Date of visit: ___ / ___ / _____

New Patient Packet

Demographics:

Patient Name: _____

DOB: ____ / ____ / _____ Gender: ☐ M ☐ F Social Security Number: _____-____-_____

Address: _____ City: _____ State: ____ Zip: _____

Mobile #: _____ Secondary contact #: _____ (☐ Home ☐ Work ☐ Other:_____)

Primary Insurance: _____ Insurance ID #:_____

Secondary Insurance: _____ Insurance ID #:_____

Emergency contact name (relation): _____ Contact #:_____

Primary care physician's name: _____ Office #: _____

Were you referred for this visit? ☐ YES ☐ NO If yes, please write his/her name: _____

Patient Email Address:_____

How did you hear about Jax Spine & Pain Centers?

☐ Google ☐ Facebook ☐ Friend ☐ Family ☐ TV ☐ Radio ☐ Print ad ☐ Other:_____

Race: _____ Ethnicity: _____ Primary Language: _____

Advanced Directive: _____ Are you Currently Employed: ☐ Full Time ☐ Part Time ☐ Student ☐ No

Reason for visit/Pain history:

What is the reason for your visit? _____

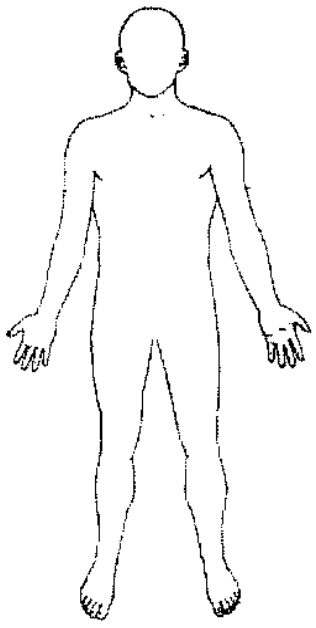
Was there an accident, fall, work injury or motor vehicle accident? ☐ YES ☐ NO

If yes, please specify: _____

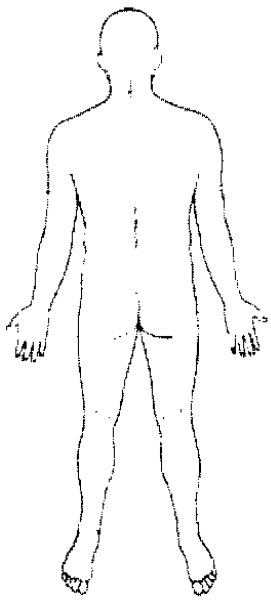
Have you retained an attorney for this accident or work injury? ☐ YES ☐ NO

If yes, please give the name of your attorney: _____

Please mark on the diagram where you experience your symptoms (X = pain; // = numbness)



Right Left



Left Right

When did your pain begin? _____ Has your pain gotten worse, better or the same? _____

Do you recall being treated for this pain before? ☐ YES ☐ NO

Do you recall seeing a pain management physician before? ☐ YES ☐ NO

If yes, please give the name of your physician:_____

How did your pain start?_____

On a scale of 0-10 (10 being the worst pain imaginable), what is the:

AVERAGE daily pain: ____ WORST daily pain: ____ BEST daily pain: ____ Is the pain constant? ☐ YES ☐ NO How would you describe the pain (choose all that apply):

☐ Achy ☐ Burning ☐ Sharp ☐ Stabbing ☐ Dull ☐ Pins/Needles ☐ Other: _____

Do you experience any numbness? ☐ YES ☐ NO If YES, where?_____

Do you experience any weakness? ☐ YES ☐ NO If YES, where?_____

Does the pain spread? ☐ YES ☐ NO If Yes, where?_____

What makes your pain better?_____

What makes your pain worse?_____

Have you had any of the following therapies/treatments?

Therapy/treatment	**Helpful?**		**Therapy/treatment**	**Helpful?**	
☐ Physical therapy	☐ YES	☐ NO	☐ Trigger point injections	☐ YES	☐ NO
☐ Chiropractic therapy	☐ YES	☐ NO	☐ Joint injections	☐ YES	☐ NO
☐ Psychological counseling	☐ YES	☐ NO	☐ Nerve blocks	☐ YES	☐ NO
☐ Biofeedback	☐ YES	☐ NO	☐ Epidural steroid injections	☐ YES	☐ NO
☐ Acupuncture	☐ YES	☐ NO	☐ Facet blocks	☐ YES	☐ NO
☐ Brace support	☐ YES	☐ NO	☐ Radiofrequency ablation	☐ YES	☐ NO
☐ TENS unit	☐ YES	☐ NO	☐ Spinal cord stimulation	☐ YES	☐ NO
☐ Massage	☐ YES	☐ NO	☐ Peripheral nerve stimulation	☐ YES	☐ NO
☐ Other:					

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Have you had any imaging or diagnostic tests performed?

Study	Month	Year	Hospital, Imaging Center or location
☐ X-ray of the:			
☐ CT scan of the:			
☐ MRI of the:			
☐ EMG/NCV of the:			
☐ Other:			

Do you currently have or in the past 12 months experienced any of the following?

☐ Decreased level of activity	☐ Chronic/frequent cough	☐ Urinary retention
☐ Fatigue	☐ Shortness of breath	☐ Painful urination
☐ Depression	☐ Chest pain	☐ Blood in urine
☐ Anxiety	☐ Heart palpitations	☐ Dark urine
☐ Memory loss	☐ Swelling in hands/feet	☐ Swollen glands
☐ Persistent fever	☐ Enlarged veins	☐ Muscular weakness
☐ Difficulty with sleep	☐ Nausea	☐ Swollen joints
☐ Chills	☐ Vomiting	☐ Joint stiffness
☐ Weight gain	☐ Difficulty swallowing	☐ Muscle aches
☐ Weight loss	☐ Abdominal cramping	☐ Leg cramps
☐ Lightheadedness	☐ Coughing blood	☐ Poor coordination
☐ Dizzy/fainting spells	☐ Heartburn	☐ Dry skin
☐ Hallucinations	☐ Bowel incontinence	☐ Yellow skin
☐ Night sweats	☐ Chronic constipation	☐ Skin rash
☐ Headaches	☐ Chronic diarrhea	☐ Hair changes
☐ Easy bruising/bleeding	☐ Change in bowel habits	☐ Erectile dysfunction
☐ Vision problems	☐ Rectal bleeding	☐ Heavy menstruation
☐ Ringing in ears	☐ Black tarry stools	☐ Irregular menstruation
☐ Hearing loss	☐ Frequent urination	☐ Hives
☐ Seizures	☐ Urinary incontinence	☐ Scarring/keloids

Other symptoms you would like us to know about:

Past Medical History:

Please list your medical problems (high blood pressure, heart disease, cancer, COPD, asthma, diabetes, kidney disease, liver disease, hepatitis, HIV, depression, anxiety, seizures, osteoporosis, etc.):

_____

_____

_____

_____

Past Surgical History:

Please list your previous surgeries/procedures (please include month and year if known):

_____

_____

_____

_____

Allergies (please include type of reaction if known)**:**

_____

_____

Medications (please include dosage and frequency if known):

_____

_____

_____

_____

_____

_____

Are you on any blood thinners? ☐ YES ☐ NO If yes, please list: _____

What pharmacy do you use?

Name: _____ Phone:_____

Address: _____

Do you recall taking any of the following pain medications in the past?

Medication	Helpful?		Medication	Helpful?	
☐ Neurontin (Gabapentin)	☐ YES	☐ NO	☐ Robaxin (Methocarbamol)	☐ YES	☐ NO
☐ Lyrica (Pregabalin)	☐ YES	☐ NO	☐ Skelaxin (Metaxalone)	☐ YES	☐ NO
☐ Topamax (Topiramate)	☐ YES	☐ NO	☐ Voltaren (Diclofenac)	☐ YES	☐ NO
☐ Cymbalta (Duloxetine)	☐ YES	☐ NO	☐ Mobic (Meloxicam)	☐ YES	☐ NO
☐ Milnacipran (Savella)	☐ YES	☐ NO	☐ Toradol (Ketorolac)	☐ YES	☐ NO
☐ Effexor (Venlafaxine)	☐ YES	☐ NO	☐ Advil (Ibuprofen)	☐ YES	☐ NO
☐ Elavil (Amitriptyline)	☐ YES	☐ NO	☐ Aleve (Naproxen)	☐ YES	☐ NO
☐ Pamelor (Nortriptyline)	☐ YES	☐ NO	☐ Morphine	☐ YES	☐ NO
☐ Ultram (Tramadol)	☐ YES	☐ NO	☐ Percocet (Oxycodone)	☐ YES	☐ NO
☐ Zanaflex (Tizanidine)	☐ YES	☐ NO	☐ Norco (Hydrocodone)	☐ YES	☐ NO
☐ Flexeril (Cyclobenzaprine)	☐ YES	☐ NO	☐ Other:	☐ YES	☐ NO

Social History:

Relationship status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Occupation: _____ ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student

Do you smoke or use tobacco? ☐ YES ☐ NO If yes, how often? ☐ 1-2x/day ☐ 3-6x/day ☐ >7x/day

Do you consume alcohol? ☐ YES ☐ NO

If yes, how often do you drink? ☐ Monthly or less ☐ 2-4x/month ☐ 2-3x/week ☐ >3x/week

Do you currently use any illegal and/or non-prescribed drugs? If yes, which? _____

Have you ever used any illegal and/or non-prescribed drugs? If yes, which? _____

Are you in recovery from alcohol or drug abuse? ☐ YES ☐ NO If YES, when did you quit?_____

Family History (Please list any medical history of your first-degree relatives)**:**

Father: _____

Mother: _____

Siblings: _____

Patient/Doctor Treatment & Medication Agreement

Jax Spine & Pain Centers is primarily an *interventional* practice as opposed to a *pain medication* management practice.

The purpose of this Agreement is to prevent misunderstandings about certain medicines that might be prescribed for a pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

This Agreement is essential to the trust and confidence necessary in a physician/patient relationship and the trust that the physician undertakes to treat the patient based on this Agreement.

By signing this agreement you will have read, understood, and agreed to these rules:

- If I break this Agreement, my doctor may stop prescribing my medications and I may be DISCHARGED from the practice.
- I will keep Jax Spine & Pain Centers notified OF MY CURRENT PHARMACY AND THEIR PHONE NUMBER.
- I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.
- I will not use ANY medications that were not prescribed to me or ILLEGAL substances (narcotics) (e.g., heroine, cocaine, methamphetamines, LSD).
- If recommended by the physician, I will submit to an evaluation by an addiction specialist, which may include a psychiatric evaluation and subsequent treatment.
- I will not SHARE, SELL, or TRADE, my medication with anyone.
- If I am prescribed controlled medications by Jax Spine & Pain Centers, I will not attempt to obtain any further controlled pain medications from any other doctor or practice.
- I will SAFEGUARD my pain medication from loss or theft. Lost or stolen medicines WILL NOT be replaced.
- Refills of my prescriptions for pain medication will be made only during regular office hours. ALL refill requests must be made THREE business days in advance. NO REFILLS WILL BE AVAILABLE DURING EVENINGS, WEEKENDS, OR HOLIDAYS.
- I understand that I must be seen at a minimum of every NINETY DAYS to request a Schedule II controlled medication (opioid) refill or my refill will be denied until I am seen.
- I authorize my doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation or any possible misuse, sale, or other diversion of my pain medicine. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- I authorize my doctor to provide a copy of this Agreement to my pharmacy.
- I will submit to a blood or urine test if requested by my doctor to determine compliance with my program of pain control medication.
- I will use my medicine at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time.
- If at any time I break my medication contract, I am aware that the local Sheriff's Office may be notified and my records could be released to them.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment and medications have been adequately answered. If requested, a copy of the Agreement has been given to me.

This Agreement has been reviewed and signed on this _____ day of _____ in the year of _____.

Patient Name: _____ Patient Signature: _____

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

Assignment of Medicare Benefits:
I hereby authorize and assign all payments and/or authorized Medicare benefits due to me for medical services rendered to me, directly to **Jax Spine & Pain Centers.** I authorize **Jax Spine & Pain Centers** to release medical records and other information related to medical services provided by **Jax Spine & Pain Centers** to Medicare, which is necessary to process claims for services rendered, for the payment of a bill, determination of benefits, appeal of claims, utilization and quality review purposes or health care operations. I direct my insurance company to send payments directly to **Jax Spine & Pain Centers** to be payable to **Jax Spine & Pain Centers**. In the event that I receive a check directly from my insurance company payable to me for services rendered by **Jax Spine & Pain Centers**, I understand that this payment belongs to **Jax Spine & Pain Centers**. I agree to endorse the back of the check payable to **Jax Spine & Pain Centers** and promptly deliver the check to **Jax Spine & Pain Centers**. I understand that I am financially responsible for all charges not covered by Medicare for which I have signed an Advance Beneficiary Notice (ABN) of Non-Coverage. I permit a copy of this assignment to be used in place of the original.

Assignment of Benefits:
I hereby authorize and assign all payments and/or insurance benefits due to me under my insurance plan for medical services rendered to me, directly to **Jax Spine & Pain Centers**. I authorize **Jax Spine & Pain Centers** to furnish medical records and other information related to medical services provided by **Jax Spine & Pain Centers** to my insurance company or health maintenance organizations, other payers, payor network organizations, and the contractors or third-party administrators of any of these parties which is necessary to process claims for services rendered, for the payment of a bill, determination of benefits, appeal of claims, utilization and quality review purposes or health care operations. I direct my insurance company to send payments directly to **Jax Spine & Pain Centers** to be payable to **Jax Spine & Pain Centers**. In the event that I receive a check directly from my insurance company payable to me for services rendered by **Jax Spine & Pain Centers**, I understand that this payment belongs to **Jax Spine & Pain Centers**. I agree to endorse the back of the check payable to **Jax Spine & Pain Centers** and promptly deliver the check to **Jax Spine & Pain Centers**. I permit a copy of this assignment to be used in place of the original.

Caution: Please read carefully before signing. Please ask to view a copy of our charges. If you do not completely understand this document, please ask us to explain it to you. If you sign below, we will assume you understand and agree to the above.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving medical services at **Jax Spine & Pain Centers**. I have not received any promises or guarantees from anyone at **Jax Spine & Pain Centers** as to the results that may be obtained by any treatment or service; and I agree **Jax Spine & Pain Centers**' prices for medical services, treatment and supplies are reasonable, usual and customary.

Patient Signature: _____ Date: _____

Patient Name: _____

Legal Representative Signature: _____ Date: _____

Name of Legal Representative: _____

Legal Representative Authority to Act for Patient (Parent, Guardian, Power of Attorney, Healthcare Surrogate, etc.):

_____

JAX SPINE&PAIN CENTERS

FINANCIAL POLICY

- Payment is due at the time of service unless other arrangements have been made in advance. For your convenience, we accept cash, check, MasterCard, Visa, Discover, and American Express credit cards.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered"; you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. It is your responsibility to know your insurance benefits.

- You are responsible for promptly responding to your insurance company to provide any additional information they may request regarding your treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in your account becoming due and payable, in full immediately.

- Be prepared to present your insurance card and proof of identity (e.g. driver's license) at each visit. You are responsible for providing a change of address, phone number and/or insurance information anytime a change occurs.

- A prepayment of your deductible and coinsurance is required for your portion of our fees, based on our contract with your insurance plan. Any balance remaining, after your health plan pays, is your responsibility. Payment is due upon receipt of a statement from our office. Such payment is not contingent on any insurance, settlement or judgment payment.

- There is a $35.00 service fee on all returned checks in addition to the amount of the check. NSF (non-sufficient funds) checks must be redeemed with certified funds (cashier's check, credit card, money order, certified check or cash) at or before the next office visit.

- You must provide our office with at least a 24-hour notice to cancel or reschedule your appointment or you will be charged a $25.00 cancellation or "no show" fee for an office visit and a $50.00 cancellation or "no-show" fee for a procedure, including an injection. This appointment cancellation or "no show" fee is not covered by insurance and therefore becomes your responsibility. All "no show" fees must be paid before a new appointment can be scheduled. Patients that repeatedly fail to provide the requisite notice prior to appointment cancellation may be discharged from **Jax Spine & Pain Centers**.

- We will look to the adult accompanying a minor for payment of all services rendered to minor patients.

- **Jax Spine & Pain Centers** may add one and one-half percent (1.5%) per month to any balance owed, and in the event of default, you agree to pay reasonable collection charges, not to exceed 30% of the unpaid balance at the time the account is assigned to a collection agency, and/or attorney fees, court costs and post judgment and interest as allowed by state law.

Certification: I certify that: I have read and agree to the above terms and conditions of the Financial Policy.

Patient Signature: _____ **Date:** _____

Patient Name: _____

Legal Representative Signature: _____ **Date:** _____

Name of Legal Representative: _____

Legal Representative Authority to Act for Patient (Parent, Guardian, Power of Attorney, Healthcare Surrogate, etc.):

_____

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy):_____

Address: _____City: _____ State: _____ Zip:_____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: **ALL MY HEALTH INFORMATION including any information about sensitive conditions** (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name:_____ Phone: (____)_____

Address:_____ Fax: (____)_____

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosures above from the types of sources listed**.

X _____ _____

Signature of Patient or Patient's Legal Representative — Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain: _____)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PHONE: 904-223-3321 FAX: 904-223-2169

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

_____

PHONE: _____ EMAIL:_____

☐ I authorize Jax Spine & Pain Centers to ***send*** my medical information ***to:***

☐ Myself: ☐ pick up ☐ mail to address above ☐ email/fax to_____

☐ Name of Provider or Facility: _____

Address: _____

Phone: _____ Fax: _____

☐ I authorize Jax Spine & Pain Centers to ***request*** my medical information ***from:***

Name of Provider of Facility: _____

Address: _____

Phone: _____ Fax: _____

RECORDS REQUESTED: Dates: _____

☐ Visit Notes/Procedures

☐ Radiology/Imaging: _____

☐ Related to Condition: _____

THE PURPOSE OF THIS REQUEST:

☐ Continuation of Care ☐ Transfer of Care ☐ Personal ☐ Other: _____

I DO NOT WANT THE FOLLOWING INFORMATION TO BE DISCLOSED:

☐ Substance Abuse ☐ HIV ☐ Mental Health Conditions ☐ Other: _____

I UNDERSTAND THAT: I have the right to inspect and receive a copy of the health information and there may be a charge for copies. I do not need to sign this authorization in order to receive treatment. Once information is disclosed, the information is subject to re-disclosure and no longer protected by federal privacy regulations. I hereby release Jax Spine & Pain Centers, formally known as Jacksonville Spine Center, and its employees from any liability that may arise from the release of information that I have directed. I understand that I have the right to revoke this authorization at any time and it must be in writing.

_____ _____

SIGNATURE OF PATIENT OF LEGAL REPRESENTATIVE DATE