Pain Specialties
Dr. Richard L. Smith Sanchez, M.D.
138 East Gore Street
Orlando, Florida 32806
Tel. (407)650-0033 Fax (407)650-0032
NPI # 1760417786

Dear Patient,

Welcome to Pain Specialties for pain management. We are pleased to have you as our patient. Our practice is committed to providing the best treatment for our patients.

Attached you will find a New Patient questionnaire which you need to fill out entirely. **Do not leave any blank spaces, please write N/A where appropriate**. Once completed, please send it to our offices via **email**, **Fax**, or in the enclosed **postage pre-paid envelope**. IT MUST BE RECEIVED PRIOR TO YOUR APPOINTMENT, in order for the information to be entered into the NEW Electronic Medical Record System, which is required at the time of your appointment. You may also go to our Web Site to fill out and submit the New Patient Forms online beginning in 2015. **Please take a moment to read this information concerning our office policies.**

NEW PATIENTS APPOINTMENTS:

Your appointment will be confirmed once all medical records are received and reviewed in our office. We can request your medical records once we receive your medical records release form signed (last page of your New Patient's package). For your information, we will need medical records from all your doctors who have been involved in treating your pain and/or given you prescriptions for your pain in the past: i.e. Rheumatologists, Pain Management, Orthopedics, Neurologist, Psychiatrist, and Primary Care Physician. In order to expedite the process you can call your doctors, requesting your medical records be faxed to our office at **(407)650-0332.**

We have also included a brochure with additional information about Pain Specialties. Please feel free to read it and call us if you need any additional information.

MEDICAL RECORDS AND FORMS:

We will be glad to release your medical records to you or another entity as long as an authorization release form has been signed by the patient. There may be an additional $25 charge for the completion of FMLA, Disability, Medical Records and other forms.

INSURANCE:

Our staff will assist you in every way possible to see that you get maximum insurance benefits by filing your claims promptly and properly. It is the patient's responsibility to know what services are covered by their insurance: benefits deductible, co-payments and providers on their plan. Any charges not paid by your insurance, within 45 day will become the patients' responsibility. We accept cash, checks and credit cards. (**Returned checks will have a penalty of $30)**

We will make every attempt to verify your insurance coverage as well as an estimated amount due by the patient. Please note that since insurance companies do not guarantee any amount payable until claim is submitted, what you are told at the time of your appointment is only an estimate. If you have a secondary insurance, be sure to give us the information so we can submit the claim.

If you have HMO insurance, an authorization or referral is required from your primary care physician prior to your appointment. It is the patient's responsibility to obtain the authorization or referral before your appointment with Pain Specialties. Keep in mind that an authorization or referral is not a guarantee of payment. We will be requesting the referral from your primary care physician. However, if you arrive without the necessary authorization or referral, your appointment will be re-scheduled.

Please arrive fifteen **(15) minutes** prior to your appointment. **It is essential that you bring a photo ID and Insurance Cards.** Without this information we will need to re-schedule your appointment.

MISSED APPOINTMENTS:

For any missed appointments that were not called at least 24 Hours ahead of time our policy is to asses a $25 charge. This charge is not covered by Insurance Companies and will be billed directly to you. Please help us serve you better by keeping your regularly scheduled appointments.

PRESCRIPTIONS:

If you are prescribed medications by Dr. Richard L. Smith you must be seen every (3) three months and request your refills forty eight (48) hours prior to the due date. **THERE WILL BE NO EXCEPTIONS TO THIS POLICY** in order to comply with DEA rules.

We are pleased that you have entrusted your Pain Management care to us. We value you as our patient and intend to provide you with the very best care and service. If you have any questions about any of our policies, please feel free to write or call us.

I acknowledge reading the above policies.

Patient Signature: _____ Responsible Party: _____ Date _____

Richard L. Smith, MD P.A.
138 East Gore Street Orlando, Florida 32806

New Patient Form

Patient:_____ ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Separated**

Home Phone:_____ **Cell Phone:** _____ **Work Phone:**_____

Date of Birth:_____ **Age:**_____ **Sex:** ❑**M/**❑**F Social Security#:**_____

Home Address: _____ **Apt #:** _____

City: _____ **State:**_____ **Zip:**_____

Driver's License #: _____ **email Address:**_____

Employer:_____ **Phone:** _____

Business Address: _____

Occupation:_____ **Student: FT PT** **School:**_____

Emergency Contact:_____

Home Phone: _____**Relationship:** _____

Do you have Health Insurance? ❑**Yes** ❑ **No**

Do you have a Secondary Insurance? ❑**Yes** ❑**No**

Primary Care Physician: _____**Phone:**_____

Primary Insurance Company: _____

Address: _____

Policy Holder's Name: _____ **Policy #:** _____**DOB:**_____

Group #: _____ **Customer Service#:** _____

Relationship to Patient: _____

Secondary Insurance Company: _____

Policy Holder: _____ **Policy#:** _____ **DOB:**_____

Group #: _____ **Customer Service#:**_____

Relationship to Patient:_____

Do you authorize PAIN SPECIALTIES to RELEASE information to your Spouse/Other? Yes No

If Yes, Spouse/Other Name:_____**Relation:** _____

How did you hear about our office? ❑**Yellow Pages** ❑**Internet** ❑ **Friend** ❑ **Referral Physician**

PHARMACY: _____**PHARMACY PHONE#:**_____

Do you have a Living Will / Health Care Proxy? ❑**Yes /** ❑**No If Yes, please provide copy to our office.**

Patient Signature:_____ **Date:**_____

- **Please Bring Driver's License and Insurance Card to your Appointment**

Pain Specialties
Pain Control for Adults & Children
LEADERS IN INTEGRATIVE MEDICINE
Richard L. Smith Sanchez, M.D.
Medical Director
Boad Certified Anesthesiology
Board Certified in Pain Management
138 East Gore Street • Orlando, FL 32806
(407) 650-0033 • Fax: (407) 650-0032

INFORMED CONSENT
FOR
OPIOID MAINTENANCE THERAPY
IN THE
TREATMENT OF INTRACTABLE PAIN

This Agreement is entered into by _____ , (the "Patient") and outlines the requirements relative to the use of controlled substances prescribed by Dr. Richard L. Smith at Pain Specialties ("PS") for the treatment of chronic pain. The goal of PS and the Patient is to improve the Patient's ability to work and/or function.

In signing this Agreement, patient acknowledges receipt of the following information from PS, its physician and staff, and will adhere to stated guidelines contained in the information:

1. **Controlled substances (i.e., morphine, fentanyl, propoxyphene, butorphanol, oxycodone, hydrocodone, hydromorphone, benzodiazepense, methadone, codeine, etc.) are useful for pain control, but have high potential for misuse and/or abuse. The patient recognizes that the use of controlled substances is regulated and monitored by local, state, and federal agencies. PS carefully adheres to these regulations.**

2. **Controlled substances may be prescribed alone or in combination with other classes of medications such as stimulants, tranquilizers, muscle relaxants, antihistamines, anti-depressants and anti-nausea medications.**

3. **Controlled substances are potentially dangerous and, it taken improperly, may lead to excess sedation, respiratory depression and death.**

4. **Controlled substances may cause a variety of side effects, including but not limited to nausea, vomiting, constipation, dry mouth, weight gain or loss, itching, allergic reactions and the suppression of one or more of the following: the immune system, thyroid function, menstrual cycle, and hormone production.**

5. **Controlled substances may cause psychological dependence (addiction). If necessary, Patient agrees to PS physician's guidance and to**

   - **Participate in any treatment program described**
   - **Undergo detoxification, if necessary**
   - **Obtain psychological and/or medical treatment**

6. **Patient understands that tolerance (the need to increase the dose of medication in order to achieve the same pain relief) may occur in some individuals. Patient further understands that pain may decrease as a result of other treatment modalities or in the natural course of the disease process. In either of these instances, the physician may find it appropriate to adjust (increase or decrease) pain medication. *Patient will not adjust medications,***

7. **The abrupt cessation of controlled substances *may be dangerous, and lead to withdrawal symptoms* (i.e., abdominal/muscle cramps, sweats, chills, vomiting, generalized aching). Withdrawal, while extremely unpleasant, is NOT life threatening. Should it become necessary to discontinue medications, it will be done only under the guidance of the PS physician.**

8. **Patient will use controlled substances within the parameters given by PS. In the event that a specific medication is not effective, PS will exchange it with a new prescription. The old prescription (unused portion of the medication) must be returned to PS and will be discarded according to PS policy. Patient will not hold PS responsible for problems caused by non-compliance in the taking of medication. Patient will follow the guidance of PS physician in the *event* prescriptions are changed or adjusted. In no event will any changes to medications be undertaken without the patient being seen by the physician at PS.**

9. ***If* you are a female, you must agree to use appropriate measures to prevent pregnancy during the course of treatment with opioids and agree that we may perform a pregnancy test if we suspect that you are pregnant.**

10. **Patient will take strict precautions to prevent access to medication. Patient may not provide medications to anyone else. PROVIDING CONTROLLED SUBSTANCES TO ANYONE ELSE, INCLUDING FAMILY MEMBERS, IS CONSIDERED NARCOTIC DISTRIBUTION AND IS A FELONY. Patients responsible for this behavior risk having such information forwarded to local authorities. PS is not responsible *for* any emergency situation, overdose, or dependence that arises by the taking of medication by anyone other than the Patient.**

11. **Stolen and/or lost prescriptions or medication will not be replaced without a valid police report. This will only be done ONCE. Information regarding lost and/or stolen prescriptions will be recorded in *the* medical record.**

12. **Patient agrees to inform all other physicians of medications being taken and to request that the other physician consult with PS regarding the co-administration of medications.**

13. **Patient agrees to maintain a Primary Care Physician (PCP) throughout the course of treatment at PS. This information must be provided to PS no later than the second visit. Failure to do so may result in termination from PS.**

14. **Patient agrees to waive confidentiality to PS staff with immediate family members who wish to discuss their concerns regarding treatment and related issues.**

15. **Patient agrees to allow PS physician to communicate with your other physicians and any pharmacists regarding your use of controlled substances.**

16. **THE FOLLOWING ARE CONDITIONS FOR IMMEDIATE TERMINATION FROM PS:**

- **Obtaining narcotics from any other physician while in the care of PS.**
- **Altering or forging a prescription. (This is a felony and will be reported.)**
- **Misuse of any medication, or non-compliance in the use of medication.**
- **The use of any illegal substances.**

17. **Patient will not expect to receive any additional medication before the next refill and/or scheduled appointment, even if your prescription runs out. Patient will be responsible for his own scheduling and no additional last minute changes will be made for vacation, nips, etc. PLEASE PLAN IN ADVANCE.**

18. **Patient agrees to random urine and/or drug screening to ascertain the • use of prescribed medications and to detect the use of non-prescribed medications.** Patient **also agrees that PS has he authority to request, receive and discuss the results of drug screening tests taken by any other party. Patient further agrees to accept financial responsibility for any drug-screening test. PS reserves the right to: (1) share results of drug screening tests with the patient's insurance carrier, (2) to share test results showing illegal substances with the appropriate law enforcement authorities.**

19. **Patient agrees to comply with any random medication audit. When requested, patients will be required to present themselves with unused medication at PS. Failure to comply may result in termination from PS.**

20. **Patient will keep all scheduled appointments at PS.**
21. **Patient agrees to comply with additional therapy modalities (i.e., physical therapy, aquatic therapy, psychotherapy, diagnostic testing, etc.) as prescribed by PS physician, and to actively participate in all aspects of PS program for the management of pain.**

22. **Patient agrees to adhere to manufacturer's instructions in the taking or prescribed medications (orally, via patch, etc.) when using heavy machinery or operating a motor vehicle. PS takes no responsibility for Patient's failure to adhere to manufacturer's guidelines. Patient acknowledges chat it is ILLEGAL to operate a motor vehicle while impaired by such medications and runs the risk of being charged with DUI.**

23. **Medication will be stopped if PS physician thinks that**

- **If it is not effective for your pain**
- **Your functional activity is not improved**
- **If you give**
- **If you sell**
- **If you misuse the medications**
- **If you develop rapid tolerance or loss of *effect* from *this treatment***
- **If you develop side effects that are significant in the view of the physician**
- **If you obtain narcotic medication from sources other than PS physician.**

24. **You *agree* to follow physician's advice about stopping the treatment with narcotic medication.**

Patient signature: _____ Date: _____

Print Name: _____

Physician/Office *Staff* Signature: _____

A copy of this Agreement may be sent to Patient's Primary Care Physician

(PCP). PCP's Name: _____

Address:_____

City:_____ State:_____ Telephone #: _____

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New Patient Questionnaire

Date: _____

Name: _____ **Age:**_____
Last **First** **Middle Initial**

How were you referred to our office? (Please Check One) ❑Dr. ❑Web Site ❑Insurance ❑Friend ❑Other

Name and Relationship of person referring: _____ **Phone #:**_____

1) Your chief complaint(s) are: ***(Check all that apply)*** Pain in: ❑Neck / ❑Mid-back / ❑Low-back /❑Right arm ❑Left arm / ❑Right leg / ❑Left leg / ❑Headache

2) Please list the area of worst pain: _____

3) Your pain began on: (Please give exact date): _____

4) If you cannot give an exact date, how long have you had your pain? _____ Months _____ Years

5) Did your pain begin after an injury or trauma? _____ Yes _____No

a) If "Yes", please give date of trauma or injury. _____

b) If "Yes", please describe in detail what happened _____

c) If "Yes", please list any other injuries or trauma that occurred before the above date of injury _____

d) If "Yes", please list any other injuries or trauma that occurred after the above date of injury _____

6) Please list other physicians who have treated your pain. _____

7) Your pain is described as: (Check all that apply to each body area).

a) Body area: _____ **❑Aching /❑Burning /❑Dull /❑Sharp /❑Stabbing /❑Shooting /❑Throbbing**

b) Body area: _____ **❑Aching /❑Burning /❑Dull /❑Sharp /❑Stabbing /❑Shooting /❑Throbbing**

c) Other Descriptions for your pain: _____

8) Your Pain is made better by (Check/ list all that apply) ❑ Exercise ❑Physical Therapy ❑Massage ❑Medications ❑Rest

Other activities that make your pain better? _____

9) Your pain is made worse by: (Check/ list all that apply)

❑ Lifting _____lb	❑Bending	❑Stooping
❑Standing	❑Sitting	❑ Lying Flat
❑Sleeping to long	❑Sex	❑Walking

Other activities that make you pain worse? _____

10) List all pain medications you are currently using, including "over-the-counter":

a)_____ **c)** _____

b) _____**d)**_____

11) List all pain medications you have used in the past:

_____

_____

12) List any pain medications you did not tolerate, and the reason why the medication(s) was discontinued:

_____

---

13) Do you have any of the following associated with your pain? (Circle/list all that apply)

❑Bladder Incontinence ❑Muscle Spasm ❑Stiffness (where?)_____

❑Coldness in Limb ❑Numbness (where?)_____ ❑Tingling/Pins & Needles (where?)_____

❑Dizziness ❑Skin Sensitivity (where?)_____ ❑ Weakness in Arm (s) (L/R)____Leg (s) (L/R)_____

❑Fevers ❑Skin Discoloration ❑Weight Loss of _____Lbs. over the past _____Months

Are there any other symptoms associated with your pain?

_____

_____

14) Have you had any of the following tests related to your present pain complaint(s)? (Check/list all that apply)

❑X-ray of (Check) ❑Neck/Back: When? _____ ❑Bone Scan ❑Bone Density

❑CT scan of (Check) ❑Brain/Neck/Back: When? _____ ❑Nerve Conduction Study ❑EMG

❑M.R.I of (Check) ❑Brain/Neck/Back: When? _____❑Thermo-gram ❑Functional Capacity

Any other tests not listed? _____

15) Please check / list all treatments/injections you have undergone for management of your pain.

❑Physical therapy: When? _____❑Chiropractic: When? _____❑Acupuncture: When ? _____

❑Epidural blocks: When? _____❑Did they help? ❑Yes ❑No How long did they help? _____

❑Facet blocks: When? _____❑Did they help? ❑Yes ❑No How long did they help? _____

❑Trigger Injections: When? _____ ❑Did they help? ❑Yes ❑No How long did they help? _____

Psychological management? (Check all that apply) ❑Biofeedback ❑Stress Management

Any other treatments not listed above:_____

16) How many times do you wake up at night because of pain (not because of having to use the bathroom') (Please check one) ❑Not at all ❑1-2 times ❑2-3 times ❑3-4 times ❑ Greater than 4 times

17) Do you snore, or has a family member told you that you snore? _____Yes_____No

a) If "Yes", do you wake up gasping for air or very short of breath? _____Yes_____No

b) If "Yes", do you wear a breathing device for sleep apnea? _____Yes_____No

18) Check the best number that "rates" your pain severity. (For headaches, go to Items 21-31).

a) Worst possible pain: ❑**No pain** ❑**0** ❑**1** ❑**2** ❑**3** ❑**4** ❑**5** ❑**6** ❑**7** ❑**8** ❑**9** ❑**10** ❑**(Unbearable)**

b) Least possible pain: ❑**No pain** ❑**0** ❑**1** ❑**2** ❑**3** ❑**4** ❑**5** ❑**6** ❑**7** ❑**8** ❑**9** ❑**10** ❑**(Unbearable)**

c) Pain right now: ❑**No pain** ❑**0** ❑**1** ❑**2** ❑**3** ❑**4** ❑**5** ❑**6** ❑**7** ❑**8** ❑**9** ❑**10** ❑**(Unbearable)**

19) Your pain is:

a) Constant: Where? _____

b) Intermittent: Where? _____

20) Do you feel your pain has: (Check one) ❑Worsened ❑Improved ❑Remained the same?

HEADACHE PATIENTS: Please proceed to question 21 on the next page.
NON - HEADACHE PATIENTS: Please proceed to question 35 on the next page.

HEADACHE PATIENTS: Complete numbers 21-34 ONLY if you are being evaluated for HEADACHES today

21) How many days per month do you have **NO** headaches? ____**days**

22) How many days per month is your worst headache of the day a **NAGGING** headache? ____**days**

23) How many days per month is your worst headache of the day an **INTERFERING** headache? ____**days**

24) How many days per month is your worst headache of the day an **INCAPACITATING** headache? ____**days**

Total Days 30

25) What is your headache presently? (Check one) ❑**0** ❑1 ❑2 ❑3

26) How long do your headaches typically last? _____ Hours _____Days

27) When did your headaches begin? _____week(s) ago _____ month(s) ago _____ year(s) ago

29) Do you have a family history of headaches? _____**Yes** _____**No**

30) If '"Yes," Who? _____

31) Associated with your headaches, do you experience: (Circle/list all that apply)

❑Blurred vision ❑Double vision ❑Loss of vision ❑Sensitivity to light ❑Fatigue

❑Sensitivity to sound ❑Unequal pupils ❑Eye tearing ❑Nausea ❑Vomiting

Other symptom: _____

28) Did your headaches begin as a result of an Injury as described, in numbers 3-5? _____**Yes** _____**No**

32) Location of your headaches: (Check/list all that **apply)**

❑Back of head ❑Forehead ❑Around Eyes ❑Behind Eyes ❑Other:_____

33) Description of your headaches: (Check / list all that apply)

❑Aching ❑Throbbing ❑Stabbing ❑Dull ❑Other: _____

34) Are your headaches "triggered" by: (Check / list all that apply)

❑Exercise ❑Stress ❑Alcohol ❑Neck Movement ❑Food(s):List:_____

NOTE: ALL patients must complete the rest of this form.

****

PAST MEDICAL HISTORY

35) Do you currently have, or have you ever had any of the following conditions or illnesses? (check/list) _______

- ❑ AIDS
- ❑ Alcoholism: Abstinent since ________
- ❑ Anemia
- ❑ Asthma
- ❑ Atrial fibrillation
- ❑ Bleeding disorder
- ❑ Bronchitis acute/chronic
- ❑ Cancer of: When?
- ❑ Cataracts
- ❑ Chemical addiction to _____________
- ❑ Chicken pox
- ❑ Diabetes: _____Type I _____Type II
- ❑ Emphysema
- ❑ Epilepsy/Seizure: Last one?
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gout
- ❑ Heart attack: When? _____________
- ❑ Heart disease
- ❑ Congestive heart failure
- ❑ Heart valve problems: aortic_____mitral
- ❑ Hepatitis A,B,C: When? ___________
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ HIV positive
- ❑ Kidney failure: When? ___________
- ❑ Kidney stones? When? ___________
- ❑ Liver disease/cirrhosis
- ❑ Mononucleosis
- ❑ Multiple sclerosis: How long? _______
- ❑ Neuropathy Diabetic neuropathy
- ❑ Pacemaker implant: When? ________
- ❑ Pneumonia: When? _______________
- ❑ Polio
- ❑ Prostate Enlargement____
- ❑ Psychiatric disorder:
- ❑ Anorexia
- ❑ Anxiety
- ❑ Bulimia
- ❑ Depression
- ❑ Rheumatic fever: When?______
- ❑ Stroke: When? _____________
- ❑ Suicide attempt: When? ________
- ❑ Thyroid disease
- ❑ Hyperthyroid
- ❑ Hypothyroid
- ❑ Tuberculosis
- ❑ Ulcer:
- ❑ Duodenal: When? ____________
- ❑ Stomach: When? _____________
- ❑ Venereal disease: When? _______

Please list any other medical conditions you have or have had in the past that are not listed above:

____

____

35) Please list hospitalizations, for medical conditions or injuries, including "year".

a)___________________________________ Year _________ **c)** _______________________ Year _______

b) ___________________________________ Year _________ **d)** _______________________ Year _______

PAST SURGICAL HISTORY

37) Please list any previous surgeries and "year".

a) _____ **Year** _____ **c)**_____ **Year** _____
b) _____ **Year** _____ **d)**_____ **Year** _____

38) Do you PRESENTLY have ANY of the following? (Check all that apply)

❑Depression ❑Crying/Near-crying episodes ❑Anxiety ❑Irritability ❑Useless feelings
❑Poor concentration ❑ Poor memory ❑ Frequent thoughts of suicide ❑Active suicidal plan

---

a) Are you presently being treated by a psychologist/psychiatrist? _____Yes _____ No
b) If "Yes", please list the name of the doctor(s):_____
c) Have you ever attempted suicide? _____Yes _____No. If "Yes", when:_____ By what method?_____
_____
d)Do you have or have you ever had a chemical/drug dependency or addiction history? _____Yes _____No
e)If "Yes", to (d), please list actual chemical/drug, including alcohol: _____

FAMILY HISTORY

39) Fill in the health history about your family.

Relationship	**Age**	**State of Health**	**Age at Death**	**Cause of Death**
Father				
Mother				
Brother				
Brother				
Sister				
Sister				
_____				
_____				

40) Do you have a blood relative with a history of: (Check/list all that apply)

❑Alcoholism ❑Arthritis ❑Asthma ❑Cancer: What kind? _____ ❑Diabetes ❑Heart Disease
❑Hypertension ❑Kidney Disease ❑Tuberculosis Other: _____

OCCUPATIONAL HISTORY

41) Work History (Check /list all that apply):

a) Occupation: _____ b) Are you working now? ____Yes ____NO

c) If "No", when did you stop? _____

d) If not working, why did you stop? ❑Pain ❑Disability ❑ Laid Off ❑Retired

❑Could not perform job because of work restrictions

PERSONAL / SOCIAL HISTORY

42) Marital status: (Check only one) ❑ Single ❑Married ❑Divorced ❑Separated ❑Widowed

43) Educational History: (Check highest level achieved) ❑Pre-High School

❑High School ❑9 ❑10 ❑11 ❑12 **❑GED ❑College** ❑1 ❑2 ❑3 ❑4 **❑PhD ❑MD ❑DO ❑JD**

44) Smoking History: ____packs daily for _____year(s). Quit? Year _____

45) Alcohol History: (Check/complete all that apply)

_____Beers daily _____for year(s) ❑Drink occasionally ❑Drink socially ❑Do not drink

Quit drinking alcohol? Year _____

46) Illicit Drug Use:

a) History of ___ Yes ___ No. If "Yes", what substance(s)? _____

b) Ever been arrested/convicted of drug trafficking, abuse, misdemeanor charges related to the use of controlled substances? ____ Yes ____ No. If "Yes" when? _____ where? _____ what substance(s)_____

47) Hobbies / Sports / Leisure Activities: _____

48) Does pain PREVENT you from doing hobbies / leisure activities: _____ Yes **_____** No.

49) Does pain LIMIT you from doing hobbies / leisure activities: _____ Yes **_____** No.

50) Does pain PREVENT you from having sexual activity? _____ Yes **_____** No.

51) Does pain LIMIT you from having sexual activity? _____ Yes **_____** No.

52) What are your expectations regarding your pain?

53) Allergies to medications: (Please NAME the medication(s) and the TYPE of allergic reaction to each

a)_____ Reaction: **_____** **b)** _____Reaction: _____

c)_____ Reaction: **_____** **d)** _____Reaction: _____

54) Please list all other prescribed medications (other than your pain medications) you take and <u>DOSAGE:</u>

a) _____ **b)**_____

c) _____ **d)**_____

e)_____ **f)** _____

g) _____ **h)**_____

55) Please list all over-the-counter medications, including herbal medications, e.g., St. John's Worth, Ginseng:

a) _____ **b)**_____

c) _____ **d)**_____

REVIEW OF SYSTEMS

56) GENERAL: (Check / list all that applies)

❑Fevers ❑Fatigue ❑Night sweats ❑Weight gain _____ lbs. over past _____ ❑weeks/ ❑months

❑Chills ❑Weakness arm(s) ❑Weakness leg (s) ❑Weight loss _____lbs. over past_____ ❑weeks/ ❑months

Anesthesia problems:_____

57) EYES: (Check/list all that apply)

❑Vision loss ❑Blurred vision for _____months ❑Double vision ❑Visual flashes

58) EARS, NOSE & THROAT (Check all that apply)

❑Bleeding gums ❑Difficulty swallowing ❑Earaches ❑Ear discharge ❑Hay fever

❑Hearing loss ❑Hoarseness ❑Nose bleeds ❑Ear ringing ❑Sinus trouble

59) RESPIRATORY (Check/ list all that apply)

❑Shortness of breath _____with: ❑Mild exertion ❑Moderate exertion ❑Heavy exertion

❑Wheezing

❑Shortness of breath at: ❑Rest ❑Night ❑Lying flat

❑Chronic cough: ❑Unchanged _____ ❑Worsening over past___ months

60) CARDIOVASCULAR (Check all that apply)

_____ Chest pain or chest tightness that is **brought on by exertion** over past __ months

_____ Chest pain that is **not associated** with exertion. Do you have a pacemaker? ____

❑Palpitations ❑Rapid heartbeat ❑Varicose veins

61) GYNECOLOGICAL (Check all that apply)

❑Abnormal pap smear: When? _____

❑Painful intercourse ❑Vaginal bleeding between periods ❑Excessive with periods

Hot flashes: ❑Yes ❑No

62)SKIN/BREAST (Check all that apply)

❑Dry skin ❑Rash on _____ ❑Skin cancer: Location: _____

❑Skin lesion(s): Location: _____

❑Nipple discharge: ____ Right __ Left Bloody? ____ Yes ____No

❑Breast lump: Location: _____

63) GASTROINTESTINAL (Check all that apply)

❑Loss of appetite ❑Bowel habit changes ❑Constipation ❑Nausea: When?____

❑Hemorrhoids ❑Incontinence, stool ❑Indigestion ❑Diarrhea ❑ Heartburn: ❑After meals ❑At night

❑Abdominal pain: When? _____ ❑Rectal bleeding: When?_____ How often? _____

❑Vomiting? When? _____ How often?_____ ❑Associated with blood? ____Yes____ No

64) GENITOURINARY (Check all that apply)

❑Blood in urine: When? _____ How often?_____ ❑Associated pain? ___Yes ___ No

❑Frequent urination ❑ Incontinence, urine ❑Painful urination ❑Urgency

MALE ONLY: ❑Ejaculation problem ❑Erection problem ❑Penis discharge

65) HEMATOLOGICAL! LYMPHATIC (Check all that apply)

❑Anemia ❑Swollen lymph nodes Where? _____ ❑Blood transfusion: Date: _____

66) ENDOCRINOLOGICAL (Check all that apply)

❑Brittle hair ❑Brittle nails ❑Hyperglycemia ❑Hypoglycemia ❑Heat/Cold Intolerance

❑Hypocalcaemia ❑If diabetic, please list your average blood sugar number:_____

67) ALLERGIC/ IMMUNOLOGICAL (Please list)

Allergies to other medication(s)?_____

Immunological disorder: _____

68) NEUROLOGICAL (Check all that apply)

❑Muscle weakness: Where?_____ ❑Numbness/ ❑Tingling: Where? _____

❑Gait disturbance ❑Mental status changes ❑Forgetfulness ❑Seizure: When? _____

❑Dizziness ❑Fainting episodes? How often? _____

_____

Patient Signature **Date**

Notice of Privacy Policy Practices and Patient Consent Form

It is the policy of our practice that all physicians and staff preserve the integrity and confidentiality of the Protected Health Information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical & PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patient to the highest degree possible. Patients should not fear about providing information to our practice and its physicians and staff for purpose of treatment, payment and healthcare operations (TPO). To that end, Pain Specialties, will:

Adhere to the standards set forth in the Notice of Privacy Practices.
Collect, use and disclosed PHI only in confidence with state & federal laws and current patient covenants and/or authorizations, as appropriate. Our practice WILL NOT disclosed PHI outside of TPO, such as marketing, employment, life insurance applicants, etc. without WRITTEN authorization.
Use and disclose PHI to remind patients of their appointment only with their permission.
Recognize that PHI collected about patients must be accurate, timely, complete and available when needed. Our practice will:

- Implement reasonable measures to protect the integrity of all PHI maintained about patients.

Recognize that patients have the right to privacy. *Pain* Specialties will respect the patient's individual dignity at all times. Our practice will respect the patient's privacy to the extent consistent with providing the highest quality of medical care possible and with efficient administration of the facility.
Act as responsible information stewards and treat all PHI as *sensitive and confidential.* Consequently, our practice will:

- Treat all PHI data as confidential in accordance with professional ethics, accreditation standards and legal requirements.
- Not disclose PHI data unless the patient or its authorized representative has properly consented to or authorized the release or the release is otherwise authorized by law.
- The patient has the right to inspect and obtain a copy of its record. In addition the patient has the right to request an amendment to its medical file in accordance with the law and professional standards.

Our practice WILL NOT TOLERATE any violation of this policy. Violation of this policy is ground for disciplinary action, up to and including termination of employment and criminal and professional sanctions in accordance with our rules and regulations.
Our practice may change this policy in the future in accordance to state mandates. Any changes will be effective upon the release of a revised privacy policy and it will be available upon request.

I hereby give my consent for *Pain* Specialties to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Pain Specialties, Notice of Privacy Practices provides a more complete description of such uses and disclosures,

I have the right to review the Notice of Privacy prior to signing this Consent. Pain Specialties reserves the right to review its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pain Specialties at:

Richard L. Smith, MD P.A.
DBA: Pain Specialties
138 East Gore Street Orlando, FL 32806

With this Consent, Pain Specialties may mail to my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others. **Decline: _____**

With this Consent, Pain Specialties may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential**. Decline:** _____

With this Consent, Pain Specialties may e-mail to my home or other alternative location any items that assist the practice in carry out TPO, such as appointment reminder cards and patient statements. I have the right to request that *Pain* **Specialties** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this Consent.
Decline: _____

By signing this Consent, I am consenting to **Pain Specialties** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I **do not** sign this Consent, or **later revoke** it, Pain **Specialties** *may decline to provide treatment to me.*

Print Name:_____ Patient Signature:_____ Date:_____

If patient has a GUARDIAN: Print Name:_____ Signature:_____ Date:_____

CONSENT FOR TREATMENT, PAYMENT AND HEALTHCARE

OPERATIONS

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. This Notice provides you with information to protect the privacy of your confidential health care information, hereafter referred to as protected health information (PHI). The Notice also describes the privacy rights you have and how you can exercise those rights. Please review it carefully before signing. If we change our Notice, you may obtain a revised copy by requesting it at your visit, or in writing to our MEDICAL RECORDS DEPARTMENT.

Pain Specialties is committed to maintaining and protecting the confidentiality of our patient's personal information. This Notice of Privacy Practices applies to Pain Specialties are required by federal and state law to protect the privacy of your individually identifiable health information and other personal information. We are required to provide you with this Notice about our policies, safeguards and practices.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form you consent to our using and disclosing protected health information about you for the limited purpose of receiving treatment from us, obtaining payment for the healthcare services provided to you, and our own health care operations.

You have the right to revoke this consent, but such revocation must be made in writing. Your revocation will be honored on the day that it is signed and received by our office, except where we have already made disclosures in reliance upon your prior consent.

I agree to the terms contained within this Consent Form:

_____
(Patient's Signature)

Date:_____ _____
(Print Name)

OR

_____
(Signature of Patient's Representative)

_____
(Relationship to Patient)

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HELATH INFORMATION TO
RICHARD L. SMITH, MD P.A.
138 East Gore Street Orlando, FL 32806
407-650-0033 **Fax 407-650-0032**

Date:_____

Patient Name: _____

Date of Birth: _____ SS #: _____

I, _____ hereby authorize RICHARD L. SMITH, MD to

☐ Release copies
☐ Obtain Records

Only 1 Physician Per Release

From:
Name of Physician, healthcare facility or Group _____

Address: _____

Phone: _____ Fax: _____

For the purpose of:

- ☐ Continued Treatment
- ☐ Personal Use
- ☐ Patient Communication
- ☐ BEHAVIORAL HEALTH
- ☐ Other: _____

Dates of Service:

INFORMATION TO BE DISCLOSED:

❑**History & Physical**	❑**Diagnostic testing**	❑**EMG**
❑**Progress Notes**	❑ **MRI**	❑**Nuclear Medicine**
❑**Hospital Discharge Summary**	❑**CT Scans**	❑**X-Rays**
❑**Operative Reports**	❑ **Bone Scan**	❑**Other:_____**

If applicable, I also give permission for the following to be disclosed (please Initial)

_____Infection with AIDS or HIV

_____Behavioral Health Services or Psychiatric Care

_____Treatment for Alcohol/Drug Abuse

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will NOT apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that any disclosure of information carries with it the Potential for an unauthorized disclosure and information may not be protected by federal confidentiality rules. If I have any questions about disclosures of my health information, I can contact the privacy officer at 9407) 650-0033. The facility, its employees, officers and physicians are hereby released form any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

☐ **I understand this expires within 1 (one) year of signature.**

_____ _____
Patient Signature **Date**

_____ _____
Witness **Date**

Me explicaron la razón de este documento y estoyde acuerdo que despachen expediente.

_____Firma de Paciente