

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City State Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Social Security # \_\_\_\_\_ Sex:  Male  Female

Date of Birth: \_\_\_\_\_ Marital Status:  Married  Single  Widowed  Divorced

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Is this a work related injury:  Yes  No

Is this injury related to a car accident:  Yes  No

**PHARMACY:** \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**PRIMARY INSURANCE:** If your insurance policy/policies are under another subscriber, please give their information.

Subscriber Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Is Patient covered by other insurance?  Yes  No

**ALTERNATE MAILING ADDRESS:** If you are a seasonal resident, please give alternate address information.

Street Address: \_\_\_\_\_

City State Zip \_\_\_\_\_

**PLEASE READ AND SIGN**

**Authorization to Treat:** I hereby grant permission to the physicians and staff to perform any necessary procedures to treat the medical conditions for which I am seeking assistance. I understand that, except in an emergency situation, the staff will discuss with me my treatment options and that I will have the opportunity to accept or refuse specific treatments at that time.

**Assignment of Benefits:** I certify that the information I have given is correct. I hereby authorize payment to South Lake Pain Institute, PA of the benefits payable to my physician(s). In applying for payment under Title XVIII of the Social security Act, I request payment of authorized benefits be made on my behalf to those who accept this assignment. I further understand that I am responsible for any charges not covered or payable by this assignment. Even though South Lake Pain Institute, PA accepts assignment of insurance company payments, insurance carriers occasionally send payment checks to the patient for services rendered by the physician. I agree to forward such payments I receive to South Lake Pain Institute, PA as soon as I receive them.

**Charges for Services:** The charges for South Lake Pain, PA Institute are for the physician's professional fees and services. These charges do not include hospital facility fees. The facility fees will be billed separately by the facility.

**Payment for Services:** As a courtesy to you, we will file claims with your insurance company. Monthly statements are mailed to patients if they are responsible for some portion of the bill. Patients who have no insurance coverage, or a copay or deductible are aware that payment is due at the time of service. Please call our office with any questions regarding your account.

**Patient Responsibility for Payment:** I understand that my insurance coverage is a contract between my insurance carrier and me, NOT between the insurance carrier and South Lake Pain Institute, PA. Ultimately, all fees are my responsibility. Should timely payments not be made on my account, I understand that a 10% (ten percent) late payment fee may apply if my account should exceed 60 (sixty) days past due. I understand that all copays and previous balances must be paid prior to seeing provider. If balances are not paid, appointment may be rescheduled. South Lake Pain Institute, PA reserves the right to refuse treatment and/or services to me until my account is brought current. I authorize South Lake Pain Institute, PA to retain the services of an attorney or collection agency to assist with the collection. Any expenses incurred by South Lake Pain Institute, PA for such action shall become an additional liability for which I assume responsibility. I understand that if my insurance requires a referral that is my responsibility to have a referral at time of visit from your Primary Care Physician or current treating physician.

I understand that I am required to notify the office if I am not able to keep my scheduled appointment. I understand that I will be charged \$25.00 for a follow up office visit, \$150.00 for procedures, and \$75.00 for New Patient appointments if I fail to cancel/reschedule within 24 (twenty-four) hours. I understand that I will be charged an additional fee for any returned checks. I understand that I will be charged for copies of all medical records. The fee for copies is \$1.00 per page up to 25 pages and \$.25 per page thereafter. These fees are to be paid prior to records being sent. I am required to give the office at least 30 days notice if requesting records. I understand that there is also a fee for medical forms. The cost of these forms will be discussed after reviewed.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**South Lake Pain Management  
Julie Saranita, D.O.  
845 Oakley Seaver Drive  
Clermont, Florida 34711**

**CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT,  
OR HEALTH CARE OPERATIONS**

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information (“protected health information”) and patient medical record information by South Lake Pain Management (the “Practice”) in order to carry out treatment, payment, or health care operations. The Patient should review the practice’s Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient’s requested restriction(s), such restrictions are then binding on the Practice.

Patient acknowledges and agrees that the Practice may disclose Patient’s protected health information and Patient medical record information to the following individuals who are either the Patient’s family members, legal representatives, guardians, health care surrogates, or have Power of Attorney on behalf of the Patient:

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The Patient agrees that the Practice may disclose the following types of information contained the Patient’s medical records (please initial the appropriate categories listed below):

- HIV/AIDS Information
- Mental Health Information
- Substance Abuse Information
- Sexually Transmitted Disease Information
- If Patient is under the age of eighteen (18), Pregnancy Information

Patient agrees and consents to the Practice releasing information to the Patient in the following alternative manners (please initial the appropriate spaces below):

\_\_\_\_\_ Via e-mail to the Patient's designated e-mail address which is:

\_\_\_\_\_

\_\_\_\_\_ Via regular mail with any envelopes being marked personal and confidential and addressed to Patient.

\_\_\_\_\_ Via telephone, if Patient contacts the Practice and provides the appropriate information (including the Patient's name, social security number and unique personal identifier).

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action in reliance on the consent.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to the Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

**I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

\_\_\_\_\_  
Signature of Patient (or Authorized Representative\*)

\_\_\_\_\_  
Print Name

\*Please explain Representative's relationship to Patient and include a description of Representative's authority to act on behalf of the Patient:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# South Lake Pain Institute

## Acknowledgment Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy upon request.

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 use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

- I am requesting a copy of South Lake Pain Institute's Notice of Privacy Practices.
- I am declining a copy of South Lake Pain Institute's Notice of Privacy Practices.

**Patient Name**

**(Print)** \_\_\_\_\_

**(Signature)** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

DOB: \_\_\_\_\_

**Please shade your area of pain.**

PM History:

*For Office Use Only*

Weight:

Height:

BP:

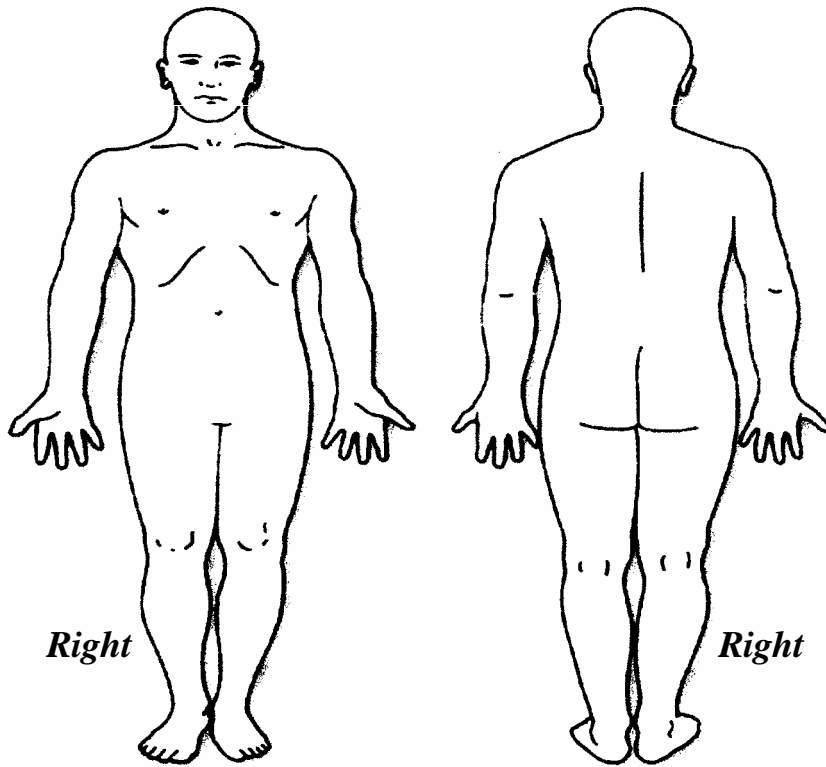
HR:

Temp:

Resp:

Ref Doc:

PCP:



***Please list all past and current treating physicians***

Physician Name

Phone Number

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# South Lake Pain Institute, PA

## New Patient Consultation

Date: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

### History of present pain problem

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

When did your pain start: \_\_\_\_\_

Location of your pain: \_\_\_\_\_

Description of your pain: \_\_\_\_\_

What event led to your present problem?:

Cancer    Operation    Car Accident    Work Related Injury    Other Injury: \_\_\_\_\_

Circle the words that describe your pain:

Aching                      Tender                      Throbbing

Burning                      Shooting                      Sharp                      Numb                      Lacinating

Is your pain (circle one):                      Continous                      Intermittent (comes and goes)

If your pain is intermittent, how long does the pain last: \_\_\_\_\_

What makes your pain better? (Circle all that apply)

Sitting   Standing   Lying Flat   Walking   Twisting   Coughing   Sneezing   Other: \_\_\_\_\_

What makes your pain worse? (Circle all that apply)

Sitting   Standing   Lying Flat   Walking   Twisting   Coughing   Sneezing   Other: \_\_\_\_\_

Rate your pain by circling the number that best describes your pain **right now**:

No Pain   0   1   2   3   4   5   6   7   8   9   10

Rate your pain by circling the number that best describes your pain **with activity**:

No Pain   0   1   2   3   4   5   6   7   8   9   10

Does your pain interfere with your sleep?    Yes    No

How many work days did you miss in the last month due to pain? \_\_\_\_\_

(Circle those that apply) Do you have any:

numbness   tingling   extremity weakness   bowel / bladder incontinence

What procedures have you had done to treat / diagnose your pain? (Check all that apply)

- tens unit    cortisone joint injections    epidurals    physical therapy    chiropractic care    other

Procedure

Date

Doctor's name / speciality

Procedure	Date	Doctor's name / speciality
_____	_____	_____
_____	_____	_____
_____	_____	_____

What test have been performed? (Check all that apply)

- X-rays    CT scans    MRI    EMG/NCS    Bone Scan

**Allergies to Medications:**

What happens when you take? symptoms / side effects:

\_\_\_\_\_

\_\_\_\_\_

**Medications**

Name

Dosage

Frequency

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List **all** previous pain medications you have tried:

\_\_\_\_\_

\_\_\_\_\_

**Medical Problems:** Please list ongoing or previous medical problems

\_\_\_\_\_

\_\_\_\_\_

**Past Surgical History**

Type of operation

Date

Type of operation	Date
_____	_____
_____	_____
_____	_____

**Family History:** Please list medical problems in **immediate family** and their relationship to you.

\_\_\_\_\_

\_\_\_\_\_

**Social History**

Do you Smoke?  No  Yes Pack/day: \_\_\_\_\_ Number of years: \_\_\_\_\_  
Do you Drink?  No  Yes How much per day: \_\_\_\_\_  
Have you tried any illicit drugs?  No  Yes What drugs: \_\_\_\_\_ How often: \_\_\_\_\_

Are there any substance abuse issues in the household?  No  Yes  
If yes, please explain: \_\_\_\_\_

Marital Status (circle one): Single Married Divorced Widowed Children  
Highest level of education completed (circle one):  
High school technical / vocational college highest degree: \_\_\_\_\_

Employment Status: Are you currently employed?  No  Yes  
Place of Employment: \_\_\_\_\_ Position: \_\_\_\_\_ Years: \_\_\_\_\_  
Why did you leave? \_\_\_\_\_

Have you ever been involved in a lawsuit?  No  Yes  
If yes, please explain: \_\_\_\_\_

**Litigation History / Work Comp**

Date of Injury: \_\_\_\_\_ Place of Employment: \_\_\_\_\_ Position: \_\_\_\_\_  
Years there: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Circumstances: \_\_\_\_\_  
Current work status: \_\_\_\_\_ Any restrictions: \_\_\_\_\_

Restrictions assigned by Dr. \_\_\_\_\_  
What Dr. have you seen for this problem before: \_\_\_\_\_

Previous W/C Injuries: \_\_\_\_\_ Functional Capacity: \_\_\_\_\_  
Evaluation performed: \_\_\_\_\_ % impairment given: \_\_\_\_\_

Disabled: \_\_\_\_\_ Date: \_\_\_\_\_ By Dr. \_\_\_\_\_

**Motor Vehicle Accidents**

Date of Injury: \_\_\_\_\_ Position in Car: \_\_\_\_\_ Seat Belt  Yes  No  
Circumstances of Accident: \_\_\_\_\_

ER by Ambulance: \_\_\_\_\_ Treatment recommended in ER: \_\_\_\_\_  
Previous MVA's: \_\_\_\_\_

**Review of Systems** Please circle any symptoms that you may be experiencing.

General:	fevers	chills	night sweats	malaise	weight gain	weight loss	loss of appetite	
Eyes:	vision problems	double vision	glaucoma	cataracts				None
	other: _____							
Ears:	hearing problems	ringing in the ears	earaches					None
	other: _____							
Nose:	nasal congestion	nosebleeds	infection					None
	other: _____							
Mouth:	problem swallowing	hoarse voice	bleeding gums					None
	other: _____							
Neck:	swollen glands	thyroid problems	other:	_____				None
Respiratory:	cough	difficulty breathing	asthma	other:	_____			None
Cardiac:	chest pain	high blood pressure	heart irregularity					None
	palpitations	swelling in the legs						
	other: _____							
Gastrointestinal:	heartburn	nausea	vomiting	constipation				None
	stomach upset	hepatitis	diarrhea					
	other: _____							
Urinary:	frequency	burning with urination	incontinence					None
	other: _____							
Musculoskeletal:	joint aches	muscle weakness	muscle cramps					None
	other: _____							
Neurology:	headache	dizziness	seizures					None
	numbness	tremors	stroke					
	other: _____							
Hematology:	blood disorder	bleeding gums						None
	other: _____							
Psych:	depression	anxiety	bipolar					None
	other: _____							
Infections:	HIV	Hepatitis						None
	other: _____							