NEW PATIENT REGISTRATION FORMS (FIRST VISIT ONLY 8 PAGES)

River Coast Pain Management

RCPM 1899 Murrell Rd Suite #130 Rockledge Fl 32955

NEW PATIENT Medical History

Date _____

Patient Name _____ Date of Birth _____ Language_____

Address _____ City_____ State _____ Zip_____

SSN _____Phone #_____

Family Physician/Internist:_____ Phone #_____

Previous Pain Management Physician_____ Phone #_____

Emergency Contact _____ Contact Phone #_____

NEW PATIENT REGISTRATION MEDICAL INFORMATION

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	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Alzheimer's	☐	☐	Nervous Disorder	☐	☐
Low Blood Pressure	☐	☐	Emphysema/Asthma	☐	☐	Chest Pain /Angina	☐	☐
Bleeding / Bruising (recent)	☐	☐	History of Diabetes	☐	☐	Heart Attach	☐	☐
Hypoglycemia	☐	☐	Cancer / Tumors	☐	☐	Osteoporosis	☐	☐
Stroke	☐	☐	Ulcer	☐	☐	Pace Maker	☐	☐
Active Seizure Disorder	☐	☐	Anemia	☐	☐	BipolarDisorder	☐	☐
Liver Disease	☐	☐	Fractures	☐	☐	Headaches	☐	☐
Glaucoma	☐	☐	Hiatal Hernia	☐	☐	Insomnia	☐	☐
Light-Headedness / Dizziness	☐	☐	Anxiety/Panic Attack	☐	☐	Depression (recent)	☐	☐
Are you currently in pain	☐	☐						

Location of pain _____

If you answered yes to any of the above are you under the care of a Physician for these conditions ☐ ☐

Allergies:_____

_____

_____

	Yes	No		Current Medications
Do you Drink Alcohol?	☐	☐	1	_____ ____Mg____# ____Times a day
Have you been treated for addiction?	☐	☐	2	_____ ____Mg____# ____Times a day
Do you smoke?	☐	☐	3	_____ ____Mg____# ____Times a day
Are you employed?	☐	☐	4	_____ ____Mg____# ____Times a day
Are you married?	☐	☐	5	_____ ____Mg____# ____Times a day

PATIENT SIGNATURE_____ DATE_____

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Location of Pain:_____ Duration of Pain_____

Circle the word that best describes your pain:

Sharp	Gnawing	Aching	Tender	Shooting	Numb	Exhausting	Burning
Miserable	Penetrating	Stabbing	Throbbing	Tiring	Unbearable	Nagging	_____

What Time of day is the pain the worst:? Morning Afternoon Evening Night

Is the Pain: Occasional Continuous

How is your Pain since your last visit? (Circle one below)

Low 0 1 2 3 4 5 6 7 8 9 10 High

What CURRENT medications have you been PRESCRIBED to help your pain?

1. _____ ____mg _____# _____Times a day
2. _____ ____mg _____# _____Times a day
3. _____ ____mg _____# _____Times a day
4. _____ ____mg _____# _____Times a day
5. _____ ____mg _____# _____Times a day

Are you having any side effects from any medication: Yes No

Explain if Yes :

_____

What activities make your pain worse?:_____

Disclaimer

I swear that the above information is true and accurate to the best of my knowledge.
I swear that I have complied with the Doctor/ Patient agreement, and have **NOT RECIEVED ANY CONTROLLED SUBSTANCES** from any other physician or medical facility within the last 28 days. I understand that obtaining controlled medications from another physician or medical facility can result in my dismissal from this practice and may lead to criminal charges being brought against me by the authorities.

Patient Signature:_____ Date:_____

Staff Witness:_____ Staff Signature:_____

River Coast Pain Management

By Florida Statute 893.13 (7a8), it is a third degree felony, punishable by up to 5 years in prison and up to a $5,000 fine to:

Withhold information from a practitioner from whom the person seeks to obtain a controlled substance or a prescription for a controlled substance that the person making the request has received a controlled substance or a prescription for a controlled substance of like therapeutic use from another practitioner within the previous 30 days.

I,_____, authorize River Coast Pain Management to do the following:

1. Cooperate fully with any city, state, and or government official with any investigation regarding Florida Statute 893 and or 831.
2. Patient waives any applicable privilege Florida Statute 395, right of privacy, or confidentiality with respect to any investigation of any possible misuse, sale, or other diversion of medications. River Coast Pain Management will release any all medical records associated with my office visit(s)

If you have seen a physician who prescribed a controlled medication within 28 days of this visit please disclose the following:

Doctor's Name _____

Doctor's Office Address_____

Address Line 2 _____

Doctor's Office Phone Number _____Date Seen _____

Medications Prescribed

1. _____ ____mg _____# _____Times a day
2. _____ ____mg _____# _____Times a day
3. _____ ____mg _____# _____Times a day
4. _____ ____mg _____# _____Times a day
5. _____ ____mg _____# _____Times a day

Patients Name_____ Signature_____ Date_____

Patients Date of Birth_____ Sate ID#_____

Witness Name_____Signature_____Date:_____

River Coast Pain Management

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED & HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a Federal Law that requires all medical records and individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, to be kept CONFIDENTIAL. This Act gives you, the patient, significant rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse your personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use or disclose your health information.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities obtaining reimbursement, for services, confirming coverage, billing or collection activities, and utilization reviews. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, and cost-management analysis. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may use or disclose protected health information to, payment, or health care operations in the follow circumstances:

- In emergency treatment situations.
- If we are required by law to treat you.
- We may contact you to provide appointment reminders of information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Doctor or office management

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are however not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information

- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy with respect to protected health information.

This notice is effective as of August 16, 2014 and we are required to abide by the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal complaint against us at the address below, without fear of retaliation from us. Complaints can be filed with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

For more information about HIPPA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave. SW
Washington DC 20221
(202) 619-0257 Toll Free 1-877-696-6775

I have received a copy of the above letter on this date _____/_____/_____

Name:_____ Signature:_____

River Coast Pain Management

REFUND POLICY

NO REFUNDS WILL BE GRANTED FOR:

1. Failing a urine analysis.
2. Failure to disclose prescription fill from other doctors within the past 30 days.
3. Counterfeit or modified MRI's or any other documentation
4. Any disagreement on the course of treatment or prescriptions written by the doctor.
5. Avoiding a drug screen.

Refund request based on fraud, deceit, avoidance, malingering or for any reason not the fault of this practice will not be entertained, considered or granted.

NAME_____ SIGNATURE_____ DATE_____

NARCOTIC MEDICATION RESPONSIBILTY & NO REPLACEMENT POLICY

LOST STOLEN OR MISPLACED NARCOTIC MEDICATIONS WILL NOT BE REPLACED. PLEASE SECURE YOUR MEDICATIONS. DO NOT KEEP THEM IN YOUR CAR, CABINET, CHECKED BAGGAGE, OR ANY EASILY ACCESSABLE OR UNSECURE AREA. FAILED DRUG SCREENS FOR ANY REASON INCLUDING THEFT OF MEDICATION ARE GROUNDS FOR DISMISSAL FROM THIS PRACTICE AND A REPORT BEING FILED AGAINST YOU WITH LAW ENFORECEMENT.

NAME_____ SIGNATURE_____ DATE_____

PLEASE SAFE GUARD YOUR MEDICATIONS

River Coast Pain Management

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PAIN MANAGEMENT AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This agreement is to help you and your provider stay within the law regarding controlled prescription drugs.

___ I understand that there is a risk of psychological and / or physical dependence and addiction associated with the chronic use of controlled substances.

___ I understand that this Agreement is important to the trust and confidence needed in a doctor / patient relationship and that my doctor agrees to treat me based on this Agreement.

___ I understand that if I break this Agreement, my doctor will stop prescribing these pain control medicines. He will taper off my medicine over a period of a few days, to avoid withdrawal symptoms and refer me to a drug-dependence treatment program.

___ I will be agreeable to seeking mental health (psychiatric or psychological) treatment, if my doctor thinks it necessary.

___ I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life and how well the medication is helping to relive the pain.

___ I will not use illegal controlled substances, including Cocaine, MDMA, and amphetamines, nor will I misuse or self prescribe legal controlled substances. The Use of Alcohol is to be AVOIDED, especially when driving or operating machinery.

___ I will not share my medication with anyone.

___ I will not try to get any controlled medications, including opioid pain medications or any anti-anxiety medications from any other provider.

___ I will keep my medications safe from loss, theft or unintentional use by others. LOST OR STOLEN MEDICATIONS WILL NOT BE REPLACED!

___ I agree that Refills of my prescriptions for pain medications will be made ONLY at the Time of an office visit.

___ I authorize my doctor and pharmacy to cooperate fully with any law enforcement agency in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy, primary doctor and or local emergency room. I give up any right of privacy of confidentiality with respect to these authorizations.

___ I agree that I will do a blood or urine test when requested by my doctor, without delay or evasion, to check on my compliance with my pain management program.

___I understand that my doctor will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program Website regularly throughout my treatment.

___ I agree to not use my medicine faster than my prescribed rate and that use of my medicine at a faster rate will lead to me being without medication for a period of time.

___ I will make myself available for random drugs screens and pill counts on short notice.

___ I AGREE TO FOLLOW THESE GUIDELINES THAT HAVE BEEN FULLY EXPLAINED TO ME.

All of my questions and concerns regarding my treatment have been adequately answered and I have received a copy of this document.

This agreement is entered into this _____ day of _____, 20_____

Patient Name_____ Patient Signature_____

Doctor Name_____ Doctor Signature_____

Witness Name_____ Witness Signature_____

RCPM

RCWO

Patient Pain History Note Date

Describe your history related to chronic pain.