (Answer only if 65 years and older.)

____ NO ____ Yes : ___ 1 fall with injury ___ 2 or more falls with injury

___ 1 fall without injury ___ 2 or more falls without injury

CONSENT FOR E-PRESCRIBING & MEDICATION HISTORY

I understand that as a part of my electronic health record, Resolute Pain Solutions will transmit my prescriptions electronically as permitted, to the pharmacy that I designate as my primary pharmacy provider. Additionally, Resolute will obtain the history of all of my past prescriptions dating back two years from pharmacy benefit managers and I understand that the prescription history will become a part of my electronic health record. By signing below I hereby give consent to the above actions.

Signature of Patient or Legal Representative:_____Date:_____

RECORD RELEASE & ASSIGNMENT OF INSURANCE

I hereby authorize Resolute Pain Solutions to re-release any and all medical information that has been previously requested from any physician, hospital, or clinic where I have been treated. I also understand that this authorization to re-release medical information shall only be valid for the purposes of second opinions or referral from Resolute Pain Solutions additional specialist evaluation. I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full, at the time of service, unless other arrangements are made in advance. I hereby authorize the payment of benefits of my insurance policy, if any, to be paid directly to Resolute Pain Solutions for services rendered. I further authorize the release of any medical information required by my insurance carrier. I understand that I am financially responsible for any charges incurred in the collection of this account, should I default on payment. Such charges include, but are not limited to legal fees, collections fees, interest charges or late charges.

Signature of Patient or Legal Representative: _____Date: _____

PRIVACY PRACTICE NOTICE

I understand that the privacy practice notice of my rights regarding privacy of my protected health information is posted in all office locations and a written copy will be provided to me at my request.

Signature of Patient or Legal Representative:_____Date:_____