FLORIDA PAIN CENTERS
PAIN MANAGEMENT
CONSULTANTS, PA

Gene D. Mahaney, MD
Gilberto Acosta, MD
Velimir Micovic, MD
Adam M. Shuster, DO
Manuel Souza, ARNP

23 Barkley Circle, Fort Myers, FL 33907 • Scheduling: 239-333-1177 • Fax: 239-939-4733

April 27, 2011

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.

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.

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 with you 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 have these reports, it is important to bring them with you to your initial visit for the physician to review. 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 SW Florida 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

## PATIENT DEMOGRAPHIC INFORMATION

| ____________________ | ____________________ | ____________________ | ________________ |
|---|---|---|---|
| First Name | Middle Name | Last name | Nick Name |

SSN:_____________________ DOB:_____________ Drivers License #:___________________________

_____________________________________________________________________________________________

| Street Address | City, State | Zip Code | Phone Number |
|---|---|---|---|

_____________________________________________________________________________________________

| Mailing Address | City, State | Zip Code |
|---|---|---|

_____________________________________________________________________________________________

| Northern Address | City, State | Zip Code | Phone Number |
|---|---|---|---|

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:___________________________________________________________________________

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**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 # _________**
**Patient Health History Page 2 of 3**

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

________________________________________________________________________________________________

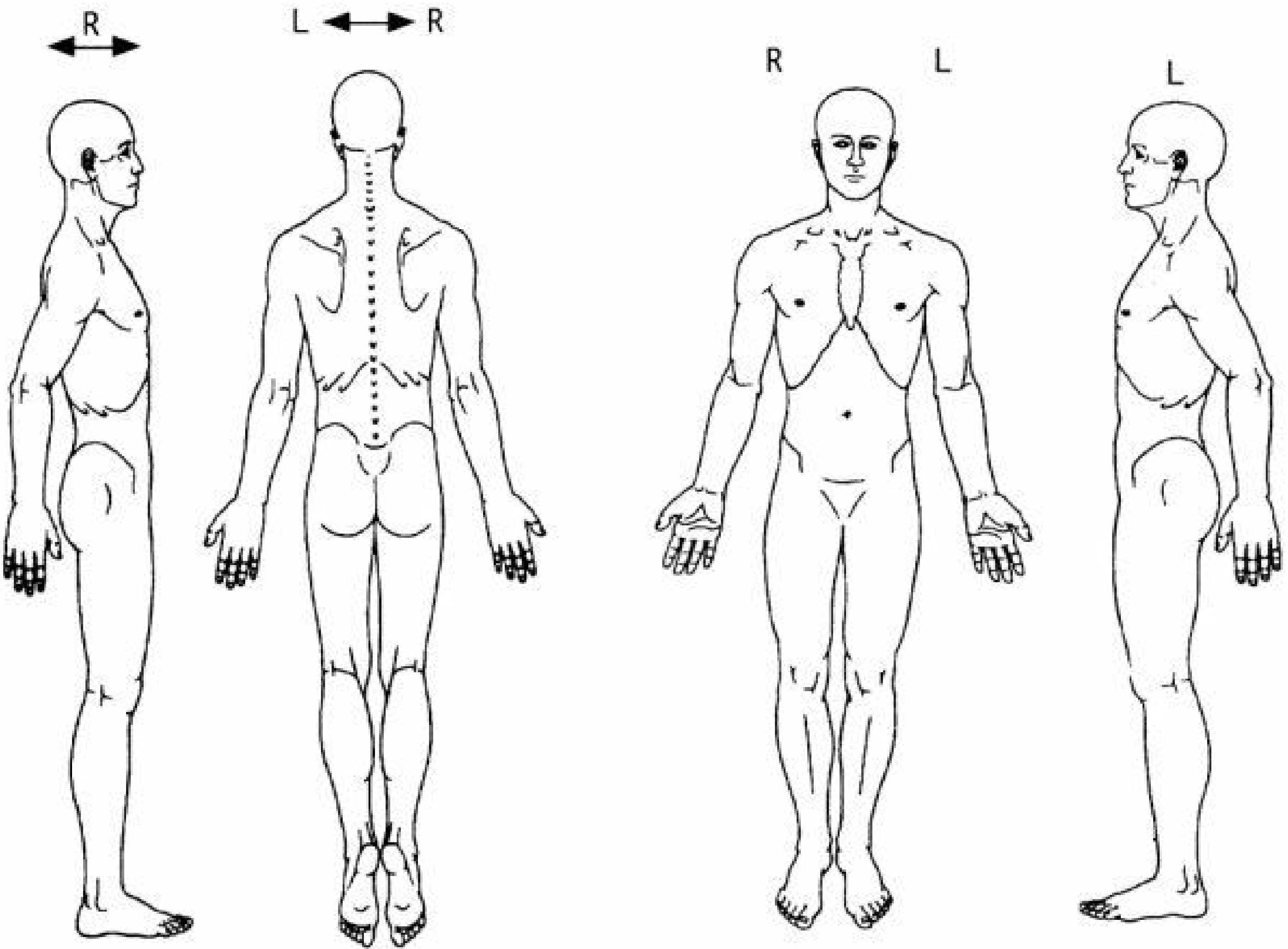
**Please circle the types of pain you are having:** Burning Stabbing Aching Sharp

**How long have you experienced this pain?** _____Hours _____Days _____Months _____Years

**On a scale of 1-10 with 10 being the worst pain you have ever experienced, what would you rate your pain today?**

| No Pain ▼ | | | | Moderate Pain ▼ | | | | | Worst Pain ▼ |
|---|---|---|---|---|---|---|---|---|---|
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |

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




________________________________________ ________ **Admitted by:**_____________________

**Patient/Legal Guardian Signature** **Date**

**________, Chart # _________**

**Patient Health History Page 3 of 3**

FLORIDA PAIN CENTERS
PAIN MANAGEMENT
CONSULTANTS, PA

## 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/disclose the information:

**Pain Management Consultants of Southwest Florida, P.A.**

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 upon 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.A.
23 Barkley Circle, 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, marijuana, 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, or Shuster.

• 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.

# CONSENT FOR USE OF OPIOID MEDICATONS AND CONTROLLED SUBSTANCES _______, Chart # ___________

• I agree to have blood/urine test to determine compliance with my pain medicine regimen. My Physician has the right to order random drug screen tests and it will be sent to a participating lab.

• I agree to unannounced "call-ins" where I can be called and asked to come into the office, bringing all medications with only 24 hours notice, I will inform the office of all medications I am currently taking. Should any other physicians including dentists prescribe any other medications for any reason; I will notify Drs Acosta, Mahaney, Micovic or Shuster by calling the office and speaking to the nurse or leaving a message on the next working day.

• I understand that it is my responsibility to keep my appointments and that missing an appointment may result in doing without my medications for a period of time long enough to induce withdrawal.

• I agree to have laboratory testing as needed, to ensure safe use of my medications. These tests may include, but are not limited to, tests of renal and liver function.

• I understand that refills of opioids and other controlled substances are made only at the time of an office visit. **Controlled substances will not be refilled after regular office hours, on weekends or on holidays.**

• I will give my physician and the staff permission to contact any other physician that I may see, to discuss my pain medication usage.

• I give my physician or his staff permission to contact my pharmacy to obtain information related to my medication usage.

• I understand that treatment with controlled substances will be discontinued if any of the following occur and/or my physician concludes:

- ☐ Medications have not produced effective relief and/or side effects are unacceptable.
- ☐ There is any evidence of improper use of controlled substance as defined above.
- ☐ I give away or sell my medications.
- ☐ I lose or misplace my medications or prescriptions.
- ☐ I do not take the medications as prescribed.
- ☐ I obtain opioids or other controlled substances from any other source.
- ☐ I abuse any other substance (narcotics, alcohol, marijuana, cocaine, etc.)
- ☐ I fail to abide by the statements in this consent form.
- ☐ I fail to follow this treatment plan.

I understand that management of pain with controlled substances may delay the diagnoses of potentially life-threatening illnesses (e.g. cancer), and thus reducing the chance of survival.

By signing below, I indicate that I have read this entire document and understand it. I consent to the use of opioids in an attempt to control pain and improve the quality of my life. I understand that my treatment with opioids and other medications will be carried out according to the rules above. I understand that if I do not follow the conditions outlined in this consent form, I can endanger my health as well as my life.

**Patient Signature** **Date** **Witness Signature** **Date**

**________, Chart # _________**

**Witness Name Printed**

Controlled Substance Agreement/Consent
Page 2 of 2

FLORIDA PAIN CENTERS
PAIN MANAGEMENT
CONSULTANTS, PA

## LABORATORY DRUG SCREENING CONSENT

I, ____________, request that payment of authorized benefits is made on my behalf to the laboratory Ameritox, 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, Ameritox, 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 Ameritox, 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 Ameritox, 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 nutriceuticals 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.A. 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 x 200. 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 # _________**

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 your 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.A., 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.A., 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 # _________**

Patient Information/Financial Policy Agreement
Page 2 of 2

FLORIDA PAIN CENTERS
PAIN MANAGEMENT
CONSULTANTS, PA

# HIPAA Notice of Patient Privacy Practices & Acknowledgement

- Pain Management Consults of SW Florida, PA (PMC) is structured as an organized healthcare arrangement, which allows for the sharing of protected health information among groups and services listed in the Notice to carry out services for Treatment, Payment or Healthcare Operations.
- Your protected health information may be released to other healthcare professionals for the purpose of providing you with quality healthcare. Providing this health information will assist in coordinating the care you need, such as prescriptions, blood work, x-rays or other diagnostic tests.
- Your protected health information may be released to your insurance provider for the purpose of PMC receiving payment for providing you with needed healthcare services.
- Your protected health information may be released in connection with our healthcare operations. PMC might share your health information to perform an evaluation of our quality of services provided to you at your office visits. PMC might share health information among outside agencies for review and certification or licensing of our services provided.
- Your protected health information may be released to public or law enforcement official in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your protected health information may be released to other healthcare providers in the event you need emergency care.
- Your protected health information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your protected health information may be released only after receiving written authorization from you for treatment, payment or healthcare operations. You may revoke your permission to release protected health information at any time. It must be in writing with effective date and be specific to the health information being protected. PMC is not required to agree to your request if action has already been taken or if your authorization was obtained as a condition for obtaining insurance coverage and the law gives the insurer the right to contest a claim.
- You may be contacted by PMC by phone, mail or by leaving a message on an automated answering devise to remind you of appointments, to schedule appointments, verify insurance or demographic information or inform you of test results. You have the right to request a more confidential way of providing this information at the time of your initial appointment. PMC will honor all reasonable requests.
- You have the right to request a restriction on the use of your protected health information. However, PMC may choose to refuse your restriction if it is in conflict with providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status. PMC might disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, your location or your general health condition or death. PMC will also use our professional judgment and our experience with common practice to make reasonable decisions when releasing your health information that is directly relevant to the person's involvement in your health care.
- You have the right to review and photocopy any/all portions of your heath information. PMC has the right to assess a fee for the photocopying of the health information.
- You have the right to request an amendment to your health information. It must be in writing and explain why the information should be amended. PMC can deny the amendment and if so, a written explanation will be provided.
- You have the right to know who has accessed your protected health information and for what purpose other than for Treatment, Payment, Healthcare Operations, and other activities or those disclosures directly authorized by you. PMC requires that the request for accounting of the disclosures be in writing.
- You have the right to possess a copy of this Statement of Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- PMC is required by law to protect the privacy of its patients. It will keep protected any and all patient health information and will provide patients with a list of duties or practices that protect health information upon written request.
- PMC will abide by the terms of the notice, currently in effect.
- You have the right to complain to PMC if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your written complaint to: **Pain Management Consultants, PA, 23 Barkley Circle, Fort Myers, FL 33907**
- All complaints will be investigated. No personal issue will be raised for filing a complaint with Pain Management Consultants, PA.
- You may also submit a written complaint to: **Region IV, Office of Civil Rights, US Dept. of Health and Human Svcs., Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, SW, Atlanta, GA 30303-8909**

***By electronically signing this form, you are acknowledging that a staff member of Pain Management Consultants, PA has explained how your protected health information will be handled in various situations and a copy of this statement will be provided upon request.***

_______________________________________________

Patient Signature Date

**_______, Chart # ________**

FLORIDA PAIN CENTERS
PAIN MANAGEMENT
CONSULTANTS, PA

Gene D. Mahaney, MD
Velimir Micovic, MD
Gilberto Acosta, MD
Adam M. Shuster, DO

Phone: 239-333-1177 ● Fax: 239-939-4733 ● www.flpaincenters.com

October 1, 2010

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

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

# Standard Disclosure 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 |

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 upcoded, 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 |

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.

FLORIDA PAIN CENTERS
PAIN MANAGEMENT CONSULTANTS, PA

Gene D. Mahaney, MD
Velimir Micovic, MD
Gilberto Acosta, MD
Adam M. Shuster, DO

23 Barkley Circle, 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.A. 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