Advanced
Pain Management Clinic

3003 Claire Lane • Building 100 • Jacksonville, FL 32223
904-683-2596 • FAX 904-683-2597 • www.painawayjax.com
info@painawayjax.com

Patient Last Name_____First Name_____Middle Initial___
Mailing Address_____City_____State_____ZIP_____
Home Address_____City_____State_____ZIP_____
Home Phone Number_____Work Phone Number_____
Cell Phone Number_____Alternative Phone Number_____
Email Address_____
Birth Date_____Social Security Number_____Gender: M / F Marital Status:_____

Reason for
Visit:_____

_____

_____

Were you injured in an automobile accident? ❑ Yes ❑ No
Is this visit related to a Personal Injury? ❑ Yes ❑ No

Employment Status: [ ] Full Time [ ] Part Time [ ] Unemployed [ ] Retired [ ] Disabled
Employer:_____ Phone Number:_____

Primary Insurance Information:

Insurance Company Name:_____
Address:_____Phone Number:_____
Group/Policy Number:_____Indentification Number:_____
Guarantor Name:_____Relationship to Insured: ❑Self ❑Spouse ❑Child ❑Other
Guarantor's Birth Date_____Guarantor's Social Security Number_____Gender: M / F

Secondary Insurance Information:

Insurance Company Name:_____
Address:_____Phone Number:_____
Group/Policy Number:_____Indentification Number:_____
Guarantor Name:_____Relationship to Insured: ❑Self ❑Spouse ❑Child ❑Other
Guarantor's Birth Date_____Guarantor's Social Security Number_____Gender: M / F

Referring Physician (if any)_____Phone Number:_____
Primary Care Physician_____Phone Number:_____
Referring Patient (if any):_____

Person to be contacted in case of emergency:_____
Phone Number:_____Relationship:_____

In signing this form you agree that all of the above is true and correct as of date signed. You also understand that we bill you insurance as a courtesy to our patients usual and customary fees. If you insurance does not pay your claims for whatever reason, you understand that you are ultimately responsible for your bill.

_____ _____
Patient or Patient Representative Signature Date

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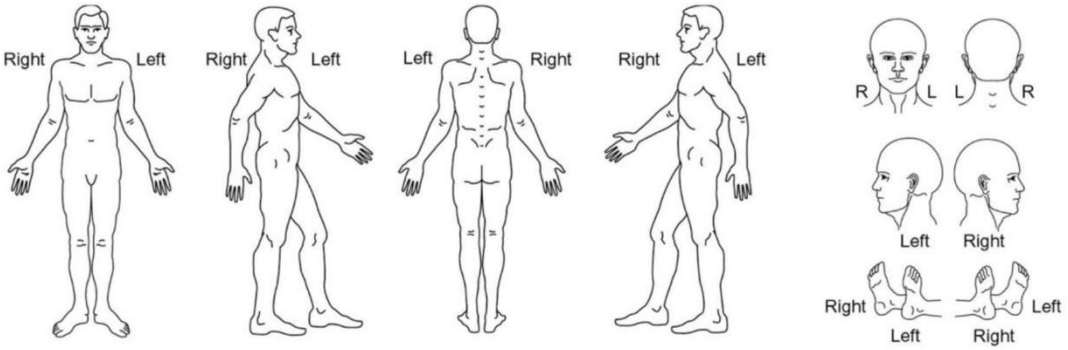
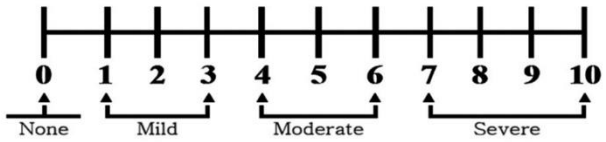
MARK an "X" on the drawing where you have pain.

CIRCLE where the pain is the **worst.**

If the pain travels, use an "arrow" to indicate the direction.



USING THE PAIN SCALE ***BELOW***, RATE YOUR PAIN:



What number is your pain right now?_____

What number is the best your pain gets?_____

What number is the worst your pain gets?_____

Approximately, when did this pain begin?_____

What caused your current pain episode_____

How did your current pain begin? ❑Gradually ❑ Suddenly

Describe the character of your pain: ❑sharp ❑shooting ❑aching ❑burning ❑throbbing ❑stabbing ❑dull

❑Other_____

How often does your pain occur? ❑Constant ❑Changes in severity but always present ❑Intermittent

What other factors worsen or affect your pain?_____

What other factors relieve your pain?_____

Are there any associated symptoms? (numbness, weakness, tingling, incontinence, etc.) _____

_____

What are your goals that you wish to achieve with pain management?_____

_____

What diagnostic tests and/or imaging have you had?_____

_____

Please mark all treatments you have had: ❑Spine Surgery ❑Physical Therapy ❑Chiropractic ❑Psychotherapy ❑Brace Support ❑Acupuncture ❑Massage ❑TENS ❑PENS ❑Oral Steroids ❑Joint Injections ❑Nerve Blocks ❑Epidural Steroid Injection (Cervical / Thoracic / Lumbar) ❑Facet Injections (Cervical / Thoracic / Lumbar) ❑Radiofrequency Nerve Ablation (Cervical / Thoracic / Lumbar) ❑Spinal Cord Stimulation (trial only / permanent) ❑Trigger Point Injections (regular / occasional) ❑Osteopathic Manipulations ❑Other Steroid injections

❑Other Treatments_____

_____

Please list other Pain Management doctors you have consulted for your pain.

_____ _____

Are you willing to change your diet? Y / N Are you willing to exercise? Y / N

What do you do for fun?_____

_____

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PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Thyroid Disease _____
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Lyme Disease
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems_____
- ❑ Heart murmur
- ❑ Pneumonia History
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Fibromyalgia
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

Past Surgical History

Date:	Surgery:	Hospital or Surgery Center:	Surgeon:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			

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PERSONAL HISTORY

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

What is your current or past occupation? _____

Are you currently working? : ❑ Yes ❑ No Hours/week _____ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability & how long?_____

Are you presently involved in a lawsuit? Y / N _____

CURRENT MEDICATIONS and ALLERGIES

Do you have any medication allergies: **Y / N** Do you have any medication intolerances? **Y / N**

Medication (Allergy or Intolerance)	**Reaction**
1.	
2.	
3	
4.	

Please list all medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength and frequency per day)**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	

Substance Use

Do you use tobacco/ smoke?: Y / N Have you ever smoked?: Y / N How much?_____ How Long? _____

Do you use alcohol? Y /N How much?_____ How often per week?_____

Have you ever tried to quit alcohol? Y / N Why?_____

Please list below any unprescribed mood/mind altering drugs below:

1.	**4.**
2	5.
3.	6.

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Please circle if any of the following apply to you:

1. **General**: change in appetite, chills, fatigue, fever, lightheadedness, night sweats, sleep disturbance, weight gain, weight loss, dizziness
2. **Allergy/Immunology:** AIDS, HIV Positive, hives, itching, rash, sneezing, unusual reaction to medication(s), food, animals or insects, wheezing, seasonal allergies, Hepatitis
3. **Eyes**: blurred vision, change in vision, diminished visual acuity, discharge, flashes of light in the visual field, loss of vision, red eye
4. **ENT**: decreased hearing, decreased sense of smell, difficulty swallowing, masses, nosebleed, ringing in the ears, swollen glands, missing/loose teeth
5. **Endocrine:** diabetes, thyroid problems, excessive sweating, excessive thirst, frequent urination, hair loss, heat intolerance
6. **Lungs**: cough, hemoptysis, pain with inspiration, shortness of breath, wheezing, COPD
7. **Breast:** breast lump or mass, nipple discharge
8. **Heart**: chest pain, claudication, cyanosis, difficulty lying flat, fluid accumulation in the legs, heart problems, irregular heartbeat, palpitations, rheumatic fever, swelling in hands/feet, blood thinners, use aspirin, easy bleeding or bruising, history of transfusions
9. **Gastrointestinal**: abdominal pain, blood in stool, change in bowel habits, colitis, constipation, difficulty swallowing, frequent diarrhea, heartburn, nausea, stomach problems, vomiting, liver or gallbladder disease, black/tarry stools
10. **Urinary**: abdominal swelling, blood in the urine, difficulty urinating, frequent urination, heavy uterine bleeding, kidney problems, loss of urine with cough or laughter, pain in lower back, painful urination
11. **Musculoskeletal**: arthritis, back problems, carpal tunnel, history of gout, joint stiffness, muscle aches, painful joints, sciatica, swollen joints
12. **Vascular**: cold extremities, decreased sensation in extremities, pain/cramping in legs after exertion, painful extremities, ulceration of feet, varicose veins, history of bloot clots
13. **Skin**: changing moles, discoloration, hair changes, hives, keloid formation, masses, nail changes, rash, skin cancer, any skin disease
14. **Neurologic**: balance difficulty, difficulty speaking, blackouts, fainting, burning pain, headache, head injury, loss of strength, loss of use of extremity, memory loss, new onset headache, paralysis, seizures, stroke, tics, tingling/numbness, transient loss of vision, tremor
15. **Psychiatric**: under care of mental health professional, auditory/visual hallucinations, delusions, anger issues, eating disorder, feelings of anxiety, feelings of depression, mental or physical abuse, psychiatric condition, substance abuse, suicidal thoughts, suicidal plans, domestic abuse

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FINANCIAL POLICY

We believe that everyone benefits when our patients understand our financial policies.

Thank you for choosing Advanced Pain Management Clinic, LLC, the office of Dr. Michael Willens as your healthcare provider. We are committed to providing the best medical care possible. We hope that you leave our office with an appreciation for the value of services you have received. Please understand that payment of your bill is considered part of your treatment. Accordingly, we ask all of our patients to pay for their services at the time services are rendered. The following information outlines our Financial Policy which we ask you to read, sign and return to us prior to your treatment. A copy will be provided for you upon request.

All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.

All applicable co-pays, personal balances, both current and prior, are due at time of service. We accept cash and credit cards (VISA or MasterCard).

Regarding Insurance

We are currently participating with Medicare, Aetna, BCBSFL, Cigna, United Health Care, AvMed and TriCare Standard. We do not accept Medicaid or other insurance companies other than those previously listed. We do accept assignment of benefits but in all cases we require that the guarantor (the person who is financially responsible) is *personally* liable for all balances not covered by insurance. If you are not insured by a covered plan, payment in full is expected at the time of each visit or you must make satisfactory payment arrangements with the administrator.

If you do not have an up-to-date insurance card, it may take some time to verify your coverage. We must obtain a copy of your driver's license and current valid insurance card by the date of your first visit. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You must pay for these services in full at the time of the visit.

The introduction of high deductible policies has made it difficult to estimate all charges at the time of your visit. **In the event your insurance company denies payment and/or issues a denial on a non-covered or not medically necessary service for the amount charged by the physician, you agree to be responsible for services rendered at the time of the visit.**

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Credit Card Policy

It is our policy that all patients must guarantee payments for all services rendered.

A valid credit card must be provided in order to cover and guarantee all patient balances. **If you do not have a valid credit card, please speak with the Office Administrator to make alternative arrangements.**

By providing the below information, you consent to have your credit card charged for your balance.

Credit card information is kept secure and confidential. In addition, your financial institution generally provides fraud protection and you are generally not be liable for any fraudulent charges.

All credit card usage fees are paid by the patient and are automatically added to the balance by our financial institution to any balance paid by credit cards.

You may refuse to provide a guarantee of payment however, you will not be treated unless other arrangements are made with the Office Administrator.

The following information is required to be provided:

VISA MasterCard AMEX

Card #_____

Exp. Date: _____

V-Code _____ (three numbers on the back of the card or four numbers on front of AMEX)

Usual and Customary Rates

We are committed to providing the best treatment for our patients and we charge usual and customary fees for our locality and specialty. If your insurance company uses a different fee schedule, you will be responsible for any balance remaining. We update our fee schedules each year – you can request a copy of these fees at any time.

Claims Submission

As a courtesy, we will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company and we are not a party to that contract. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

Coverage Changes

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

Missed Appointment/No Show Policy

Our policy and charges may change. Notice is generally given prior to policy change.
For office visits, unless canceled at least 24 business hours in advance, our policy is to charge **$100.00 for a missed appointment**. For scheduled procedures, unless canceled at least 48 business hours in advance, our policy is to charge **$200.00 for a missed procedure appointment**. Please help us to serve you better by keeping scheduled appointments. This fee is generally not covered by insurance so it will be your personal responsibility.

Past Due Accounts

Accounts are considered past due after 90 days. Patients who are sent additional statements will have a statement handling fee of $15.00 charged to each statement unless other satisfactory payment arrangements are made and kept. Overdue accounts will be referred to a collection agency along with the issuance of a 1099 to the IRS for cancellation of debt. Collection fees that we pay to secure past due balances will be added to your account. Once an account had been referred collections, Dr. Willens will terminate the patient relationship and only continue services for thirty (30) days for emergencies on a cash basis. You will be responsible for all collection fees charged to the practice in attempts to collect the past due amount.

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Co-Payments and Deductibles

All co-pays and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your patient portion responsibility at each visit.

Checks

We no longer accept personal checks.

Refunds

An office visit is complete when you have received an evaluation and management recommendation. **Refunds are not given because you do not agree with the recommendation**. A refund may be issued if you are not able to see the doctor because of unforeseeable circumstances, overpayment, or other reasons deemed reasonable by management.

Medical Records

All of our patient records are kept confidential. By law, we are required to keep the records in our possession for seven years. Copies may be furnished to you when you request them in writing with exception to state law. Our policy requires 48 business hours advance notice for preparation of copies, as well as prepayment for those copies. Our charges are as follows:

For the first 25 pages, the cost is $1.00 per page. For each page in excess of 25 pages, the cost is $0.25 cents each.

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Please be aware of the following fees:

Effective: February 18, 2022

Due to the high costs when a patient fails to show up for an appointment, the following no show fees are enforced.

Under reasonable and extenuating circumstances, these fees may be reduced. Please contact Office Administrator on a case-by-case basis.

No Show Fees:

- **Office Visits: $100** If not cancelled at least one (1) full business day before scheduled appointment

  (Example: 9 a.m appointment on Monday must be cancelled before 8:59 a.m. on Friday)

- **Physical Therapy: $100** If not cancelled at least one (1) full business day before scheduled appointment

- **Fluoroscopic Procedures: $200** If not cancelled at least two (2) full business days before scheduled appointment

Forms:

- We charge **$100** for the doctor to review and sign all forms.

X_____ Date:_____

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ACKNOWLEDGEMENTS AND ASSIGNMENTS

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:

I _____ understand that in the course of providing care to me that Michael Willens, D.O. and or Advanced Pain Management Clinic, LLC., will receive, create, maintain and disclose information about me for the purpose of the practice's and other health provider's provision of treatment, securing payment from me, an insurer, other third-party payer or responsible party, and/or in connection with the health care operations of the Practice(s) and/or the operations other health providers who have treated me and as otherwise required or permitted by State and/or Federal Law. I understand that a further description of these anticipated uses and disclosures of my health information appears in the Notice of Privacy Practices. Except for genetic information, I agree to the sharing, utilization, examination and disclosure of any of my health information, including but not limited to known or suspected HIV/AIDS infection, mental health records, communicable diseases, substance abuse and/or treatment, if applicable, as is reasonably necessary by the practice, its employees and other members of its workforce for the limited purpose of rendering treatment, securing payment for treatment rendered and conducting the practice's operations. I further agree to the disclosure by the practice of such information, as is reasonably necessary, to other health providers involved in my treatment and their employees and other members of their workforce for treatment, payment and health operations, to any private or governmental insurer, including Medicaid and Medicare and its intermediaries and agents, other third-party payers, or other financially responsible party for the purpose of determining benefits and securing payment, and as otherwise permitted by State and/or Federal law. This consent may be revoked at any time but, only to the extent that the practice has not acted in reliance on it. If not previously revoked, this consent will remain valid as long as I am a patient of the practice and for such period of time thereafter as is reasonably necessary to serve the purpose for which it was given; namely, the provision of treatment, securing payment for services rendered and conducting health operation.

 Initials_____

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BILLING POLICIES:

I further expressly agree and acknowledge that my signature on this document authorized Michael Willens, D.O. or Advanced Pain Management Clinic, LLC., or their employees to submit claims for services rendered without obtaining my signature on each and every claim to be submitted for myself and /or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I am aware that for either practice to bill to my insurance carrier on my behalf is a courtesy being extended to me and it NOT required by law. I further agree and fully understand that I am legally bound to furnish the checks paid to me by my carrier for the services I am receiving from this practice. I also agree and fully understand that as a non-participating physician, Dr. Willens is not bound or legally obligated to accept the payment from my insurance company as payment in full for the services I am receiving, and I will receive a balance bill for the amounts not paid by my carrier. I hereby authorize the above named insurance company/companies to assign directly all benefits payable on my behalf.

I hereby authorize the above named insurance company/companies to assign directly all benefits payable. I make this an irrevocable assignment of benefits. I understand that any insurance checks issued belong to Michael Willens, D. O., or Advanced Pain Management Clinic LLC., for services rendered and I agree to endorse them over should I receive them or otherwise repay any amounts paid to me. Failure to do so would be a crime under Florida Law. I (we) am (are) aware that if payment is not made within a reasonable amount of time by the insurance carrier(s), and the matter is submitted to a collection agency or attorney, I (we) will be responsible for payment of all costs associated with that collection activity, including but not limited to reasonable attorney fees and court costs.

I fully understand that once the account is past due the practice reserves the right to begin adding interest at 1% per month simple interest, and if sent to collection, I (we) will be responsible for costs for collection agents and /or reasonable attorneys fees and /or costs of litigation.

Patient SIGNATURE_____ Date_____

Insured SIGNATURE_____ (if different)

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective February 18, 2022, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to

report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to: Privacy Officer: Melissa Edwards, 3003 Claire Lane, Bldg 100, Jacksonville, FL 32223.

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Pain Management Clinic

3003 Claire Lane • Building 100 • Jacksonville, FL 32223
904-683-2596 • FAX 904-683-2597 • www.painawayjax.com

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of Advanced Pain Management Clinic's Notice of Privacy Practices (the "Notice"). The Notice contains information regarding potential uses and disclosures of my protected health information - that term is defined under the Health Insurance Portability and Accountability Act of 1996 "HIPAA" that may be made by the Practice, and of my rights and the Practice's legal duties with respect to my protected health information. I have had the opportunity to review the Notice and take a copy with me if I so choose.

On behalf of [ ] self; [ ] personal or legal representative

_____
Patient's Signature

_____
Patient's name

_____
Date

****

IF PATIENT REFUSES TO SIGN ACKNOWLEDGEMENT, COMPLETE THIS SECTION:

_____ Patient refuses to sign Acknowledgement. The staff of Advanced Pain Management Clinic made the following attempt to obtain a signature from the patient:

_____

_____

X_____
Signature of Chief Privacy Official

_____
Date

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Consent for Medical Treatment

I am the patient or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize care encompassing all diagnostic and therapeutic regimens necessary in the judgment of my provider, for myself, my minor child, or other. I am aware that the practice of medicine is not an exact science. I acknowledge that no guarantees have been made to me as a result of treatments or performed examinations.

I have read this form completely, have had the opportunity to ask questions, and have been fully informed as to the contents of this agreement.

I do hereby authorize the release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to Michael S. Willens, D.O., Advanced Pain Management Clinic, LLC.

_____ _____

Signature of patient or responsible party Date

_____ _____

Witness Signature Date

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Long-term Controlled Substance AGREEMENT

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. This is not a legally enforceable contract.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or or relapse occurring in a person with a prior addiction. The extent of this risk is not certain. Tolerance and Dependence will develop. This means more medicine will be needed to get the same effect and if the medicine is stopped suddenly, you will get sick. At some point, the medicine will stop working.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason, **the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of Dr. Willens to consider the initial and/or continued prescription of controlled substances to treat your chronic pain**. Please initial by each number to confirm that you have read, understand, and will abide by this agreement.

____1. All controlled substances must come from Dr. Willens, or, during his absence, by the covering physician, unless specific authorization is obtained for an exception. No other physician may prescribe a controlled substance.

____2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. A MAXIMUM of 28-day prescription will be given without refills. Patients will need to be seen at a minimum of monthly for refills unless other arrangement are made.

____3. You must inform our office immediately of any new medications, additional treating physicians or medical conditions, and of any adverse effects you experience from any of the medications that you take. If you refuse to release information from other treating providers, you may not receive controlled medications.

____4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or any other professionals who provide your health care for purposes of maintaining accountability. The Florida Prescription Drug Monitoring Program is used to confirm compliance.

____5. You may not share, sell, or otherwise permit others to have access to these medications. In addition, you may not take any illicit or any other controlled drugs. You may not take anyone else's medication.

____6. These drugs should not be stopped abruptly, as an abstinence syndrome (withdrawal) will likely develop and can be dangerous. Do Not Crush, Chew, Cut, Break, or use the medication in any unprescribed manner.

____7. Unannounced urine or serum toxicology screens will be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder. <u>If prescribed medications are not found in UDT, discharge may result since the patient is non-compliant with treatment</u>.

____8. Prescriptions and bottles of these medications may be sought by individuals with addiction and chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them. If medications are stolen, they may not be replaced.

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____9. **Original containers of medications must be brought in to each office visit for possible pill count and inspection. YOU MAY NOT TAKE MORE OF YOUR MEDICINE THAN PRESCRIBED. You may not take any controlled medication that is not currently approved by this office.** This includes **old prescriptions** of which should have been disposed.

____10. Since the drugs may be hazardous or lethal to a person or animal who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

____11. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.

____12. Early refills will generally not be given. Prescriptions will be issued only on the same day as an office visit.

____13. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. It is your responsibility to make certain you do not run out of medication. Please PLAN AHEAD.

____14. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration and your patient chart. This may be used in prosecution against you.

____15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician and/or referral for further specialty assessment. In addition, you may be discharged from the practice without a prescription for controlled substances.

____16. Renewals are contingent on keeping scheduled appointments. **Please do not phone for prescriptions after hours or on weekends or become disruptive with the staff. This is grounds for discharge.**

____17. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

____18. The risks and potential benefits of these therapies are explained elsewhere and you acknowledge that you have received such explanation.

____19. No controlled medication will be prescribed without an office visit. All prescriptions are electronically sent to pharmacies unless the pharmacy does not accept electronic prescriptions

_____ _____
Patient Signature Date

_____
Patient Name (Printed)

_____ Phone: _____
Name of Pharmacy

_____
Address or Location

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SAME DAY Urine Drug Screen NOTICE

This practice requires regular urine drug testing (UDT) for proper care and in order to protect public safety and be in compliance with state and federal laws.

This notice is to inform you that **your insurance company covers this UDT as a covered service.** However, in order to receive benefits under your insurance policy, you must go to the outside laboratory facility contracted by your insurance company.

Due to the nature of UDT, the sample must be given on the same day as it is ordered. Failure to have this test performed ON THE SAME DAY will be interpreted as a positive result. This may affect our ability to prescribe controlled medications and may result in your discharge from the practice

If you are unable or unwilling to go to your covered laboratory ON THE SAME DAY when selected, we have made arrangements for you, solely as a courtesy and a convenience, to have your UDT performed at our facility. However, **your insurance company does not cover this test performed at our facility and it will not be billed for this service.** If you choose to use our facility for your UDT, you will be 100% responsible for the fee directly to APMC. Again, it is offered only as a CONVENIENCE and COURTESY service to you and you may choose to have your UDT performed at the laboratory designated by your insurance company.

Please check one choice below:

_____ I have fully read the above statement and I choose to have the Urine Drug Testing performed in the office. I agree to pay the charge of **$40** for this service directly to Advanced Pain Management Clinic, LLC. I understand that my insurance company will NOT be billed if I choose to have the UDT done in the office and I will NOT make a claim. I understand that my insurance company does cover this service if I go to a contracted laboratory. However, I choose to pay out-of-pocket for this courtesy service offered by APMC for my convenience. At any time, I may choose to have this test done at a contracted laboratory and I may cancel this agreement simply by notifying my doctor.

_____ I have fully read the above statement and I choose to have my Urine Drug Testing performed at a contracted laboratory. I understand and agree to have them performed ON THE SAME DAY ordered.

X_____ _____

Patient Signature Patient Printed Name

_____

Date

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HIPAA-COMPLIANT RELEASE AND GENERAL AUTHORIZATION
FOR RELEASE OF INFORMATION AND PROTECTED HEALTH INFORMATION

I authorize Advanced Pain Management Clinic, LLC.:

- ☐ To release my medical records to:
- ☐ To request my medical records from:

_____

_____

_____

_____

The undersigned hereby authorizes to disclose, to furnish and to discuss with ADVANCED PAIN MANAGEMENT CLINIC, LLC. 3003 Claire Lane, Building 100, Jacksonville, Florida, 32223, (904) 683-2596 (telephone), (904) 683-2597 (facsimile), the entire contents of any and all files and materials in your possession relating to the undersigned, for the records and dates specified below:

Medical records and Protected Health Information (PHI) including the following: hospital admission and discharge forms; dictated reports; physician's orders and progress notes; clinical or diagnostic test results; radiological or imaging studies; medications sheets; operative information; physical or occupational therapy records; nursing information and progress notes; mental health records, emergency room information; itemized billing records, memoranda or correspondence, transfer forms, history and physical, lab results, psychiatric/counseling, neurodiagnostic testing and rhythm strips and tracings, nursing records and **entire medical record or chart**. This shall include all medical, dental, osteopathic, podiatric and chiropractic records, charts and specially all psychological records as well.

Inclusive dates:_____. (If not specified, include **all dates of service**).

I hereby acknowledge or consent to the release of information that may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

I understand that:

- I may refuse to sign this Authorization and that it is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization.
- I understand that I have the right to revoke this authorization, in writing at any time except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that I uses and disclosures already made based upon my original permission cannot be withdrawn. I may revoke this Authorization at any time in writing, but if I do, it will not have any affect and documentation requested for purposes as may be required by them for any lawful use.
- I may see and obtain a copy of the information and documentation described on this form, for a reasonable copy fee, if I ask for it
- I affirm that I have received a copy of this form after I signed it.
- I am signing for myself, or in the event of a minor, as natural guardian of said minor.

A photocopy of this Authorization for Release of Information is binding and has the full force and effect as the original. This Authorization shall remain in effect until canceled by me in writing.

DATE:_____ SIGNATURE:_____

NAME (Printed)_____DOB_____