New Patient Intake Packet

Demographics

Patient Name: _____ Patient DOB: _____

Gender: ☐ Male ☐ Female /Mobile # _____Secondary #: _____

Social Security Number: _____ Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Separated

Address: _____ City _____ State _____ Zip _____

Race:_____Ethnicity: _____Primary Language: _____

Primary Insurance: _____ Member ID: _____ ___

Secondary Insurance: _____ Member ID: _____

Primary Care Physician: _____ Office Phone: _____

Emergency Contact:

Name: _____ Phone #: _____

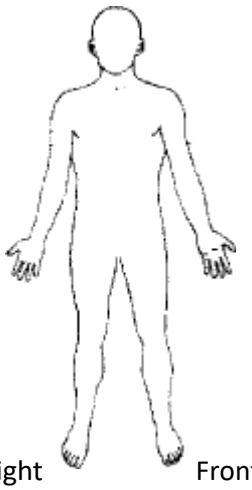
How is this person related to you? _____

Do you have an Advanced Directive/Power of Attorney/Living Will ☐ Yes ☐ No

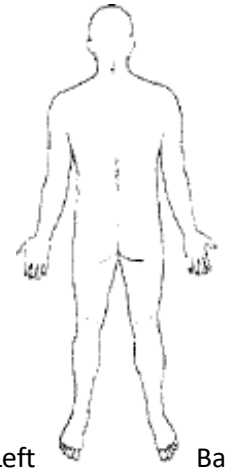
Occupation: _____ FT ☐ PT ☐ Retired ☐ Unemployed ☐ Student ☐

How did you hear about us? Google ☐ Facebook ☐ Friend/Family ☐ TV ☐ Radio ☐ AD ☐ Other ☐

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



Front Right Front Left



Back Left Back Right

About your pain:

Is your pain a result of an accident, fall, work injury, or motor vehicle accident? YES ☐ NO ☐

If yes:

Please specify: _____

Has this injury or pain been treated by another physician? _____

Have you retained an attorney: _____

If yes, attorney name: _____

Primary Location(s) of Pain: _____

How did your pain start? _____

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

What makes your pain better? _____

What makes your pain worse? _____

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

If yes, physician name: _____

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

If yes, physician name: _____

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

AVERAGE daily pain: _____ WORST daily pain: _____ BEST daily pain: _____

How would you describe the pain (choose all that apply):

Constant ☐ Achy ☐ Burning ☐ Sharp ☐ Stabbing ☐ Dull ☐ Pins/Needles ☐ Other

Have you experienced any of the following?

Numbness	☐ Yes	☐ No	If yes, where:_____
Weakness	☐ Yes	☐ No	If yes, where:_____
Spreading pain	☐ Yes	☐ No	If yes, Where:_____

Previous Treatments

Please indicate if you have had any of the below treatments or therapies before and if they were 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 ☐
Acupuncture	Yes ☐	No ☐	Epidural Steroid Injections	Yes ☐	No ☐
Brace Support	Yes ☐	No ☐	Facet Blocks	Yes ☐	No ☐
TENS Unit	Yes ☐	No ☐	Massage	Yes ☐	No ☐
Radiofrequency Ablations	Yes ☐	No ☐	Spinal Cord Stimulation	Yes ☐	No ☐
Biofeedback	Yes ☐	No ☐	Peripheral Nerve Stimulation	Yes ☐	No ☐

Previous Imaging

Please indicate if you have had any of the following imaging or diagnostic testing performed

Study	Month	Year	Facility, Hospital or Imaging Center
X-Ray of the:			
MRI of the:			
CT of the:			
EMG / NCV of the:			
Other:			

Previous Medications

Please indicate if you recall taking any of these medications in the past? (Not Current)

Medication			Medication		
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 ☐			

Past Medical History

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

_____

_____

Prior surgeries – please include month and year if known:

_____

_____

Allergies:

_____

_____

Medical History of first-degree relatives:

Mother: _____

Father: _____

Sibling(s): _____

Current Health Status

Current Medications, including blood thinners (please include dosage & frequency if known)

_____

_____

_____

Pharmacy

Name: _____ Phone: _____

Address: _____

Social History:

Do you smoke or use tobacco? ☐ Yes ☐ No If yes, how often? _____

Do you consume alcohol? ☐ Yes ☐ No If yes, how often? _____

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? _____

Initial Wellness Assessment

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please check the box that most appropriately describes your feelings.

	Not at all	Several days	More than half the days	Nearly everyday
Little Interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed: or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in someway	☐	☐	☐	☐

Patient Name: _____

DOB: _____

MR #: _____

Patient Email and Text Message Informed Consent

Jax Spine & Pain Centers, Centurion Spine & Pain Centers and their affiliates, agents, independent contractors and any "covered entity" or "business associate" (as those terms are defined in the HIPAA Privacy Rule) with which your information may be shared under HIPAA (collectively, "Jax Spine & Pain Centers and Centurion Spine & Pain Centers") may communicate with you by e-mail, text message, and/or other forms of unencrypted electronic communication (together, "Electronic Messaging") to the telephone number(s), email address(es) or other locations reflected on your account or as otherwise provided below. Jax Spine & Pain Centers and Centurion Spine & Pain Centers may use automatic dialers or pre-recorded voice messages when it communicates with you through Electronic Messaging. All Electronic Messaging may be made a part of your medical record. This form provides information about Jax Spine & Pain Centers and Centurion Spine & Pain Centers' use, risks, and conditions of Electronic Messaging. It also will be used to document your consent for Jax Spine & Pain Centers and Centurion Spine & Pain Centers communication with you by Electronic Messaging.

How we will use Electronic Messaging: Jax Spine & Pain Centers and Centurion Spine & Pain Centers may use Electronic Messaging to communicate with you regarding a wide range of healthcare related issues, including:

- reminders of appointments or actions for you to take before an appointment, follow-ups from appointments, and notices about preventive services, treatment options, coordination of your care and other available health services;
- information regarding insurance, billing statements, eligibility for programs/benefits, and account balances.

Risk of using Electronic Messaging: Electronic Messaging has a number of risks that you should consider, including:

- Electronic Messaging can be circulated, forwarded, sent to unintended recipients, and stored electronically and/or on paper.
- Senders can easily misaddress Electronic Messaging and send the information to an unintended recipient.
- Backup copies of Electronic Messaging may exist even after deletion.
- Electronic Messaging may not be secure and can be intercepted, altered, forwarded or used without authorization or detection.
- Electronic Messaging service providers may charge for calls or messages received.
- Employers and Online providers have a right to inspect Electronic Messaging sent through their company systems.
- Electronic Messaging can be used as evidence in court.

Conditions for the use of Electronic Messaging: Jax Spine & Pain Centers and Centurion Spine & Pain Centers cannot guarantee, but will use reasonable means to maintain, the security and confidentiality of the messages we send. By signing where indicated below, you acknowledge your consent to the use of Electronic Messaging on the following conditions:

- **IN A MEDICAL EMERGENCY, DO NOT USE ELECTRONIC MESSAGING, CALL 911.** Urgent messages or needs should be relayed to us by using regular telephone communication.
- Electronic Messaging may be filed into your medical record.
- Jax Spine & Pain Centers and Centurion Spine & Pain Centers is not liable for breaches of confidentiality caused by you or any third party.
- You are solely responsible for any charges incurred under your agreement with your Electronic Messaging service provider (for example, per minute, per message, per unit-of-data-received basis or otherwise).

Expiration and Withdrawal of Consent: Unless you earlier withdraw your consent, this consent will expire upon the end of your treatment relationship with Jax Spine & Pain Centers and Centurion Spine & Pain Centers. You may choose to stop participating in Electronic Messaging at any time by informing Jax Spine & Pain Centers and Centurion Spine & Pain Centers in writing as described herein. You further understand that withdrawing this consent will not cause you to lose any benefits or rights to which you are otherwise entitled, including continued treatment, payment or enrollment or eligibility for benefits. To withdraw consent and stop participating in Electronic Messaging, please contact our office at 904-223-3321.

Patient Acknowledgment and Agreement: I have read and fully understand this consent form. I understand the risks associated with the use of Electronic Messaging between Jax Spine & Pain Centers and Centurion Spine & Pain Center and me, and I consent to the conditions and instructions outlined, as well as any other instructions that Jax Spine & Pain Centers and Centurion Spine & Pain Centers may impose to communicate with me by Electronic Messaging.

I understand that Jax Spine & Pain Centers and Centurion Spine & Pain Centers will send Electronic Messaging to those telephone number(s) and email address(es) in my account.

Release. In consideration of Jax Spine & Pain Centers and Centurion Spine & Pain Centers services and my request to receive Electronic Messaging as described herein, I hereby release Jax Spine & Pain Centers and Centurion Spine & Pain Centers from any and all claims, causes of action, lawsuits, injuries, damages, losses, liabilities or other harms resulting from or relating to the calls or messages, including but not limited to any claims, causes of action, or lawsuits based on any asserted violations of the law (including without limitation the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, the Health Insurance Portability and Accountability Act, any similar state and local acts or statutes, and any federal or state tort or consumer protection laws).

_____ _____ _____

Patient (or Authorized Representative) Signature **Patient's Name (PRINT)** **Date**

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., heroin, cocaine, methamphetamines, LSD).
- I understand that my doctor may stop prescribing my medications and I may be discharged from the practice if I participate in the consumption or use of alcohol (ETOH) or un-approved Benzodiazepines as the combination of alcohol and or Benzodiazepines can be fatal if taken with an opiate.
- 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 me 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 (PRINT): _____ 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 (PRINT): _____

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

Name of Legal Representative: _____

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

_____

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 our practice.

- 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 (PRINT): _____

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

Name of Legal Representative: _____

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

_____

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 OR LEGAL REPRESENTATIVE **DATE**

AUTHORIZATION TO VERBALLY DISCLOSE INFORMATION TO FAMILY MEMBERS, FRIENDS OR OTHERS INVOLVED IN CARE

You have the right to identify family, friends, or others involved in your care to verbally receive medical or payment information about you. Under HIPAA requirements, Centurion Spine and Pain Centers is not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members, friends or others involved in your care, you must sign this form.

I authorize Jax Spine and Pain Centers to discuss my medical information and financial information (as checked below) with the following individuals.

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER

Type of information to be verbally disclosed (check all boxes that apply):

❑ All medical information including any diagnostic test results

❑ Health plan information (billing, benefits, payments, authorizations) including updating demographic

❑ Other information. (describe): _____

I understand that I have the right to revoke this consent, in writing, except where Jax Spine and Pain Centers has already made disclosures in reliance on my prior consent. This consent shall remain an effect until revoked in writing.

I hereby release Jax Spine and Pain Centers that acts in reliance on this authorization from any liability that may accrue from releasing my medical or payment information to the individual(s) listed above.

Patient Name (PRINT) _____ Signature: _____

Date of Birth: _____ Date: _____