Central Florida Pain and Rehab Clinic

Working together to improve your quality of life

3727 N. GOLDENROD RD., STE 103, WINTER PARK, FL 32792
Phone: (407) 673-9533 * Fax: (407) 673-1442
www.cfprc.com

NEW PATIENT INFORMATION FORM

PATIENT INFORMATION/INFORMACION DEL PACIENTE

NAME/NOMBRE _____ DOB/FECHA NACIMIENTO _____

SOCIAL SECURITY/SEGURO SOCIAL _____ GENDER/SEXO ( )F ( )M

MARITAL STATUS/ESTADO CIVIL ( ) SINGLE/SOLTERO ( ) MARRIED/CASADO ( ) DIVORCED/DIVORCIADO ( ) WIDOW/VIUDO ( ) OTHER/OTRO

RACE/RAZA (OPTIONAL) ( ) HISPANIC/HISPANO ( ) AFRICAN-AMERICAN/AFRO-AMERICANO ( ) ASIAN/ASIATICO
( ) WHITE/BLANCO ( ) AMERICAN INDIAN/INDIO-AMERICANO ( ) OTHER

ETHNICITY/ETNIA ( ) HISPANIC OR LATINO/HISPANO O LATINO ( ) NOT HISPANIC OR LATINO/NO HISPANO O LATINO

LANGUAGE/IDIOMA ( ) ENGLISH ( ) ESPAÑOL ( ) ENGLISH & ESPAÑOL ( ) OTHER

MAILING ADDRESS/ DIRECCION DE CORREO _____
ADDRESS/DIRECCION CITY/CIUDAD STATE/ESTADO ZIP CODE/CODIGO POSTAL

PHONE CONTACT/TELEFONOS DE CONTACTO _____
HOME/CASA WORK/TRABAJO CELL/CELULAR

EMERGENCY CONTACT/CONTACTO DE EMERGENCIA _____

RELATIONSHIP/PARENTEZCO _____ PHONE/TELEFONO _____ HOME ¦ WORK ¦ CELL

PCP/DOCTOR PRIMARIO _____ PHONE/TELEFONO _____

EMPLOYER NAME/EMPLEADOR _____ PHONE/TELEFONO _____

HEALTH INSURANCE/SEGURO MEDICO

PRIMARY INSURANCE/SEGURO PRIMARIO _____

POLICY NUMBER/NUMERO POLIZA _____ GROUP NUMBER/NUMERO GRUPO _____

POLICY HOLDER/PROPIETARIO POLIZA _____ DOB/FECHA NACIMIENTO _____

RELATIONSHIP/PARENTEZCO _____ PHONE/TELEFONO _____

OTHER INSURANCES _____

AUTO INSURANCE/SEGURO DE AUTO

INSURANCE NAME/NOMBRE ASEGURADORA _____

AGENT NAME/NOMBRE AGENTE _____ PHONE/TELEFONO _____

DATE OF ACCIDENT/FECHA ACCIDENTE _____ CLAIM NUMBER/NUMERO DE RECLAMO _____

POLICY NUMBER/NUMERO DE POLIZA _____

ATTORNEY NAME/NOMBRE ABOGADO _____ PHONE/TELEFONO _____

ENGLISH: I represent and affirm that the above information is true and correct, and it is my understanding that **Central Florida Pain & Rehab Clinic** is relying on the above information that I have provided. I have read the "Consent for Treatment, Acknowledgment of Liability and Assignment of Benefits" forms on the following page and as the patient, or patient's authorized representative of general agent for the purpose of signing this document. I hereby accept its terms.
ESPAÑOL: Declaro y afirmo que la información anterior es verdadera y correcta, y es mi entendimiento de que **Central Florida Pain & Rehab Clinic** se basa en la información anterior que he proporcionado. He leído los formatos anexos " Consent for Treatment, Acknowledgment of Liability and Assignment of Benefits " y que tanto el paciente como su representante autorizado para firmar este documento aceptan sus términos.

_____ _____
PATIENT SIGNATURE/FIRMA PACIENTE DATE/FECHA

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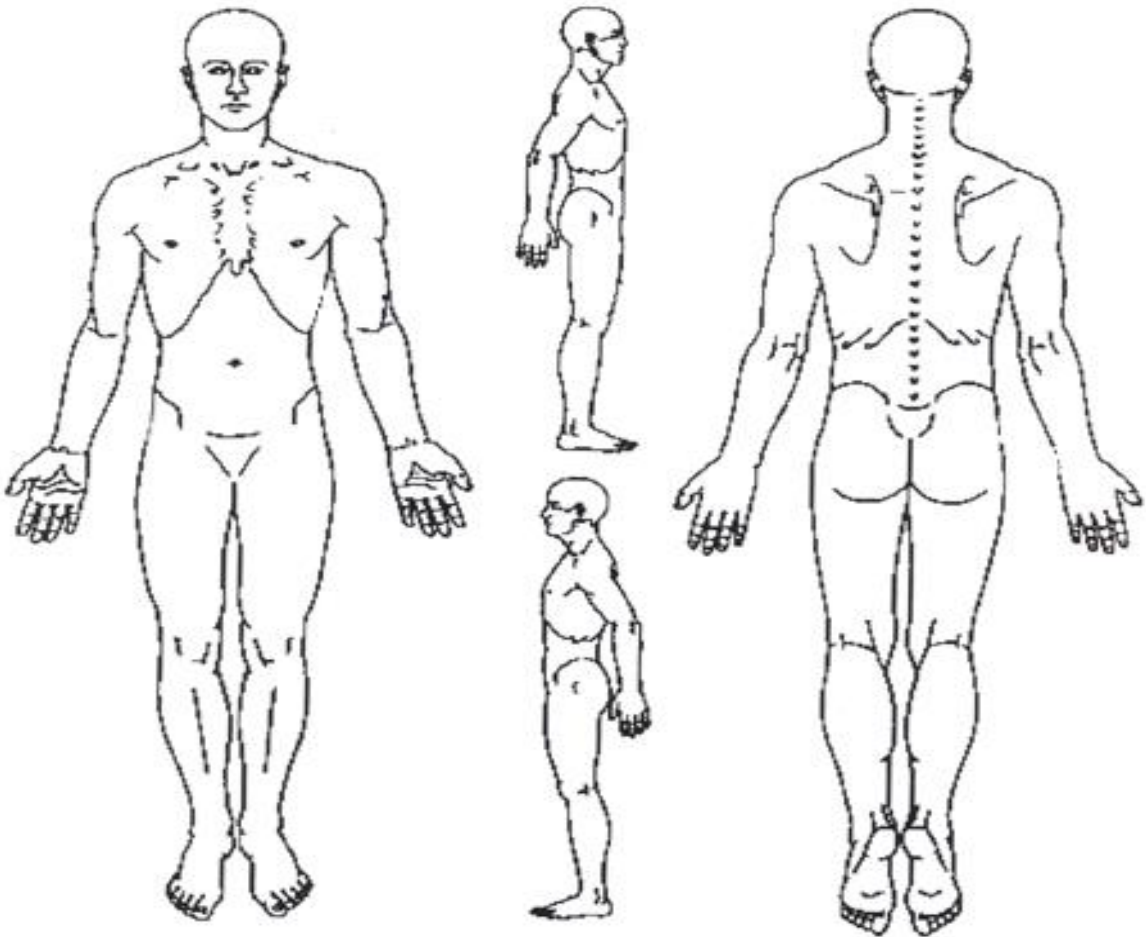
PAIN DIAGRAM FORM

_____ _____ _____
Patient Name / Nombre del Paciente | DOB / Fecha de Nacimiento | Date / Fecha

How Long Have You Had Pain _____ Years _____ Months _____ Weeks.

Desde Hace Cuanto Tiene el Dolor _____ Años _____ Meses _____ Semanas

On the Diagram Below, Please Indicate Where You Are Experiencing Pain or Other Symptoms.
En el Siguiente Diagrama, Favor Indicar Donde Esta Usted Experimentando Dolor u Otros Síntomas.



A = Ache / Molestia - Dolor	**B** = Burning / Quemazón	**N** = Numbness / Adormecimiento
P = Pins and Needles / Hormigueo	**S** = Stabbing / Punzadas	**O** = Other / Otro

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MEDICAL QUESTIONNAIRE

____
Date / Fecha

Patient Name / Nombre Paciente	DOB / Fecha Nacimiento	☐ Lt / Izq ☐ Rt / Der Handed / Mano dominante	Age	☐ F ☐ M Gender / Sexo
______________________	____________________		______	

1. Chief Complain / Queja Principal: ____

2. How long have you had this problem? / Por cuánto tiempo ha tenido este problema? ______________

3. Please specify a date / Por favor especifique la fecha: ______________

4. It this work related?	☐ Yes	☐ No	If yes, did you notify to your supervisor?	☐ Yes	☐ No
Es relacionado al trabajo?	☐ Si	☐ No	Si es así, lo notifico a su supervisor?	☐ Si	☐ No
5. Did you have similar complaints in the past?	☐ Yes	☐ No	Tuvo problemas similares en el pasado?	☐ Si	☐ No
6. Do you have any other complaints?	☐ Yes	☐ No	Describe: ______________________________		
Tiene usted alguna otra queja?	☐ Si	☐ No	Describir: ______________________________		

7. Please list any physician you have seen in the past for this condition / Favor liste los médicos que usted ha visto anteriormente por esta condición :

Physician Name / Nombre Médico	Treatments / Tratamientos
- - - - - - - - - - - - - - - - - - - -	- -
- - - - - - - - - - - - - - - - - - - -	- -
- - - - - - - - - - - - - - - - - - - -	- -
- - - - - - - - - - - - - - - - - - - -	- -

8. Past Medical Treatment / Tratamientos Médicos Anteriores:

Surgery / Cirugías	☐ Yes / Si	☐ No	Psychiatric Care / Cuidados Psiquiátricos	☐ Yes / Si	☐ No
Massage / Masaje	☐ Yes / Si	☐ No	Physical Therapy / Terapia Física	☐ Yes / Si	☐ No
Psychology / Psicólogo	☐ Yes / Si	☐ No	Chiropractic Care / Quiropráctico	☐ Yes / Si	☐ No
Acupuncture / Acupuntura	☐ Yes / Si	☐ No	Muscle - Joint Inject / Inyección (Muscular - Coyuntura)	☐ Yes / Si	☐ No
Traction / Tracción	☐ Yes / Si	☐ No			

Others / Otros ____

9. What part of your body hurts the most? / Qué parte de su cuerpo duele más? ____________________

10. Does the pain travel to other parts of your body? / El dolor viaja a otras partes del cuerpo? □ Yes / Si □ No

If yes, where? / Si es cierto, donde? _____

11. Since the onset, is the pain: / Desde el día que ocurrió el dolor, este está:

Better / Mejor	□ Yes / Si □ No	Intermittent / Intermitente	□ Yes / Si □ No
Worse / Peor	□ Yes / Si □ No	Constant / Constante	□ Yes / Si □ No
Same / Igual	□ Yes / Si □ No		

12. In a scale from 0 – 10, please rate your usual pain: / En escala del 0 al 10 cuanto le duele usualmente:

Least (menos) ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ Most (mas)

13. Please check what best describes your pain: / Favor marque lo que mejor describa su dolor:

Burning / Quemazón	□ Yes / Si □ No	Shooting / Irradiado	□ Yes / Si □ No
Stabbing / Puñaladas	□ Yes / Si □ No	Sharp / Punzadas	□ Yes / Si □ No
Throbbing / Palpitaciones	□ Yes / Si □ No	Dull / No tan fuerte	□ Yes / Si □ No
Pressure / Presión	□ Yes / Si □ No	Ache / Molestia	□ Yes / Si □ No

14. Please check what of the following makes your pain worse: / Favor mencione qué agrava su dolor:

Sneezing / Estornudar	□ Yes / Si □ No	Walking / Caminar	□ Yes / Si □ No
Stress / Estrés	□ Yes / Si □ No	Coughing / Toser	□ Yes / Si □ No
Prolong Standing Estar de pie por mucho tiempo	□ Yes / Si □ No	Bending Over / Backwards Doblarse para adelante / atrás	□ Yes / Si □ No
Prolong Sitting Estar sentado por mucho tiempo	□ Yes / Si □ No	Lifting something Levantar algo	□ Yes / Si □ No

Others / Otros: _____

15. Which of the following makes your pain feel better? / Cuáles de los siguientes le alivia su dolor?

Cold Compress / Compresas Frías	□ Yes / Si □ No	Medication / Medicinas	□ Yes / Si □ No
Hot Compress / Compresas Calientes	□ Yes / Si □ No	Resting / Descansar	□ Yes / Si □ No
Exercising / Ejercitarse	□ Yes / Si □ No	Others / Otros _____	

16. What time of the day does your pain feel worse? / A qué horas del día su dolor se agrava?

_____

17. Please check mark what best applies in association with your pain: / Favor marque que es lo que más se asocia a su dolor:

Loss of bowel or bladder control / Pérdida del control de sus necesidades básicas	□		
Balance Difficulty / Problemas de balance	□	Anxiety / Ansiedad	□
Difficulty Sleeping / Dificultad al dormir	□	Fever – Chills / Fiebre - Escalofrío	□
Weakness / Debilidad	□	Where / Donde: _____	
Numbness / Adormecimiento	□	Where / Donde: _____	
Pins and Needles / Hormigueo	□	Where / Donde: _____	

PAST MEDICAL HISTORY / HISTORIA MEDICA ANTERIOR

Asthma / Asma	☐	Arthritis / Artritis	☐	Blood Clots / Coágulos de Sangre	☐
Cancer / Cáncer	☐	Depression / Depresión	☐	Pulmonary Embolism / Embolia pulmonar	☐
Anemia / Anemia	☐	Thyroid Disease / Tiroides	☐	Liver Diseases / Enfermedades del hígado	☐
Ulcers / Ulceras	☐	Hypertension / Hipertensión	☐	Kidney Diseases / Enfermedades del riñón	☐
Diabetes / Diabetes	☐	Osteoporosis / Osteoporosis	☐	Heart Diseases / Enfermedades del corazón	☐
Gastritis / Gastritis	☐	Bleeding Disorder / Sangrado	☐	Skin Diseases / Enfermedades de la piel	☐
None / Ninguno	☐	Others: / Otros: _____			

PAST SURGICAL HISTORY / HISTORIA QUIRURGICA ANTERIOR

Surgical Procedure / Procedimiento Quirúrgico	Date / Fecha	Physician Name

FAMILY MEDICAL HISTORY / HISTORIA MEDICA FAMILIAR

Asthma / Asma	☐	Diabetes / Diabetes	☐	Skin Diseases / Enfermedades de la piel	☐
Cancer / Cáncer	☐	Thyroid Disease / Tiroides	☐	Kidney Diseases / Enfermedades del riñón	☐
Arthritis / Artritis	☐	Osteoporosis / Osteoporosis	☐	Heart Diseases / Enfermedades del corazón	☐
None / Ninguno	☐	Others: / Otros: _____			

LIST OF CURRENT MEDICATION / LISTA DE LOS MEDICAMENTOS ACTUALES

Name of Medication / Nombre del Medicamento	Dose / Dosis	Quantity per day / Cantidad por día

Drugs Allergies / Drogas a las que es alérgico	Reaction / Reacción

SOCIAL HISTORY / HISTORIA SOCIAL

Single / Soltero (a) ☐ Married / Casado (a) ☐ Divorced / Divorciado (a) ☐ Widow / Viudo (a) ☐

Do you smoke? / Usted fuma? ☐ Yes / Si ☐ No _____ cigarettes per day / cigarrillos por día

Do you drink alcohol? Usted bebe alcohol? ☐ Yes / Si ☐ No _____ drinks per day / tragos por día

Have you ever use any illegal drugs? / Ha usado usted alguna droga ilegal? ☐ Yes / Si ☐ No Name of the drug(s) / Nombre de la(s) droga(s) _____

EMPLOYMENT HISTORY / HISTORIAL LABORAL

What is your occupation? / Cuál es su ocupación? _____

How long have you work there? / Por cuánto tiempo ha estado usted trabajando allí? ___ mm ___ yy/aa

Are you disabled? / Es usted deshabilitado? ☐ Yes / Si ☐ No

If yes, please explain: / Si es así, por favor explique: _____

_____

If your work requires to lift more than 10 lb, please specify maximum: / Si su trabajo requiere levantar mas de 10 lb, por favor indique el peso máximo: _____

Has your work being affected by your current condition? Su trabajo ha sido afectado por su condición actual? ☐ Yes / Si ☐ No

If yes, please explain: / Si es así, por favor explique: _____

_____

FUNCTIONAL HISTORY / HISTORIA FUNCIONAL

Please check mark which of the following has been affected by your condition: / Favor marque cuál de los siguientes ha sido afectado por su condición:

Physical or Hand Activity / Actividades Físicas o Manuales

Walking / Caminar	☐	Touch / Tocar	☐
Stairs / Escaleras	☐	Grasp / Agarrar	☐
Sports / Deportes	☐	Write / Escribir	☐
Lifting / Levantar peso	☐	Type / Mecanografiar	☐

Traveling /Viajes

Driving / Manejar	☐
Flying / Volar	☐

Various Activities /Actividades Varias

Sexual Function / Función sexual	☐

Personal Hygiene /Higiene personal

Bathing / Bañarse	☐
Dressing / Vestirse	☐
Eating / Comer	☐
Going to the bathroom / Ir al baño	☐

REVIEW OF SYSTEMS / REPASO DE SISTEMAS

Please check mark what applies the best to you: / Favor marque lo que mejor aplique a su caso:

General	Loss of Appetite Pérdida del Apetito	☐	Weight Loss Pérdida de Peso	☐	Weight Gain Aumento de Peso	☐	Fatigue Fatiga	☐	Fever Fiebre	☐
Skin **Piel**	Color Changes Cambios de Color	☐	Rashes Salpullido	☐	Lumps Nódulos	☐				
Head **Cabeza**	Concentration Concentración	☐	Headaches Dolor de Cabeza	☐	Memory Memoria	☐				
Eyes **Ojos**	Excessive Tearing Lagrimar mucho	☐	Blurry Vision Visión Borrosa	☐	Eye Glasses Anteojos	☐	Pain Dolor	☐	Double Vision Visión Doble	☐
Ears **Oídos**	Hearing Loss Perdida de Audición	☐	Ear Infections Infección de Oídos	☐	Earaches Dolor de Oídos	☐	Vertigo Vértigo	☐	Tinnitus Silbidos	☐
Nose **Nariz**	Sinus Sinusitis	☐	Congestion Congestión	☐	Allergies Alergias	☐				
Mouth **Boca**	Sore Throat Dolor de Garganta	☐	Hoarseness Ronco	☐						
Neck **Cuello**	Lumps Nódulos	☐								
Lungs **Pulmones**	Shortness of breath Respiración Corta	☐	Sputum Flema	☐	Cough Toser	☐				
Heart **Corazón**	Palpitations Palpitaciones	☐	Chest Pain Dolor de Pecho	☐						
Abdomen	Constipation Estreñimiento	☐	Vomiting Vómito	☐	Heartburn Acidez	☐	Pain Dolor	☐	Nausea Nauseas	☐
	Diarrhea Diarrea	☐	Ulcers Ulcera	☐						
Extremities	Poor Circulation Circulación Pobre	☐	Swelling Hinchazón	☐						
Bladder **Vejiga**	Burning on Urination Ardor al Orinar	☐	Incontinence Incontinencia	☐	Urinating a lot Orinar mucho	☐	Urgency Urgente	☐		
Vascular	Leg Cramps Calambre en piernas	☐	Varicose Veins Venas Varicosas	☐	Easy Bruising Moretones	☐	Bleeding Sangrado	☐		
Endocrine **Endocrino**	Excessive Sweating Sudor Excesivo	☐	Cold Intolerance Intolerancia al Frío	☐	Heat Intolerance Intolerancia al Calor	☐				
Psych / **Neuro**	Tremors Temblores	☐	Syncope Desmayos	☐	Seizures Convulsiones	☐	Anxiety Ansiedad	☐	Depression Depresión	☐

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ACKNOWLEDGEMENT OF LIABILITY
ASSIGNMENT OF BENEFITS

- **FINANCIAL STATEMENT:** The undersigned patient and/or responsible party, hereby acknowledge personal responsibility and liability for all the medical services, which are provided by **Central Florida Pain & Rehab Clinic**.
  This personal obligation is not affected by any obligation of insurance companies to pay health care costs. I understand that **Central Florida Pain & Rehab Clinic** will process an initial claim for all services rendered to me and file it with my insurance carrier. Therefore, I authorize and request that my insurance carrier pays DIRECTLY to **Central Florida Pain & Rehab Clinic** all insurance benefits otherwise payable to me.
  I also understand and agree that my insurance policy is a contract between myself and my insurance carrier and I am ultimately financially responsible for payment of all services rendered to me, which my insurance carrier has not paid (within 90 days) or for services which my insurance carrier has determined not to be covered by my policy.

- **CONSENT FOR TREATMENT**: The undersigned hereby consents to the provision of examination, fitness evaluation, treatments, therapies, medical procedures, drugs and supplies to the patient as ordered by the patient's health care provider of **Central Florida Pain & Rehab Clinic** of their physician, physical therapist, certified athletic trainer or staff, and acknowledges that no guarantee or assurance has been made to the results of such treatments, procedures or examinations.

- **RELEASED INFORMATION: Central Florida Pain & Rehab Clinic** provided me with a Notice of Privacy Practice that gives a complete description of information, uses and disclosures. I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

- **ASSIGNMENT OF RIGHTS**: I assign exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity to the extent of my bill for total services, including exclusive, irrevocable right to receive payment for such services, make demand in my name for payments and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by an insurance company or other person or entity. I as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and/or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy and any information supporting documentation concerning or touching upon handling, calculation, procession, or payments of any claim.

- **PAYMENTS AND COLLECTION FEES:** I clearly understand and agree that if I do not pay the entire new balance within 30 days of the monthly billing a late charge of 1.5% on the balance then unpaid and owed will assessed each month (if allowed by law) I realize that failure to keep my account current may result in **Central Florida Pain & Rehab Clinic**, being unable to provide additional services except for emergencies or where there is a CASH pre-payment for additional services. In the case of default on payment on my account, I agree to pay collection cost (45%) and reasonable attorney fee incurred in attempting to collect on this amount or any future outstanding account balances. I also understand that **Central Florida Pain & Rehab Clinic** may charge an administrative surcharge of **$15.00** for processing your co-insurance and/or deductible amounts after your visit.

- **MISSED APPOINTMENTS**: I clearly understand and agree, that in order for the evaluation and treatment of my current pain problem (s) to be effective, it is extremely important for me to keep my scheduled appointments. I realize that this time has been exclusively reserved for me and agree that if I am unable to keep my appointment I will give **Central Florida Pain & Rehab Clinic**, at least 24 hours advance notice. I understand that failure to do such indicates noncompliance to my recommended plan of treatment and may result in being charged for a "MISSED" appointment fee.

In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of the Agreement shall remain enforceable. A PHOTOCOPY OF THE INSTRUMENT SHALL SERVE AS ORIGINAL.

_____	_____	_____
Printed Name	Signature	Date

Spanish Version: Por motivos legales el consentimiento del paciente debe estar consignado en este documento en inglés, pero si usted no tiene claridad con respecto a algo aquí relacionado, favor solicite la versión en español del mismo a nuestro personal.

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OPERATING POLICIES & PROCEDURES

OFFICE HOURS: Monday 8:00 am – 4:30 pm, Tuesday-Friday 8:00 am – 3:30 pm. We are closed for lunch between 12:00 pm – 1:00 pm on Mon/Wed/Fri, and from 12:00 pm – 12:30 pm on Tue/Thurs.

EMERGENCY/AFTER HOURS: You must dial 911 to seek immediate medical attention.

APPOINTMENTS SCHEDULING: We seek to accommodate the needs of our patients and will schedule your appointment at the most convenient time possible,. However, we will need all records from previous doctors who treated you for the same condition including Primary Care Physicians. These records usually must be reviewed by our doctor prior to schedule your appointment.

APPOINTMENT REMINDER CALLS: Central Florida Pain & Rehab Clinic will attempt a courtesy reminder text to patients prior to their scheduled appointment. ***This is not an obligation*** and the patient will be responsible for keeping the appointment time. In case of a patient phone number change or disconnection, the patient is responsible to communicate with us to confirm the appointment. If patient does not confirm an appointment, **Central Florida Pain & Rehab Clinic** reserves the right to cancel the appointment and charge the no-show fee.

APPOINTMENT ARRIVAL TIME: Patients must arrive on time to the scheduled appointment. Our office reserves the right to not see a patient past their appointment time.

NO-SHOW/LATE CANCELLATION POLICY: Failure to keep a scheduled appointment has, in effect, prevented another patient from receiving medical care during the allotted time slot. Cancellations or reschedules must be received **24 hours** in advance for follow up appointments, and **48 hours** in advance for procedures, so that we may accommodate patients who need to be seen. If a patient fails to no show or late cancel for an appointment and does not provide the proper notice, a no-show or late cancellation fee will be charged.
No Show/Late Cancelation fees are as follow: Follow Up Visits $ _25.00_, Procedures $ _75.00_, EMG/NCS $ _100.00_. These charges will not be billed to an insurance provider. Your appointment time is allotted to you so we will charge you for failure to call.

INSURANCE AND DEMOGRAPHIC INFORMATION: We must verify your insurance and demographic information at each visit. This ensures that we process accurate billing for you and your insurance company. You must notify the office of any changes regarding your demographic or insurance information. Changes of insurance must be verified prior to your visit, otherwise your appointment might be rescheduled.
If you do not have your insurance card or insurance information available at the time of your initial visit, you will be considered self-pay and payment will be expected at the time of service.

PAYMENTS AND COLLECTION FEES: Your co-pay, co-insurance amount and/or deductibles are due at the time of service. We are unable to discount, waive or bill these fees at a later time due to our contracts with the insurance companies. All outstanding balances are also due at the time of your visit. If, for an unforeseeable reason, you do not have the co-insurance amount and/or deductible with you at the time of service, please be aware that **Central Florida Pain & Rehab Clinic** may charge you an **administrative surcharge of $15.00** for processing these payments after your visit. ***You may be asked to reschedule your appointment if you are unable to make payment***.
We accept Cash, Visa and MasterCard.
If any pending balance it is not paid within **30 days**, a **1.5% finance charge** per month will be added. Accounts past due after **90 days**, are turned to a collections agency. An additional **40% fee** is added to account balances once they are turned to collections.

INSURANCE BILLING: As a courtesy, our office will file your insurance if you provide us with the proper information. You are expected to pay your deductible and any out-of-pocket portions at the time services are rendered. In the event your insurance overpay, we will refund you promptly. **Since your insurance coverage is a contract between you and your carrier, if payment is not received from them within 60 days, you are immediately responsible for the remaining balance.**

COMPANION POLICY: Central Florida Pain & Rehab Clinic requests scheduled patients bring only **one companion** to an appointment. In the event that more than one person accompanies a patient, **only one will be permitted in the clinical area**. All other members must remain in the waiting room.
If you must bring your child/children, for their own safety they have to remain in the waiting area during all your appointment time. If your child/children are under the age of 8, and adult must accompany them during your visit.
Central Florida Pain & Rehab Clinic will not be responsible for unattended child/children.

Initials _____

Date _____

COMPLETION OF FORMS: Employer, FMLA, insurance forms, Disability or any other paperwork that requires your provider's input, can be very time consuming for both you and your provider. Please be sure to complete all required information with your provider to review the requested information. There is a required prepayment of $10.00 per page. Processing time takes up to **10 business days** after payment is received.

PRESCRIPTION REFILLS: Please do not wait until you are out of your medication. Allow at least two working days for the provider to approve refills or for an available appointment. Medico-legal reasons require the doctor to examine the patient in the office before giving a diagnosis or offering treatment. Therefore, a patient must be seen in a monthly basis to get any controlled medication. We will not accept refill requests on Fridays after 2pm. ***Controlled substance prescription refills will not be made after office hours or on weekends***. Due to the nature of our practice all patients taking controlled substances are subject to random urine drug screening test and pill counting. In case of a patient refusing the test or an abnormal screening result, prescriptions may be denied and the patient might be discharge from the practice.

TEST RESULTS: Good medical care cannot always be accomplished over the phone, so we may advise you to schedule an office visit to discuss your concerns, problems, or test results. Test results may take up to a week and it is recommended that the patient schedule an appointment around that time to review the results with the physician. If you have any questions about bills received for lab services or diagnostic tests, we ask that you contact the service provider directly. **Central Florida Pain & Rehab Clinic** has no knowledge or jurisdiction on any other service provider.

REFERRALS & AUTHORIZATION: A referral from your Primary Physician may be needed to receive any treatment or to be seen at our office. We will request the referral or authorization from your primary doctor as a courtesy to you, however it is the patient's responsibility to make sure that the proper authorizations are given before the scheduled appointment. You may contact your primary doctor directly to request the referral or the authorization needed. If your insurance does not require a referral from your primary care, you may contact our office directly to schedule an appointment. If you are scheduling your initial appointment all previous medical records related to the condition for which you are requesting the appointment will be requested and must be received and may be reviewed by our physician prior to your appointment been scheduled. A release of medical records enables us to obtain your medical records from your previous physicians. If at all possible, you can download this document from our web page www.cfprc.com and fax it to us prior to your visit or come by our office to sign this form.

REQUESTS FOR MEDICAL RECORDS: We will release copies of a patient's medical record with written, signed patient authorization. Standard legal fees for copies apply if records are requested by the patient or if they required to be printed and mailed. You will not be charged a fee for records requested by a physician to whom we have referred you or any physician's office that will accepts records via facsimile.

TERMINATION FROM OUR PRACTICE: Our office values its patient relationships and wants to protect patients' rights. We will only terminate patient relationships with cause and after careful consideration. Reasons for termination include: repeated no-showing for scheduled appointments; not complying with recommended medical care; being hostile or abusive to staff; not compliance with the Narcotic Agreement, refusing the drug screening tests or not paying bills in a timely manner.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA): The federal government requires us to share our Privacy Notice, you can request a copy at the front desk, or download it from our website www.cfprc.com.

PLEASE REMEMBER: Please be advised, that we do not accept walk-ins, you must call to schedule an appointment with us. Cell Phones are not allowed in the clinical area. No food and drinks are allowed in the office. Due to limited space no strollers are allowed in the clinical area.

Thank you for choosing **Central Florida Pain & Rehab Clinic** for your *health care needs and for helping us provide the best care possible to you!*

_____	_____	_____
Patient Name	Patient Signature	Date

Spanish Version: Por motivos legales el consentimiento del paciente debe estar consignado en este documento en inglés, pero si usted no tiene claridad con respecto a algo aquí relacionado, favor solicite la versión en español del mismo a nuestro personal.

Central Florida
Pain and Rehab Clinic
Working together to improve your quality of life

3727 N. GOLDENROD RD., STE 103, WINTER PARK, FL 32792
Phone: (407) 673-9533 * Fax: (407) 673-1442
www.cfprc.com

CONSENT TO DISCLOSURE INFORMATION

NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I _____ , understand that as part of my health care, **Central Florida Pain & Rehab Clinic** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication between the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that gives a complete description of information uses and disclosures. I understand that I have the following right and privileges:

- The right to review the notice prior to signing this consent.
- The right to object the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that **Central Florida Pain & Rehab Clinic** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extend that the organization has already taken action in reliance there on. I also understand that by refusing to sign or revoking this consent, this organization may refuse to treat me as permitted by **Section 164.506** of the **Code of Federal Regulations**.

I further understand that **Central Florida Pain & Rehab Clinic** reserves the right to change their notice and practices and prior to implementation, in accordance with **Section 164.520** of the **Code of Federal Regulations**.
Should **Central Florida Pain & Rehab Clinic** change their notice, they will send a copy of any revised notice to the address I have provided, (whether U.S. mail or if I agree email).

I wish to have the following restrictions to use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I finally understand and accept the term of this consent.

_____ _____

Patient Signature Date

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URINE DRUG SCREENING AFFIDAVIT

SELF-PAY/LOP PATIENTS

_____
Date

I _____, hereby understand that the **Urine Screening Test is necessary and a requirement for any patient taking Narcotic Medications**. I also acknowledge, as stated in the narcotic agreement, this test will be performed randomly or as needed by the physician without previous notice.

I will be responsible for the balance and promise to pay it in full. The office fee for this test is ***$25.00*** and it will be due *thirty* (*30*) days after test is performed.

I understand that if I refuse to sign this affidavit I will not receive any controlled substances to treat my painful condition.

I also understand that by law, the sample collected will be sent to a specialty lab, which will conduct confirmations on any positive results as well as any additional screenings requested by the physician. This lab is an independent Lab and has no connection with our office; therefore they will conduct their own billing process and will submit claims to you. **Any denials or billing questions on these confirmations should be addressed directly with the Laboratory**. Our office has no knowledge or access to any billing information from any of these Laboratories.

_____	_____	_____
Patient Signature	DOB	Witness

_____
Legal Guardian (If patient is a minor)

Spanish Version: Por motivos legales el consentimiento del paciente debe estar consignado en este documento en inglés, pero si usted no tiene claridad con respecto a algo aquí relacionado, favor solicite la versión en español del mismo a nuestro personal.