Submit by E-mail Print Form

Apex Pain Management

1444 Lexington Green Lane
Sanford, FL 32771
Phone: (407)323-9099 Fax: (407)323-4565

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I understand that, under Florida Law, the classification of records checked below relating to treatment rendered to me are privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and information consent. In addition, I understand that those records will not be released to persons and agencies other than those designated by me or my personal representative or otherwise provided by Florida Law.

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____

Social Security # _____

I authorize _____ to release health information to Apex Pain Management.

Please specify the health information you authorize to be released:

Dates of treatment: _____

_____X-Ray/CT/MRI Reports _____Lab Results

_____Physician Reports _____All Medical Records

_____ (initial) I understand this authorization to release health information is voluntary, Treatment. Payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization EXCEPT in the following cases: (1) to conduct research-related treatment. (2) To obtain information in connection with eligibility or enrollment in a health plan. (3) To determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

_____ (initial) I understand that the release of information by form or fax that confidentiality cannot be assured and I accept the risk that confidentiality may be breached when faxing information.

_____ (initial) I understand that if I authorize the disclosure of my health information to someone who is not legally required to keep it confidential, it may no longer be protected by Apex Pain Management or federal confidentiality laws.

_____ (initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has a been taken pursuant to this authorization. I understand that if I revoke this authorization. I must do so in writing. Unless otherwise revoked, this authorization will expire 1 year from the date of the signature listed below.

_____	_____	_____
Print Name	Patient/Personal Representative Signature	Date
_____	_____	_____
Witness Print Name	Witness Signature	Date

Apex Pain Management Authorization for Release of Confidential Medical Information

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PATIENT REGISTRATION FORM

PATIENT NAME: _____ DATE: ____/____/_____

DATE OF BIRTH: ____/____/_____ GENDER: M ____ F ____

SOCIAL SECURITY NUMBER: _____

HOME ADDRESS: _____

(Street)

_____

(City) (State) (Zip code)

PHONE NUMBER(S) HOME: ( ) _____ CELL: ( ) _____

EMAIL: _____

EMPLOYER'S NAME: _____

ADDRESS: _____

WORK NUMBER: ( ) _____ FAX: ( ) _____

MEDICAL INFORMATION

PRIMARY PHYSICIAN: _____ PHONE: ( ) _____

ADDRESS: _____ FAX: ( ) _____

DATE OF LAST PHYSICAL: ____/____/_____

CURRENT MEDICATIONS: _____

ARE YOU ALLERGIC TO ANY MEDICATION? _____

PHARMACY NAME: _____ PHONE: ( ) _____

EMERGENCY CONTACT: _____ PHONE: ( ) _____

NEAREST RELATIVE: _____ PHONE: ( ) _____

INSURANCE INFORMATION

COMPANY NAME: _____ PLAN NUMBER: _____

GROUP NAME: _____ PHONE: ( ) _____

By my signature, all information above is true and to the best of my knowledge.

Signature: _____ Date: ____/____/_____

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Referral Source: _____

Is your problem job related? _____ Accident related? _____ Neither? _____

Please briefly describe your main problem/complaint: _____

_____

How long have you had this problem? _____

Did it start suddenly or come on slowly with time? _____

Any event, such as injuries/falls, etc., illnesses that coincides with the date your problem started? _____

_____

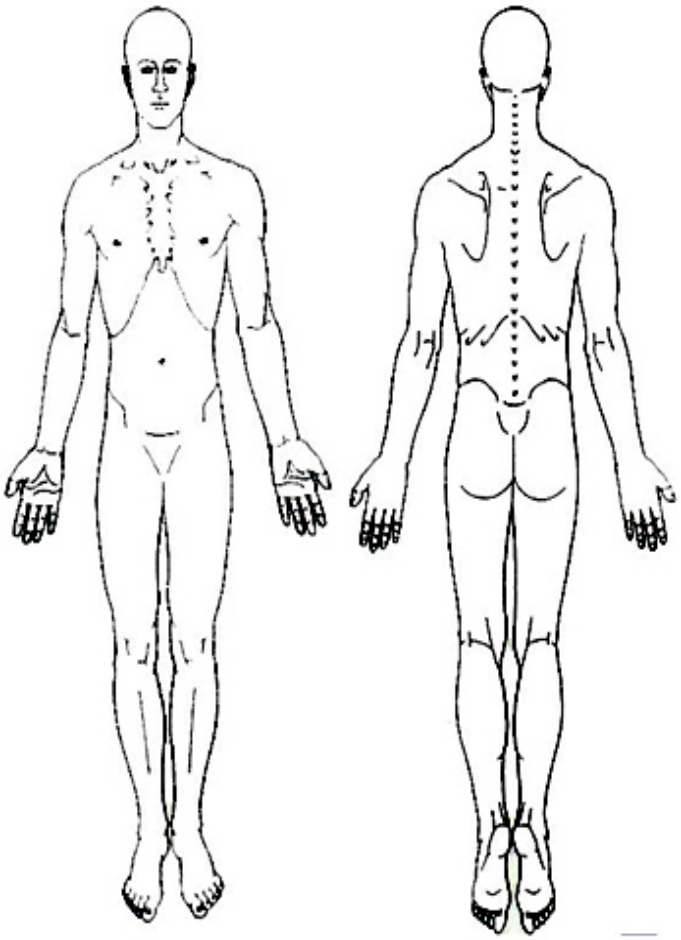
Character of pain (circle one or more) Sharp Dull Aching Burning Stabbing Toothache Type Other

Please mark an (X) on the line indicating the usual degree of your pain.

Least 0_____ 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ 8_____ 9_____ 10_____ Worst

Radiations: Does the pain radiate beyond where the pain starts? _____

Below, draw in the locations of your symptoms



Mark in "XXX for Pain, ooo for Numbness, /// for Aching, and *** for Pins & Needles"

What position(s)/activities make the pain worse?

Sitting _____, Standing _____, Bending _____,

Coughing_____, Walking _____, Bowel Movements_____,
Other_____

What position(s)/activities make the pain better?

Sitting _____, Bending _____, Home Remedies_____,

Lying Down _____, Walking _____, Standing _____,

Other_____

Do you need support to help you walk? Yes_____ No_____

If yes, what kind of support? _____

Do you wear a back, neck or any kind limb brace?

Yes_____ No _____

If yes, how long have you worn this device?

_____

Do you always have control of your bowel?

Yes_____ No _____

Are you able to empty your bladder completely?

Yes_____ No _____

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Please list below previous doctors, chiropractors, acupuncturists, etc., you have seen or have treated with for the main problem you are presenting here today.

Physician's Name Specialty Date of last visit Treatments

_____

_____

_____

For your main problem that you are presenting here today, please indicate which diagnostic tests you have had to evaluate this problem:

When? When? When?
Plain X-Ray _____ CT Scan_____ MRI _____
Bone Scan _____ Arthrogram _____ Sleep Study _____
Myelogram _____ EMG/NCV/SSEP _____ Other _____

Please indicate which treatments you have had for the problem you are presenting today?

	Yes	No	# of Sessions	Helpful?
Physical Therapy	_____	_____	_____	_____
Electrical Stimulation	_____	_____	_____	_____
Hot/Cold Packs	_____	_____	_____	_____
Ultrasound	_____	_____	_____	_____
Massage	_____	_____	_____	_____
Manipulations	_____	_____	_____	_____
Aquatics/Whirlpool	_____	_____	_____	_____
Home Exercises	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____
Injections: Joint/Epidural	_____	_____	_____	_____
Implantable Pumps	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____

Review of Systems:

	Yes	No	Amount
Weight Loss in Last 6 Months	_____	_____	_____
Anxiety	_____	_____	
Problems with Sleep	_____	_____	
Poor Appetite	_____	_____	
Fatigue	_____	_____	
Change in Bowel Movement	_____	_____	
Blood in Stool/Dark Stool	_____	_____	

_____
INITIALS

Review of Systems: (Continued)

	Yes	No	Amount
Blood in Urine	☐	☐	
Nausea/Vomiting	☐	☐	
Chronic Cough	☐	☐	
Fevers/Night Sweats	☐	☐	
Urinary Tract Disorders/Infections	☐	☐	
Tuberculosis (TB)	☐	☐	
Morning Stiffness	☐	☐	
Joint Pain/Swelling	☐	☐	
Heart Murmur	☐	☐	
Rheumatic Fever	☐	☐	
Arterial Graft Surgery	☐	☐	
Chest pain	☐	☐	
Palpitations	☐	☐	
Shortness of Breath	☐	☐	
Increased Thirst	☐	☐	
Fainting/Dizziness/Vertigo	☐	☐	
Double Vision, Etc	☐	☐	
FEMALE:			
Hysterectomy	☐	☐	When _____ Partial/Total
Abnormal Vaginal Bleeding	☐	☐	
Last Menstrual Period			When _____
Endometriosis	☐	☐	
Nipple Discharge	☐	☐	
History of Breast Biopsy	☐	☐	
Last Pelvic Exam			When _____
MALE:			
History Prostatitis	☐	☐	
Difficulty in Urinating:	☐	☐	
Rectal Test	☐	☐	When _____Results_____
PSA Test	☐	☐	When _____Results_____

SOCIAL HISTORY:

Occupation: _____ Work Status: Full Duty ☐ Light Duty ☐
Off Duty ☐ Unemployed ☐ Retired ☐

Tobacco Use Yes ☐ No ☐ Indicate Type and Quantity (Per Day) _____
Started (Age/Year) _____ Stopped (Age/Year) _____

Alcohol Use Yes ☐ No ☐ Indicate Type and Quantity _____

Have you ever been treated for substance?

	When
Dependency	_____
Abuse	_____
Addiction	_____

If yes, please circle which and indicate when.

Family History: Describe current health, cause of death, illness, diabetes, cancer, high blood pressure, etc.

Father: _____
Mother: _____
Siblings:_____

The preceding patient information has been reviewed and discussed with my patient.

_____ _____
Signature of Patient or Person Completing This Form Physician's Signature

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DOCTOR/PATIENT/CENTER AGREEMENT

This agreement between _____ (Patient), Apex Pain Management Center (the Center) and _____Gwinn Murray, MD_____ (Doctor) is for the purpose of establishing the conditions required for the use of Opiate/Narcotic medications the Doctor may prescribe for the Patient. The Doctor and the Patient agree that this agreement is an essential factor in maintaining a proper doctor/patient relationship.

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Doctor for the Patient:

- I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.
- I realize that all narcotic medications have potential side effects. In addition to analgesia, narcotics may produce dependency, addiction, respiratory depression, drowsiness, changes in mood, anxiety, mental clouding, and I will report any such side effects to the physician immediately!
- In the event of a need to discontinue taking these medications, I will consult with the doctor, and strictly follow his instructions for the safe tapering of my medications. Failure to do so may result in severe withdrawal effects and possibly even Death! I understand that even with the tapering process there may be some discomfort or withdrawal effects.
- I understand the risks, side effects, and benefits of these medications and they have been discussed with me in detail.
- Narcotics may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. I agree that I will not attempt to perform such activity until my ability to perform the activity has been evaluated.
- The individual is informed that he/she should not take other drugs such as tranquilizers, sedatives or antihistamines without first consulting with his/her physician. The individual should not use alcohol. The combination of the above drugs, alcohol and Opiates may produce dangerously profound effects such as sedation, respiratory depression and blood pressure drop.

_____ PT
- **I will not attempt to get pain medications from any other health care provider without telling them that I am taking pain medications prescribed by the Doctor. I understand it is against the law to do so, and will lead to the discontinuance of my medical treatment at this facility!**
- I will not ask to have prescriptions called in.

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- I will not use any illegal controlled substances, including marijuana, cocaine, etc.
- I agree to random urine and blood tests to assess my compliance.
- I will not share, sell or trade my medication for money, goods or services.

_____ PT
- **I will safeguard (lockbox or safe) my medication from loss or theft, if I lose my prescription, spill or misplace my medication, I will be without my prescribed medication until my next scheduled visit.**

_____ PT
- **I am responsible for taking the medication in the dose prescribed, I will not raise the dosage without the doctors prior approval. Doing so may cause an overdose, and will lead to my running out of medication early.**

- Visits will be scheduled no earlier than 21 days and no later than 30 days and are required for management of the medications. Refills will be prescribed only on this schedule basis. and will not be called in over the phone.
- It should be understood by the individual that all female patients should notify the physician if they are pregnant or possibly at risk to become pregnant. It should be known that children born when the mother is on Opiate therapy will likely be physically dependent at birth.
- In the event of an investigation I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medication and I authorize the Doctor to fully cooperate with any city, state or federal law enforcement agency, including the Florida Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication.

Doctor and Patient agree that this Agreement is essential to the Doctor's ability to treat the Patient's pain effectively and that failure of the patient to abide by the terms of the Agreement may result in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor/Patient relationship.

This Agreement is entered into on this _____ day of _____, 20_____

_____ Patient

_____ Doctor

_____ Print Name

My signature above acknowledges my understanding and agreement with the above stated terms.

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AUTHORIZATION FOR TREATMENT

I, the undersigned, a patient of Apex Pain Management Center and/or a (parent of a minor) (guardian of) (guardian advocate of) a patient of Apex Pain Management Center and the subject of this authorization, hereby authorize the professional staff of the above stated medical agency to administer treatment for the purpose of pain management, medication management for anxiety or sleep disturbance as needed.

I have been informed of the nature and purpose of treatment, common side effects thereof, alternative treatment modalities, approximate length of care, and that consent can be revoked orally or in writing prior to or during the treatment period.

I have read and fully understand the above Authorization for Treatment. No guarantee or assurance has been made to me as to the results that may be obtained.

Patient's Signature: _____

MEDICAL MALPRACTICE INSURANCE

Under Florida Law, 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 MEDICAL MALPRACTICE INSURANCE.

This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fall to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

Dated the _____ day of _____, 20_____.

Patient's Printed Name: _____

Patient's Signature: _____

Parent, Guardian or Guardian Advocate Signature: _____

Witness: _____

Apex Pain Management Center is legally required to report incidences of communicable diseases to the *Department of Public Health*. If, during the course of treatment, it is determined by staff that you have acquired a communicable disease, this information will be reported to the *Department of Public Health*. This report will be made to individuals who are required by law to be notified.

Note: The patient shall always be asked to sign this authorization form. In addition, a parent, guardian or guardian advocate may be asked to give authorization.