DIVERSE MEDICAL PROFESSIONALS

PATIENT INFORMATION AND PAIN ASSESSMENT REPORT

NAME:_____ Date:_____

Location of pain:_____ How long have you been in pain?_____

1) What caused your pain? ☐ Car/bike accident ☐ Sports Injury ☐ Work related accident
☐ Slip and fall ☐ Other:_____

2) Circle all the words that describe your pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Shooting
☐ Stabbing ☐ Lancinating ☐ Throbbing ☐ Burning
☐ Cramping ☐ Pulsating ☐ Nagging ☐ Pressure Like

3) What is the frequency of your pain? ☐ Continuous ☐ Episodic ☐ Occasional

4) When is it the worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ All the time

5) What is the severity of your pain **without** medication? (Circle one)

(No Pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **(Worst Pain Ever)**

6) What is the severity of your pain **with** medication? (Circle one)

(No Pain) ☐ 0 ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **(Worst Pain Ever)**

What **CURRENT MEDICATIONS** have you been **PRESCRIBED** to help you manage your pain?

1. _____ _____mg #_____ _____times per day
2. _____ _____mg #_____ _____times per day
3. _____ _____mg #_____ _____times per day

Which physician or pain clinic prescribed your last prescription of medications?_____

_____

When were you prescribed your last prescriptions? (Be specific with the date) _____

Are you experiencing any side effects? ☐ No ☐ Yes (Explain)_____

Our office encourages you keep your medication in a lock-box or a safe for storage. This recommendation is to protect you from theft or any minor from accessing the medications and overdosing. Fatal accidents are very prevalent(common) with opioid medications.

Patient's Signature: _____

Diverse Medical Professionals
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DIVERSE MEDICAL PROFESSIONALS

OUR POLICY ABOUT YOUR MEDICATION AND/OR YOUR PRESCRIPTIONS

PLEASE SAFEGUARD YOUR MEDICATIONS AND/OR YOUR PRESCRIPTIONS AGAINST THEFT!!

LOST, STOLEN, OR MISPLACED NARCOTICS WILL NOT BE REPLACED!

DAMAGED AND/OR RE-ISSUED PRESCRIPTIONS WILL BE REPLACED FOR AN ADDITIONAL $50 FEE!

PLEASE LOCK UP YOUR MEDICATIONS IN A SAFE LOCK BOX!

DO NOT KEEP THEM IN YOUR MEDICATION CABINET, CAR, CHECKED BAGGAGE, OR IN REACH OF CHILDREN!

PATIENT'S NAME:_____ **DOB:**_____

Patient's Signature:_____ **Date:**_____

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REFUND POLICY

NO REFUNDS WILL BE GRANTED:

1. Once you have signed in,
2. For failing a urine analysis,
3. For counterfeit or modified pharmacy reports,
4. For counterfeit or modified MRI's or any other documentation,
5. For verification of doctor shopping, and
6. For IV drug use

Any refund requested for any reason other than those listed above will be granted or denied based on an individual basis and by the discretion of the office administrator. If you have any questions, you may ask to speak to the manager.

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DIVERSE MEDICAL PROFESSIONALS

MISUSE AND/OR ABUSE OF NARCOTIC PAIN MEDICATION AGREEMENT

By Florida Statue 893.13, it is a third-degree felony, punishable by up to 5 years in prison, and a $5,000 fine if:

1. You do not tell a physician who prescribes you narcotic pain medication that you received narcotic pain medication from another physician since your last visit.
2. You possess or attempt to possess narcotic pain medication by misrepresentation, fraud, forgery, deception, or subterfuge.

I authorize Diverse Medical Professionals, PA to cooperate fully with the city, state, and/or government officials to provide a copy of this agreement as proof of authorization and compliance; furthermore, waive my right of applicable privilege to right of privacy.

By signing this document, I hereby swear under penalty of perjury that I have not been prescribed narcotic pain medication from another physician since my last visit at this facility and that I am in full compliance with Florida Statue 893.13 as it is outlined above.

PATIENT'S NAME:_____ **DOB:**_____

Patient's Signature:_____ **Date:**_____

Staff Signature:_____

If you have seen a physician who prescribed narcotic pain medication since your last visit, who is not affiliated with this office and you were prescribed narcotic pain medication, please fill out the following information:

Doctor's Name:_____

Doctor's address:_____

Doctor's Phone:_____ **Date of visit:**_____

Reason for visit:_____

_____

Medication prescribed:_____

_____

_____

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SEDATION:

If your work requires you to operate hazardous machinery or be in a state of optimum concentrations, be aware that opiate medication can cause sedation and decreased concentration. Do not participate in hazardous activities until your physician has assessed the medication's effect on you, and you are familiar with them.

ALTERNATE FORMS OF TREATMENT:

Other medications to use are anti-narcotic ones such as Advil, Celebrex, etc., muscle relaxers, and anti-anxiety medications. Physical therapy and modalities (heat, ice, ultra slow and rehabilitative exercises, etc.) are all forms of treatment that can be used. Each carries its own risks and benefits, which have been explained by your physician. It is generally recommended that your pain management program includes physical therapy whenever possible.

MALES ONLY:

I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire, and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone levels are normal.

FEMALES ONLY:

If I plan to become pregnant or believe that I have become pregnant while taking these pain medications, I will automatically be discharged from this office. I am advised to seek immediate medical care with an OB/GYN doctor. I am aware that if I carry a baby to delivery while taking these medications, the baby will be physically dependent upon opioids. I am aware that the use of opioids is generally associated with the risk of birth defects while the mother is on these pain medications.

I have read the proceeding pages regarding risks and benefits of the proposed treatment. I have been given an explanation of these, as well as alternative forms of treatment. I understand the above and have had ample time to discuss any questions or concerns with my physician. The purpose of this document is to prevent any misunderstanding about specific medications. By signing this consent voluntarily, I authorize the treatment of my pain with opioid pain medications.

PATIENT'S NAME:_____ **DOB:**_____

Patient's Signature:_____ **Date:**_____

Staff Signature:_____

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DIVERSE MEDICAL PROFESSIONALS

INFORMED CONSENT TO TAKE OPIATE/NARCOTIC PAIN MEDICATIONS

Your physician has determined that opiate pain medication is indicated for the treatment of your pain. Opiate pain medications include: Percocet, Oxycontin, Roxycodone (schedule II), Lorcet, Lortab, and Vicodin (schedule III). General schedule II medications have a greater potential for abuse and addiction, but are indicated if other medications have failed to control your pain. As with any medical treatment, there are risks and benefits to treatment with opiate medications.

BENEFITS:

Reduced pain, increased sleep, decreased fatigue, improved function at work, and increased mood and enjoyment of life.

RISKS:

Side effects such as constipation, sedation, nausea, vomiting, and itching are the most common side effects. A serious and potentially fatal side effect is respiratory depression. This usually only occurs at very high doses and in patients who take drugs with addictive effects such as tranquilizers, muscle relaxers, or sleeping medicines. You are also at an increased risk for respiratory depression, if you have a respiratory condition such as asthma. It is important to tell your physician if you are taking any other medications and if you have any other medical conditions when he/she takes your medical history. You must not use alcohol or any recreational drugs if you are taking opiate pain medications, as this can cause potentially fatal respiratory depressions. You must also inform your physician if you have liver, kidney, or gastrointestinal problems. Opiate pain medications can be dangerous or even fatal in some of these conditions.

TOLERANCE:

You may develop tolerance to opiate medications. This means that you will need to increase the dose in order to continue to get pain relief. You should never do this on your own. If the medication is not working, you must inform your physician and he/she will adjust the dose. After 5-6 months of treatment, your physician will attempt to lower the dose of medication and wean you off slowly from the medication. You should never stop medication suddenly as this may precipitate a syndrome known as withdrawal. This can be uncomfortable with rapid heartbeat, shaking, sweating, or more serious symptoms. If you experience withdrawal symptoms, call your physician, proceed to the emergency room, or call 911 immediately.

ADDICTION:

Certain patients are psychologically prone to addiction, which is not the same as tolerance. Addiction is psychosocial dependence on the medication for reasons other than pain management. If you have ever had a substance abuse problem, or been treated for a psychiatric condition, it is important to tell your physician this when he/she takes your history. You will be referred to the appropriate specialist in this case.

PATIENT'S NAME:_____ **DOB:**_____

Patient's Initials:_____

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DIVERSE MEDICAL PROFESSIONALS

MALPRACTICE INSURANCE

Under Florida law, F.S 458.320 physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.
***YOUR DOCTOR HAS DECIDED NOT TO CARRY MALPRACTICE INSURANCE.**
This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice provided pursuant to Florida law.
I have read this statement and fully understand it.

Bajo las leyes del estado de la Florida, estatuto (458.320 F.S.) se requiere generalmente que los medicos tengan seguro de mala practica medica, o sino demostrar responsabilidad financiera para cubrir posibles reclamos por mala practica medica. SU MEDICO HA DECIDIDO NO TENER SEGURO DE MALA PRACTICA MEDICA.
Esto se permite por las leyes de la Florida, sujeto a ciertas condiciones. Las leyes de la Florida imponen multas a los medicos no asegurados que no satisfagan juicios adversos derivados de reclamos de la mala practica. Este aviso ha sido provisto segun las leyes de la Florida.
Yo he leido y entiendo perfectamente este aviso.

PATIENT'S NAME:_____ **DOB:**_____

Patient's Signature:_____ **Date:**_____

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DIVERSE MEDICAL PROFESSIONALS

CONSENT FOR DRUG SCREENING

The test is taken voluntarily at least twice a year, or at **random** upon the **physician's request** at any visit without **advance notice**. If you fail your drug test; or if it shows a false negative result, your doctor will send the urine specimen to an independent lab for confirmation of medications present in your body. A failure of a test may result in your discharge from our medical care; the results will remain a part of your personal medical record.

If you choose not to take the test, you will be discharged from our medical care without any refund.

I, (print full name) _____ understand that the results will become part of my medical record. If I am not compliant the results of this test will also become part of my medical record. I have had a chance to ask questions which were answered to my satisfaction, I also understand the benefits and the risks. I request that the drug screening test be performed.

PATIENT'S NAME:_____ **DOB:**_____

Patient's Signature:_____ **Date:**_____

Staff Signature:_____

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DIVERSE MEDICAL PROFESSIONALS

NOTICE OF PRIVACY PRACTICES

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

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

As required by HIPAA, we have prepared this explanation of how we required maintaining the privacy of your health information and how we may use or disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

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 review. 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, cost-management analysis, and client service. An example would be an internal quality assessment review

We may also create and distributed 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 following circumstances:

- In emergency treatment situations
- If we are required by law to treat you, or
- 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 action for relying on your authorization.

PATIENT'S NAME:_____ **DOB:**_____

Patient's Initials:_____

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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 friend(s), 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 a 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 protected 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 April 14, 2003, and we are required to abide by the terms of Notice of Privacy Practices currently in effect. We reserve the right to change 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 the Notice of Privacy Practices and you may request a written copy of it from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or 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. We will not retaliate against you for filing a complaint.

Please contact us for more information about HIPAA or to file for a compliant:
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 can get a copy of this information at any time, upon request.
I have reviewed the Notice of Privacy Practices on this date: _____

PATIENT'S NAME:_____ **DOB:**_____

Patient's Signature:_____ **Staff Signature:**_____

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DIVERSION POLICY AND PAIN MANAGEMENT AGREEMENT

1. I authorize my physician to fully cooperate with any city, state, or federal law enforcement agency, in the event of an investigation of my possible misuse, sale, or other diversion of my pain medications.
2. I agree to waive any applicable privileges, right of privacy (HIPAA: Health Insurance Portability and Accountability Act), or confidentiality with respect to these authorizations.
3. I agree that I will submit to a blood or urine test if required by my physician to determine my compliance with my program of pain control medications.
4. I agree that I will use my medications at a rate no greater than the prescribed. In the event, I take more frequent than the prescribed dose without getting the approval from my pain doctor, this can result in immediate discharge from the above-named clinic or I will be placed on non-opioid modalities for pain management.
5. I will fully communicate with my physician about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medications are helping to relieve the pain.
6. I will not use any illegal controlled substances, including cocaine, etc. I will not share, sell, or trade these medications with anyone. I will not attempt to obtain any controlled medications, including opium pain medications, controlled stimulants, or anti-anxiety medications from **any other doctor, while I am under this physician's care**.
7. I agree to follow these guidelines that have been fully explained to me. I understand this policy is essential to help both my physician and myself to comply with the law regarding controlled substances.
8. I fully understand that I can be called at any time for pill count or random drug test, failure to do so can result in immediate discharge from the above-named clinic or I will be placed on non-opioid modalities for pain management.

DISCLAIMER

I swear the information to be true and accurate to the best of my knowledge. I have complied with the Doctor/ Patient agreement and have not received any controlled substances by any other physician or medical facility since my last visit here. I understand that by doing so may cause my immediate termination of treatment and may lead to criminal charges brought against me by the authorities.

PATIENT STATES HE OR SHE IS NOT BEING SEEN BY ANY OTHER PAIN CLINIC/PHYSICIAN.

PATIENT'S NAME:_____ **DOB:**_____

Patient's Signature:_____ **Date:**_____

Staff Signature:_____ **Physician's Signature:**_____

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PATIENT'S NAME:_____ **DOB:**_____

PATIENT INFORMATIONAL QUESTIONNAIRE

I swear to the information below to be accurate, answered honestly, and answered to the best of my knowledge. Circle your answers where applicable.

1. Are you here at this clinic only seeking help for your chronic pain?

   ☐ YES ☐ NO

2. Have you provided honest and valid medical records to this clinic?

   ☐ YES ☐ NO

3. Have you been to any pain management clinic within the past 28 days?

   ☐ YES ☐ NO

4. Are you currently using pain medications?

   ☐ YES ☐ NO

5. Do you understand that taking these medications **with** alcohol or street drugs may be fatal?

   ☐ YES ☐ NO

6. To sell or divert (switch) any medication is illegal. This clinic **will report** any illegal behavior pertaining to the misuse of medications. Are you selling or diverting any of your medication?

   ☐ YES ☐ NO

7. Are you currently working?

   ☐ YES ☐ NO

8. What is your occupation or what do you do for a living?

   _____

9. Is your work performance better when your pain is controlled?

   ☐ YES ☐ NO

Patient Initials: _____

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10. Does the treatment help you increase your physical activity and your daily living activities?

☐ YES ☐ NO

11. Will these medications affect or interfere with your work duties?

☐ YES ☐ NO

12. Are you a law enforcement officer of any type or do you have any affiliations with federal or state government agencies/programs in any way?

☐ YES ☐ NO

13. If you answered YES to Question 12, please state your job description and exact position:

_____

YOUR MEDICATION AND TOLERANCE

There is no escaping the fact that your body will respond to these medications with what is called Tolerance. Many people are frustrated by this tolerance to the medication.

You will know you are developing tolerance when you find the medications just aren't lasting as long as they used to. Also, you may find yourself taking more medications than in the past.

Needing more medication does not mean you are becoming an addict. It simply means you are a normal human being who is experiencing tolerance. Tolerance is something we can work together to confront, but first we must have a strategy.

Here is a simple strategy to battle tolerance:
One day a week cut your doses in half.
If you take four pills a day, then for one day in a week, take two pills.
Yes, you will have more pain that day. This will be your "BAD DAY."
This will help you have control over your pain

Did you read and comprehend this strategy?

☐YES ☐ NO

PATIENT'S NAME:_____ **DOB:**_____

Patient's Signature:_____ **Date:**_____

Staff Signature:_____ **Physician's Signature:**_____

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NON-OVERDOSE CONTRACT

I have chosen to enter into pain management for reasons that are important to me. I understand that the medications used are strong and powerful; they also carry certain risks in their usage. On the other hand, the benefits of using these medications will impact my quality of life in such a way that I accept all the risks.

Beside the tolerance and dependence that might occur with these medications, I am aware that there is a risk of death from overdose. My doctor has fully informed, warned, and explained to me that overdose is likely to occur if I:

- **take too much of my medicine**
- **take more than prescribed of my medicine**
- **combine my medicine with street drugs or alcohol**
- **crush, chew, inhale, smoke, or inject my medicine**

If I take my medications as prescribed, work daily to control my tolerance, have honest discussions with my doctor, and act responsibly at all times, pain management can be a safe and effective lifestyle.

If an overdose does occur, I accept the responsibility as my own. I release my doctor and this clinic from all responsibility from an action that I took despite all warnings. Furthermore, I do not want my family, any attorney they may hire, or any government or agency to pursue action against my doctor or this clinic.

I was warned in this contract and I agreed not to overdose and/or misuse these medications. I accept all the risks of pain management, and I accept to take full responsibility of all my actions.

Comments:_____

_____

_____

_____

PATIENT'S NAME:_____ **DOB:**_____

Patient's Signature:_____ **Date:**_____

Staff Signature:_____ **Physician's Signature:**_____

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