# Integrated Pain Solutions

Gary Saff, M.D.

Dear Patient:

We are looking forward to seeing you on your upcoming appointment.

Enclosed you will find a packet of new patient registration documents. If you would complete these before you arrive for your appointment, it would save you time in the waiting room. If you have any difficulty answering any of the questions, just skip those and we will help you complete the forms when you get here.

Please bring the following with you to your appointment:

1) *Current (not more than a year old) x-rays, MRI's, CT scans and myelogram films along with the interpretive reports.*
2) *Current medication list.*
3) *Drug allergy list.*
4) *Any medical records that are relevant to your pain disorder. If you are currently receiving pain medications from another physician, such as, narcotics, please also bring their office notes with you.* ***No narcotics*** *will be prescribed without these notes.*
5) *Current insurance cards and driver's license or any form of picture identification.*
6) *List of insurance questions, though it would be helpful to check with your insurance company before your appointment.*

*Our staff will also be available to help you with your questions. All necessary referrals must be obtained prior to your appointment, or you will not be able to be seen; this is your insurance company's policy.*

It is imperative that you arrive on time for your appointment. If you are more than ten minutes late, there is a possibility your appointment will be rescheduled due to schedule constraints. *There is a* ***$25.00*** *fee for appointments cancelled less than* ***24 hours*** *prior to the scheduled time.*

We accept only cash or checks for payment, which is due at time of service.

We thank you in advance for your cooperation in completing this work in preparation for your visit. Please do not forget to bring your packet.

If you have any questions, please do not hesitate to call us at (954) 772-7552 or visit our website at www.ipssf.com.

Sincerely,

*Gary Saff, M.D.*

Integrated Pain Solutions of South Florida

**Integrated Pain Solutions**

Gary Saff, M.D.

# PATIENT REGISTRATION FORM

| | | |
|---|---|---|
| *TODAY'S DATE:*<br>*REFERRED BY: (PLEASE SPECIFY)* | *DATE OF BIRTH:* _____/_____/_____<br>*MALE* ___ *FEMALE* ___ | *HEIGHT* __________ *WEIGHT* _______________ |
| LAST NAME: | FIRST NAME:<br>MIDDLE NAME: | MARTIAL STATUS:<br>___SINGLE ___ MAR ___ DIV __ WIDOW |
| ADDRESS: | CITY: | STATE:<br>ZIP: |
| HOME PHONE:<br>WORK PHONE: | CELL PHONE: | EMAIL: |
| SOCIAL SECURITY NUMBER:<br>- - | EMPLOYER: | OCCUPATION:<br>EMPLOYER PHONE NO: |
| NEXT OF KIN:<br>RELATION: | PHONE:<br>CELL: | EMERGENCY CONTACT:<br>PHONE: |
| PRIMARY INSURANCE: | SUBSCRIBER'S NAME: | SUBSCRIBER'S SS#: - -<br>SUBSCRIBER'S DATE OF BIRTH:____/____/____ |
| PATIENT RELATION TO SUBSCRIBER:<br>__SELF __SPOUSE __CHILD __ OTHER | MEMBER ID/ POLICY:<br>GROUP #: | CO-PAY AMOUNT: |
| SECONDARY INSURANCE: | SUBSCRIBER'S NAME: | SUBSCRIBER'S SS#: - -<br>SUBSCRIBER'S DATE OF BIRTH:____/____/____ |
| PATIENT RELATION TO SUBSCRIBER:<br>__SELF __SPOUSE __CHILD __ OTHER | MEMBER ID/ POLICY:<br>GROUP #: | CO-PAY AMOUNT: |

| | | | |
|---|---|---|---|
| REFERRING PHYSICIAN: | PHONE: | FAX: | EMAIL: |
| ADDRESS: | CITY: | STATE: | ZIP: |
| PRIMARY PHYSICIAN: | PHONE: | FAX: | EMAIL: |

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# COMPREHENSIVE PAIN MANAGEMENT INTAKE FORM

A. **When did your pain start?** *(Give specifity date, if possible.)* ___________________________________

B. **What caused your pain?** *(Please circle all that apply.)*

| | |
|---|---|
| *Accident* | *Other Disease:* ***(Please Specify):*** _______________________ |
| *Cancer* | *Surgery* ***(Please Specify):*** _____________________________ |
| *No obvious cause* | |

C. **Describe in your own words the pain problem(s) that you would like help with:**

_____________________________________________________________________________

_____________________________________________________________________________

D. **How often does your pain occur?** *(Please circle all that apply.)*

| | | |
|---|---|---|
| *Continuous* | *Once a day* | *Weekly* |
| *Many times daily* | *Monthly* | |

E. **Below is a list that might describe your pain.** *(Please circle all that apply.)*

| | | | |
|---|---|---|---|
| *Aching* | *Hot-Burning* | *Sharp* | *Other:* _______________ |
| *Dull* | *Shooting* | *Throbbing* | |

F. **Place circles below to indicate your lowest, highest, and average pain intensity over the past week:**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

None Mild Moderate Severe Most

G. **What makes your pain worse?** *(Please circle all that apply.)*

| | | |
|---|---|---|
| *Bending* | *Lying Down* | *Standing* |
| *Coughing/Sneezing* | *Sitting* | *Walking* |

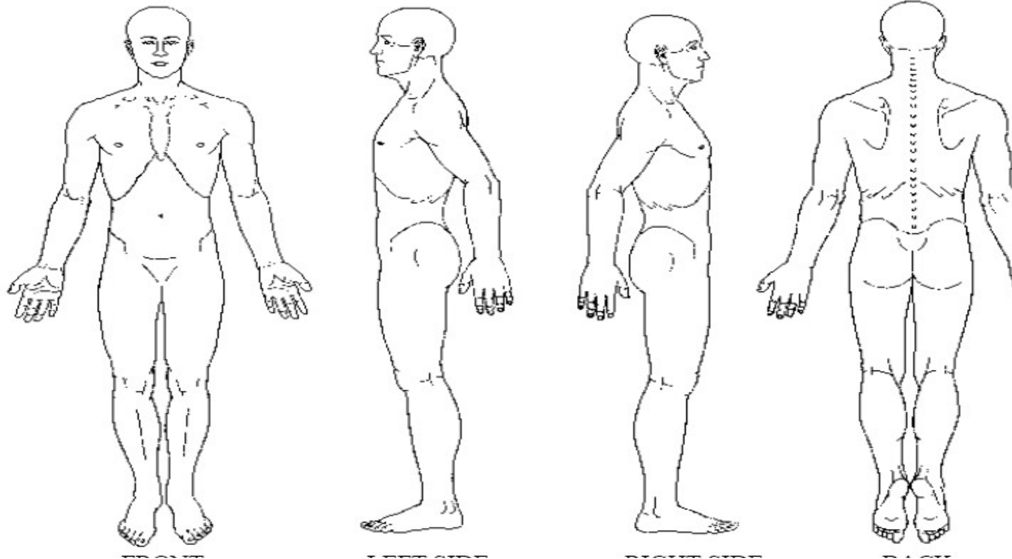
H. **What makes your pain better?** *(Please circle all that apply.)*

| | | |
|---|---|---|
| *Bending* | *Lying Down* | *Standing* |
| *Coughing/Sneezing* | *Sitting* | *Walking* |

I. **Do you have any of the following conditions associated with your pain?** *(Please circle all that apply.)*

| | | |
|---|---|---|
| *Falling* | *Muscle Weakness* | *Suicidal or Homicidal thoughts* |
| *Depression* | *Numbness / Tingling / Pins / Needles* | *Weight loss* |
| *Incontinence* | *Sleep disturbance* | |

**J. Please indicate where you have pain by marking the areas on your body.**



**K. Have you had any of the following tests to evaluate your pain?** *(Please provide details.)*

| | |
|---|---|
| *Blood Tests:* ____________________ | *EMG:* ________________________ |
| *Bone Scan:* _____________________ | *MRI:* _________________________ |
| *CT Scan:* _______________________ | *Myelogram:* ___________________ |
| *Discogram:* ______________________ | *X-Rays:* ______________________ |

**L. Please indicate any previous treatments you have tried for your pain and whether they helped your pain**: *(Please circle all that apply.)*

| | | |
|---|---|---|
| *Acupuncture* | *Epidurals* | *Psychiatric* |
| *Alternative Medicine* | *Massage* | *Surgery* |
| *Biofeedback* | *Medications* | *TENS Unit* |
| *Chiropractor* | *Physical Therapy* | *Traction* |

**M. Past Medical History**: *(Please circle all that apply.)*

| | | | |
|---|---|---|---|
| *Acid Reflux* | *Diabetes* | *Irritable Bowel Disease* | *Stroke* |
| *Angina/Heart Disease* | *Emphysema/Asthma* | *Kidney Disease* | *Skin Condition* |
| *Arrhythmia* | *Heart Attack* | *Liver Disease* | *Taking Blood Thinners* |
| *Arthritis* | *Heart Failure* | *Migraine Headaches* | *Thyroid Disease* |
| *Bleeding Disorders* | *Hepatitis* | *OCD* | *Ulcers* |
| *Cancer* | *HIV* | *Psychiatric Illness* | *Other:* ____________ |
| *Depression* | *Hypertension* | *Seizures* | |

**N. Past Surgical History** *(please indicate type of surgery, date of surgery, and physician's name):*

| Surgery | Date | Surgeon |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**O. Do you have allergies to medications?** *If yes, list them here.*

______________________________________________________________

**P. Current Medications:**

| Medication Name | Dose | How Many Times a Day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Pharmacy Name, Address, Phone Number:** ______________________________________

______________________________________________________________

**Q. Family History**

Mother: Living or Deceased *If deceased, cause:* ______________________

Father: Living or Deceased *If deceased, cause:* ______________________

Siblings: Living or Deceased *If deceased, cause:* ______________________

Siblings: Living or Deceased *If deceased, cause:* ______________________

**R. Social History:**

___ *Married* ___ *Single* ___ *Divorced* ___ *Separated* ___ *Widowed* ___ *Domestic Partnership*

With whom do you live?

___ *Self* ___ *Spouse* ___ *Children* ___ *Parents* ___ *Friends* ___ *Other:* ______________

What is your current employment status?

*Employed full-time* *Retired* *Unemployed due to other reasons*

*Employed part-time* *Self-employed*

*Homemaker* *Unemployed due to pain*

Are you on disability? *Yes*_____ *No*_____

Do you have an attorney or legal action pending related to this pain or any other health problems?

*Yes*_____ *No*_____ If yes, list attorney's name and contact information:_______________________

Do you drink alcohol? *Yes*_____ *No*_____ *If yes, please specify:* _____________________________

Do you smoke? *Yes*_____ *No*_____ *If yes, please specify:* _____________________________

Do you currently use or have you ever used/abused recreational drugs? *Yes*_____ *No*_____

If yes, specify: ______________________________________________________

**S. Do you experience any of the following?** *(Review of Symptoms and please circle all that apply):*

*Abdominal Pain* · *Diarrhea* · *Nausea* · *Sputum Production*

*Black bowel movement* · *Difficulty Urinating* · *Night Sweats* · *Swelling*

*Blood in stool* · *Dizziness* · *Pain* · *Urinary Frequency*

*Bowel or Bladder Incontinence* · *Easy Bruising* · *Palpitations* · *Vision Changes*

*Chest* · *Fever* · *Pregnancy* · *Weight Loss*

*Constipation* · *Headache* · *Rash* · *Wheezing*

*Cough* · *Lightheadedness* · *Shortness of Breath* · *Weakness/Paralysis of the arms and/or legs*

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## DIRECT PAYMENT AUTHORIZATION WITHOUT ASSIGNMENT OF BENEFITS

By way of original or a copy hereof, the undersigned patient hereby authorizes the auto insurance personal injury protection or medical payments insurance carrier to make payment directly to Provider for services and supplies necessitated by an accident occurring on or about ______________________.

***If not an auto or work related injury please disregard above paragraph.***

This authorization for direct payment does not constitute an assignment of benefits, nor is it intended, by either the undersigned patient or Provider to constitute an assignment of benefits. Further, the sole consideration for this authorization is the mutual convenience of the patient and provider.

Provider has not accepted, nor agreed to accept, an assignment of benefits from the undersigned patient and has not consented or agreed to arbitrate or do anything else that would in any way prevent the undersigned patient from enforcing any provision of the insurance contract with the applicable personal injury protection or medical payments insurance carrier.

The undersigned patient specifically has not granted an assignment of benefits to Provider, as the patient expressly desires to retain all rights to enforce the applicable insurance contract and has not transferred any right, title, or interest in said contract to Provider. The patient intends to merely authorize the applicable insurance company to pay provider directly as a convenience to the patient regarding payment of bills and to avoid the necessity of having to countersign the claim form each time the patient receives treatment. The undersigned patient has not transferred and expressly reserves the right to demand payment from any and all insurance companies obligated to pay medical bills related to treatment rendered by Provider. It is the intention of the undersigned patient and Provider that if the medical bills are not paid, that the patient will have the right and duty to pursue said medical benefits with any, and all applicable insurance companies and that the patient shall remain liable for any outstanding amounts.

Patient hereby authorizes and agrees that all future insurance claim forms submitted will read “signature on file” in box 13 and shall constitute authorization to accept this as a current and valid signature on file for all future claim forms submitted.

Patient Name: ________________________________________ Date: ________________________

Patient Signature: ______________________________________ Patient SS#: ___________________

## Authorization to use and Disclose Health Information

I, ______________________________________________ authorize my physicians, hospitals, and other health care providers to release any medical, or other information necessary for my medical treatment or for the processing of claims related to my treatment by Integrated Pain Solutions of South Florida.

## Authorization to use and Disclose Health Information to others

I authorize Integrated Pain Solutions of South Florida to use and disclose a copy of my records to:

Name of Recipient: ______________________________________________

Address: ______________________________________________

Phone #:______________________________Fax #:______________________________

Relationship to Patient: ______________________________________________

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

By: ______________________________________________ Date: ____________________
Patient Signature

By: ______________________________________________ Date: ____________________
Patient's Representative Print Name

By: ______________________________ ______________________________
Patient's Representative Signature Description of Representative's Authority

# Notice of Privacy Practices

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information.**

PLEASE READ CAREFULLY

## Department of Health Duties

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at **www.myflorida.com** and will be available by email and at all Department of Health buildings.

## Uses and Disclosures of your protected health information

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided to you.*

Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the department's divisions, bureaus, and offices.
- Investigations and audits by the state's Inspector General and Auditor General and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes including vital statistics, disease reporting, public health surveillance, investigations, interventions and regulation of health professionals.
- District medical examiner investigations.
- Research approved by the department.
- Court orders, warrants, or subpoenas.
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes. Certain uses and disclosure of psychotherapist notes will also require your written authorization.

## Individual Rights

**You have the right to request the Department of Health to restrict the use and disclosure of your protected health information** to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction.

**You have the right to be assured that your information will be kept confidential.** The Department of Health may mail or call you with health care appointment reminders. We will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

**You have the right to inspect and receive a copy of your protected health information.** Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

**You have the right to correct your protected health information.** Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department,
- Is not protected health information,
- Is by law not available for your inspection, or
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

**You have the right to receive a summary of certain disclosures** the Department of Health may have made of your protected health information. This summary does **not** include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures for health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.

This summary **does** include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6-year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

## For Further Information

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health, Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

## Complaints

If you believe your privacy rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

## Effective Date

This Notice of Privacy Practices is effective beginning April 14, 2003, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

## References

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register,* Vol. 65, No. 250 (December 28, 2000).

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register,* Vol. 67, No. 157 (August 14, 2002).

DH 150-741, 4/03; Stock Number: 5730-741-0150-0

**Florida Department of Health**
**Office of the Inspector General**
4052 Bald Cypress Way, BIN A-03
Tallahassee FL 32399-1704

**Integrated Pain Solutions**

Gary Saff, M.D.

# PRIVACY PRACTICES ACKNOWLEDGEMENT

## ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices of Integrated Pain Solutions of South Florida". Our Notice of Privacy Practices provides Information about how we may use and disclose protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at the above-listed contact information.

I, hereby, acknowledge receipt of the Notice of Privacy Practices:

Date: ________________________________

Print Name: ______________________________ Signature: ________________________________