Interventional Pain Physicians of South Florida

1500 North Dixie Highway – Suite 103 West Palm Beach, Fl 33401
1111 SE Federal Highway – Suite 228 Stuart, Fl 34994
T: 561-833-8893 F: 561-833-8939

Attached please find your new patient paperwork that is necessary for you to complete prior to your upcoming appointment. You MUST fill out these forms and return them to our office at least 2 days prior to your appointment. If we do not receive these forms, we may have to reschedule your appointment.

You can mail them back, fax them to: 561-833-8939 or email them to APM@shcr.com

Your New Patient Consultation has been scheduled on _____@_____am/pm

With:

_____ Kevin A. Chaitoff, MD
_____ Sheldon Regenbaum, MD
_____ Angela Gonzalez, PA-C
_____ Wayne Weidenbaum, MD
_____ John Nangle, PA-C

At this visit an examination and consultation will be performed. A procedure will not be performed on this visit.

****PLEASE NOTE****

IT IS OUR PROVIDERS DISCRETION WHETHER OR NOT THEY CONTINUE TO PRESCRIBE ANY MEDICATIONS THAT YOU ARE CURRENTLY PRESCRIBED BY ANY OUTSIDE PHYSICIAN

Please arrive 20 minutes before your appointment time to allow for processing of your identification.

Call when you arrive in the parking lot 561-833-8893, you must wear a mask and come alone, visitors will not be permitted into the office.

INTERVENTIONAL PAIN PHYSICIANS

PLEASE PRINT

Name: _____ Date of Birth: _____
LAST FIRST MIDDLE

Local Address: _____ City: _____ State: _____

Zip Code: _____ Telephone: _____ Cell: _____ Email: _____

Ethnicity: _____ Race: ☐ African American ☐ Caucasian ☐ Other ☐ Decline

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Employer: _____ Telephone:_____

Referring Physician: _____ Telephone: _____

Primary Care Physician (PCP):_____ Telephone: _____

Cardiologist: _____ Telephone: _____

Who is responsible for payment? _____ Health Insurance _____Auto Insurance _____ Workers Compensation _____ Self Pay

Date of Injury:_____ Claim Number: _____ Adjuster: _____

Primary Insurance Name: _____ Telephone: _____

Name of Insured: _____ ID /Group Number: _____

Secondary Insurance Name: _____ Telephone: _____

Name of Insured: _____ ID /Group Number: _____

Pharmacy: _____ Location: _____ Telephone: _____

In case of emergency, who should be notified? _____ Telephone: _____

Permission to release health information to: _____

CONSENT FOR E-PRESCRIBING & MEDICATION HISTORY

I understand that as a part of my electronic health record, Interventional Pain Physicians will transmit my prescriptions electronically as permitted, to the pharmacy that I designate as my primary pharmacy provider. Additionally, IPP will obtain the history of all of my past prescriptions dating back two years from pharmacy benefit managers and I understand that the prescription history will become a part of my electronic health record. By signing below I hereby give consent to the above actions.

Signature of Patient or Legal Representative**:** _____Date: _____

RECORD RELEASE & ASSIGNMENT OF INSURANCE

I hereby authorize Interventional Pain Physicians to re-release any and all medical information that has been previously requested from any physician, hospital, or clinic where I have been treated. I also understand that **this authorization to re-release medical information shall only be valid for the purposes of second opinions or referral from Interventional Pain Physicians additional specialist evaluation.** I acknowledge that I have received a copy of the "Notice of Privacy Practices" which sets forth Interventional Pain Physicians privacy practices and my rights regarding privacy of my PHI. I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full, at the time of service, **unless other arrangements are made in advance**. I hereby authorize the payment of benefits of my insurance policy, if any, to be paid directly to Interventional Pain Physicians for services rendered. I further authorize the release of any medical information required by my insurance carrier. I understand that I am financially responsible for any charges incurred in the collection of this account, should I default on payment. Such charges include, but are not limited to legal fees, collections fees, interest charges or late charges.

Signature of Patient or Legal Representative**:** _____Date: _____

PAIN MANAGEMENT HEALTH SURVEY **INTERVENTIONAL PAIN PHYSICIANS**

Patient Name: _____Today's Date: _____

Date of Birth _____Height: _____ Weight: _____ Sex: □ Male □ Female

CURRENT MEDICATIONS:	**NAME**	**STRENGTH**	**FREQUENCY**
Example	Motrin	800mg	2 times a day

FAMILY HISTORY **Please check (A)** Alive **(D)** Deceased

	Father __(A) / (D) __	**Mother** __(A) / (D)__	**Siblings**	**History**
Heart Disease	□	□	□	_____
High Blood Pressure	□	□	□	_____
Cancer	□	□	□	_____
Diabetes	□	□	□	_____

PAST MEDICAL HISTORY

__High/Low Blood Pressure	__Chest Pain/MI/Heart Disease	__ Lung Disease	__Thyroid Problems
__Stroke/TIA	__Anxiety	__ Kidney/Bladder problems	__Heart Arrhythmia
__Liver Disease	__Diabetes: Insulin/Pills/Diet	__Seizures/Neuro/Epilepsy	__Shortness of Breath
__Ulcer Disease	__Heart Murmur	__Cancer _____	

Other relevant past medical history _____

ALLERGIES: List All Medications, Herbal remedies and Foods you are Allergic to and type of reaction to each:

_____

_____

_____

SURGICAL HISTORY (Surgery and Year)

_____

_____

_____

SOCIAL HISTORY

Current Smoker __ Yes __ No How many cigarettes per day _____ How often __ Everyday __ Not everyday
How soon after you wake up do you smoke your first cigarette? (Minutes) _____
Interested in quitting? __ Yes __ No _____
Drink Alcohol? __ Yes __ No How much and how frequently _____
Have you used drugs other than those for medical reasons in the past 12 months? _____ Yes _____No
If yes, which drug and when was it last used _____

REVIEW OF SYSTEMS **(Please circle if you currently have any of the following conditions)**

General: appetite change, fever, chills, sweats, weight gain or loss

Hematologic: bruising, skin rashes, history of bleeding disorder, blood clots

Cardiovascular: palpitations, vertigo, angina, chest pain, heart murmur

Respiratory: shortness of breath, cough, sleep apnea, wheeze

Endocrine: fatigue, increased thirst, heat/cold intolerance

Gastrointestinal: abdominal pain, nausea, vomiting, diarrhea, constipation, black/bloody stool, rectal bleeding, acid reflux

Genitourinary: urination hesitancy/frequency, painful urination, kidney stone

Rheumatologic: joint pain, rash

Neurological: seizure, muscle weakness, headaches, memory loss

Psychiatric: depression, anxiety, suicidal ideation

Musculoskeletal: back pain, neck pain, joint pain, muscle pain, spasm

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When did your Pain Begin? _____ Days ago _____Weeks Ago _____Years Ago

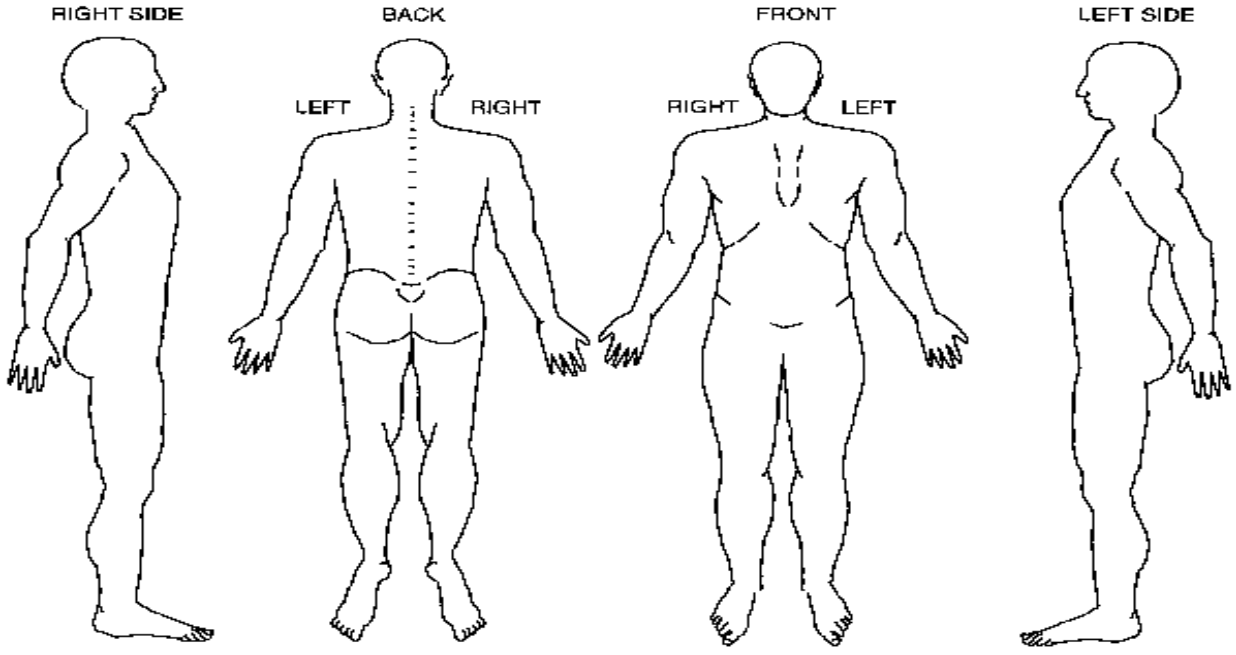
What caused your pain? __ Car Accident __ Lifting __ Work Related __ Trauma __ Sports Injury
__ After Surgery __ Malignancy __ Fall __ Spontaneous __ After an Illness
Please explain: _____

Please circle your pain level using this scale: 1-10 scale, 10 being the worst pain you've ever felt.

1	2	3	4	5	6	7	8	9	10

No Pain **Medium Pain** **Worst Pain**

WHERE IS YOUR PAIN- Mark the area on the diagrams where your pain is located



How Frequent is your Pain? _____ Occasional _____ Intermittent _____ Constant

What is the progression of your Pain since it began? ____ Worsening _____ Stable, no change _____ Improving

Have you had physical therapy, chiropractic or acupuncture in the last 6 months? Yes _____No_____

If yes, did the physical therapy, chiropractic or acupuncture make your pain worse? Yes _____No_____

Do you have a Home exercise Program? Yes_____No_____

If you have a home exercise Program, did you get it from a physical therapist or Physician? Yes_____No_____

Have you had Previous Injection Therapy? Epidurals ___**Y** ___**N** When_____ % relief_____
Other treatment _____ When_____ % relief_____

Please check the appropriate words that best describe your pain

__ACHING __SHOOTING __DULL __BURNING __TINGLING __TIGHT __CRAMPING
__HOTNESS __HEAVY __BRIEF __NUMBING __COLDNESS __INTENSE __STINGING
__SORENESS __STABBING __SHARP __TRANSIENT __CONSTANT __RADIATING __UNBEARABLE
__SEVER __ANNOYING __EXCRUCIATING

Please check any of the following activities that make your pain BETTER:

__ SITTING __ LYING FLAT __ STANDING __ LYING PRONE (BELLY DOWN) __ KNESS FLEXED
__ CHANGING POSITION __ REST __ WALKING __ BETTER IN AM __ BETTER IN PM
__ BENDING OR STOOPING

Please check any of the following activities that make your pain WORSE:

__ SITTING __ STANDING __ KNESS FLEXED __ WALKING __ STRAINING __ LYING FLAT
__ BENDING OR STOOPING __ HANGING POSITION __ WORSE IN MORNING __ LIGHT EXCERISE
__ COUGHING OR SNEEZING __ "BEARING DOWN" __ LYING PRONE (BELLY DOWN)
__ WORSE IN AFTERNOON

Does pain interfere with your sleep? Yes_____ No_____ Explain: _____

Please check any Previous (P) or Current (C) treatments you are participating in:

P C	**P C**	**P C**	**P C**	**P C**
□ □ None	□ □ Surgery	□ □ Medication	□ □ Biofeedback	□ □ Hypnosis
□ □ Physical Therapy	□ □ Epidural Blocks	□ □ Nerve/Steroid Blocks	□ □Acupuncture	□ □ TENS
□ □ Cortisone Pills	□ □ Massage Therapy	□ □ Exercise	□ □ Heat	□ □ Ice
□ □ Osteopathic/Chiropractic Manipulation		□ □ Mental Health Counseling	□ □ Trigger Point Injections	

If current, please tell us where you are receiving treatment: _____

Please check any Diagnostic Testing you have had: ____MRI ____CT Scan ____EMG ____X-Rays ____Other

Are you Currently Working? __Yes __ No **If Yes,** How Many Hours Per day _____Per week _____

ADDITIONAL COMMENTS: _____
_____

Patient Signature _____Date _____

Interventional Pain Physicians

PATIENT FINANCIAL & OFFICE POLICIES

We are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policies as an essential element of your care and treatment. We are more than willing to provide care within the guidelines of your insurance plan. It is however, your responsibility to know and understand those guidelines.

OFFICE HOURS

The office is open Monday – Thursday from 8:00 a.m. – 4:30 pm
Friday from 8:00 a.m. – 4:00 pm.

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Telephones are answered between 9 a.m. to 12 p.m. then from 1 pm to 4:00 p.m. Monday – Thursday
Friday from 9:00 a.m. to 12:00 pm

PRESCRIPTIONS FOR NARCOTICS

Patients who receive Narcotic Medications are required to have a signed Controlled Substance Agreement in their Medical Record. Prescriptions for narcotics will not be released without completing this agreement.

Do not allow yourself to run out of medication.
Your medication is your responsibility. Do not call us and say that you are out of medication and need a prescription today, we will not be able to assist you as your physician may not be in the office or available.

IF YOU ARE REQUESTING A REFILL TO BE CALLED TO YOUR PHARMACY ON ALLOWABLE MEDICATIONS, WE REQUIRE **72 HOURS NOTICE** TO PROCESS YOUR REQUEST.

There will be no Class II Narcotic medications called in to any pharmacy at any time. This is a Florida State law and a law regulated by the DEA (Drug Enforcement Administration).

HEALTH INSURANCE

You must be prepared to provide your health insurance card at every visit. **ALL HEALTH INSURANCE DEDUCTIBLES AND CO-PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.** This office files primary health insurance for those which we participate. If you have a secondary health insurance payor, we will also file a medical claim to them as well. It is your responsibility for knowing your policy information such as co-payments, co-insurances and deductibles. We will not become involved in disputes between you and your health insurance carrier. In the event your health plan determines any service to be 'not covered,' you will be responsible for the complete charge. Payment is due at the time of service.

AUTO INSURANCE

We will file a claim to your auto insurance carrier if Personal Injury Protection (PIP) Benefits are still available. **We will not file PIP to any third parties**. You will be responsible for the 20% co-insurance on your PIP insurance at the time of service, unless you provide us with health insurance, which will be filed as a secondary payor or a Letter of Protection signed by both you and your representing attorney. _____ (initial)

LETTER OF PROTECTION

If you do not have health insurance or PIP insurance and are seeking care with our office under legal representation**, before your first visit**, it is your responsibility to make sure that we have a signed Letter of Protection from your Attorney. You will need to make sure that your Legal Counsel sends us this letter unless other arrangements have been made. You have a responsibility to contact that office and inform them that you are seeking medical care from this practice. Once your legal case has settled, your Legal Counsel will hold funds from your settlement and send to us in an effort to resolve any unpaid balances. _____ (initial)

MISSED APPOINTMENTS

WE REQUIRE 24 HOUR NOTICE FOR ALL CANCELLATIONS. **Our policy is to charge $50.00** for those who miss their appointments and/or no-show for their appointment. Please help us serve all our patients better by keeping your scheduled appointments.

APPOINTMENTS

We do not see any walk-in patients, EVERYONE IS REQUIRED TO HAVE AN APPOINTMENT.
This office will call the two days ahead of time to confirm your scheduled appointment. Please remember that this is a courtesy and is not required, however, if you are scheduled and you do not get a phone call two days ahead of time, please call us to confirm. It is your responsibility to be here on time for your appointments. If you are more than 15 minutes late to your scheduled appointment we may ask that you re-schedule for another date and time.

PERSONAL INFORMATION

It is imperative that our office be provided with current information on you. We must be able to contact you. Please keep us updated of new addresses, phone numbers, place of business and insurance information. We will require you to fill out an updated patient information sheet on an annual basis or anytime there are changes to your personal information.

DISABILITY, DRIVING & OTHER FORMS

If you have a disability, financial or similar forms that needs to be completed by our office, please remember that we need at least 7 – 10 days for processing these forms.

MEDICAL RECORD REQUESTS

All medical record requests require a signed written release of information present in the patient chart. If a release is not signed the patient will be required to sign a release before processing begins. A copy of our release can be mailed or faxed. All requests for records will be processed within 15 business days. A processing fee of $1.00 for the first page and $.50 per page thereafter, plus any applicable postage will apply (pursuant to Florida Statute, Chapter 395). Payment is due prior to the release of records.

Signature of Patient or Legal Representative: _____ Date: _____

AUTHORIZATION FOR THE REQUEST OF PATIENT HEALTH INFORMATION FROM OUTSIDE HEALTH CARE PROVIDERS

Please print clearly

Patient Name: _____Date:_____

Date of Birth: _____ Social Security Number: _____

Dates of Service: From _____ thru _____

I, _____ hereby request and authorize the release of the

Following records from: _____
(Physician/Facility PHI being requested from) Phone Number/Fax Number

_____
Street City State Zip Code

_____ Consultation _____ OP Report _____ History & Physical

_____ Doctors Office Visit Notes _____ MRI / CT / X-Ray Reports _____ MRI/ CT/ X-Ray films

_____ Drug/ Alcohol Testing _____ Medication Lists _____ Lab Results

_____ Any & All Records not otherwise listed

This information is for continuity of care, unless otherwise noted: _____

Interventional Pain Physicians

Kevin Chaitoff, MD ♦ Sheldon Regenbaum, MD ♦ Wayne Weidenbaum, MD

John Nangle, PA-C * Angela Gonzalez, PA-C

1500 North Dixie Highway – Suite 103 West Palm Beach, FL 33401
1111 SE Federal Highway – Suite 228 Stuart, FL 34994

Phone (561) 833-8893 Fax (561)833-8939

Patient or Authorized Signature _____Date_____

Relationship to Patient: _____

Pursuant to Florida law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, the record may be given only to the person designated and it may be used only for the purpose listed on this form. Charges are in compliance with Florida law. I understand that once my information is disclosed to the recipient above, it may be re-disclosed to individuals not subject to HIPAA and may no longer be protected by HIPAA. I understand that signing this authorization is voluntary and will not affect my receipt of treatment. I understand that I may revoke this authorization at any time, in writing, to the address listed above provided that the information has not yet been released. This authorization expires in six (6) months unless another date is written here _____.

PLEASE FAX MEDICAL RECORDS ASAP TO (561) 833-8939

INTERVENTIONAL PAIN PHYSICIANS

Thank you for choosing our practice to assist you with your care.

We appreciate your trust and are committed to providing you with high quality, compassionate care.

We value our patients and tailor their treatment plans according to their unique needs, in doing so, we allocate time for each appointment accordingly. We realize that circumstances may occur beyond your control that may not allow you to provide 24 notification. Failure of a patient to notify the office to cancel or change their appointment without 24 hour notice is considered a "No-Show". To help remind patients of their appointments we have implemented an automated reminder system. Please assure we have your correct and most up to date phone numbers or email address at all times throughout the course of your treatment to allow us to better serve you.

The "no show "appointments will be documented in the patient record.
Charges for "no-show appointments are as follows:

Office visit $50.00
Procedure or surgical center visit $100.00

This letter will serve as notice about the office no show policy and fees.

I acknowledge that I have read and understand the policy.

_____
Print Name

_____ _____
Signature Date

Interventional Pain Physicians of South Florida

PAIN MANAGEMENT CONTROLLED SUBSTANCE ACKNOWLEDGEMENT AND AGREEMENT

The purpose of this agreement is to ensure that the patient has given accurate information upon which the doctor can rely in implementing a pain management program. It is also to prevent misunderstandings about certain medications you will be taking for pain management. This is to help both you and your physician comply with the law regarding controlled pharmaceuticals.

_____ (Initial) I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

_____ (Initial) I understand that if I break this agreement, my doctor will stop prescribing these pain-control medications, I will be discharged from my doctor's care, and I may be criminally prosecuted. In this case, my doctor will taper off the medication over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment program may be recommended.

_____ (Initial) I will communicate fully with my doctor and staff about the character and intensity of my pain, the effects of the pain on my daily life, and how well my medicine is helping to relieve my pain.

_____ (Initial) I will not use any illegal controlled substance.

_____ (Initial) I will not share, sell or trade my medication with anyone.

_____ (Initial) I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor, unless coordinated with this office.

_____ (Initial) I will safe guard my medicine from loss or theft. I understand that lost or stolen medication will not be replaced.

_____ (Initial) I agree that refills of my medication will only be available during my regularly scheduled office visits. I understand that it is my responsibility to make and keep timely appointments. Prescriptions will not be phoned in or picked up out side of these visits. Refills will not be available during evenings, weekends or holidays. **Refills require a minimum of 72 hours notice.**

_____ (Initial) I authorize the doctor, facility and pharmacy to cooperate fully with any city, county, state or federal law enforcement agencies, in the investigation of any possible misuse, sale or other diversion of my medication. I authorize my doctor to provide a copy of this agreement to my pharmacy, primary care provider and referring physician. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ (Initial) I agree that I will submit to blood or urine tests (at my own expense) if requested by my doctor to determine my compliance with my program of pain control medication.

_____ (Initial) I agree that 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.

_____ (Initial) I understand that my pain medications have the potential to impair my judgment and caution should be used when driving or operating heavy machinery, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself. I understand I should not drive a motor vehicle while taking narcotic medications and may be charged with 'Driving Under the Influence' if stopped by law enforcement officials.

_____ (Initial) I understand that alcohol may increase the effects and duration of my medication. I acknowledge that I have been advised to avoid alcohol consumption.

_____ (Initial) I have been fully informed of the psychological dependence (addiction) of a controlled substance. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the same effect of pain control, and I do know that I will become physically dependent on the medication. This will occur if I am on the medication for several weeks, and, when I stop the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.

_____ I understand that it is a criminal offense in the State of Florida to acquire or obtain or attempt to acquire
(Initial) or obtain possession of a controlled substance by misrepresentation, fraud, forgery, deception, or subterfuge. I understand that if I make any false statements in this agreement, I will be subject to criminal prosecution.

MALES ONLY

_____ I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may send me to have my blood checked to see if my testosterone level is normal and will refer me to the appropriate physician for follow-up if it is not.

FEMALES ONLY

_____ If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

1. I am not exaggerating any of the symptoms of any condition that requires pain management. I have been completely honest with my doctor regarding any condition that requires pain management.

_____
Patient Signature

2. I will not see any other physician regarding any condition that requires pain management unless I notify my doctor prior to visiting the other physician.

_____
Patient Signature

3. If my doctor prescribes pain medications, I will only use _____ pharmacy to fill prescriptions. If I intend to use any other pharmacy I will notify my doctor immediately.

_____
Patient Signature

Patient abuse of medication is a serious problem. Please read this form carefully, you will be held to this agreement by your physician and by any law enforcement agency investigating any possible abuse of the doctor/patient relationship with regard to pain management.

I do hereby state that I have read this form completely, and that all of the information is true and accurate. I understand that any false statements given in conjunction with this agreement will subject me to criminal prosecution. I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This agreement is entered into on this _____day of _____month, _____year

Patient Signature: _____

Witness: _____

Physician: _____

Annual MIPS Questionnaire General 2019

Patient Name: _____ Date: _____

1. Do you have little or no interest in doing things? ____ No

____ Yes, please check one: ____ Several Days ____ More than half the days ____ Everyday

2. Are you feeling down, depressed or hopeless? ____ No

____ Yes, please check one: ____ Several Days ____ More than half the days ____ Everyday

If you answered YES to question 1 or 2, then complete the following table. If you answered No to both question 1 and 2 then you DO NOT have to complete the table, skip to Immunizations below.

	Not at all (O)	**Several days (1)**	**More than half the days (2)**	**Everyday (3)**
3. Do you have trouble falling or staying asleep or sleeping too much?				
4. Do you feel tired or have little energy?				
5. Do you have poor appetite or overeating?				
6. Do you feel bad about yourself, feel like a failure, or feel you have let yourself or your family down?				
7. Do you have trouble concentrating on things, such as reading the newspaper or watching television?				
8. Do you move or speak so slowly that other people could have noticed? Or the opposite? Are you fidgety or restless and move around more than usual?				
9. Do you have thoughts that you would be better off dead and/or have thoughts of hurting yourself in some way?				

Have you fallen in the last 365 days? (Answer only if 65 years and older.)

____ NO ____ Yes : ___ 1 fall with injury ___ 2 or more falls with injury

___ 1 fall without injury ___ 2 or more falls without injury