Superior Pain Solutions
Live Your Life Again!

Registration Form

Patient Information		
Patient's Last Name	First Name	Middle Name
Date of Birth M/F	Social Security Number	Marital Status
Home Street Address	City/State/Zip	Occupation
Home Phone Number	Cell Phone Number	Name of Emergency Contact
Email Addres		Emergency Contact Phone Number
Last Name Spouse/Significant Other	First Name	Middle Name
Street Address	City/State/Zip	Phone Number
Patient's Employer	Employer Street Address	Employer City/State/Zip
Referring Physician Name	Address	City/State/Zip
Referring Physician Phone Number	Referring Physician Fax	
Primary Care Physician (PCP) Name	Address	City/State/Zip
PCP Phone Number	PCP Fax	
Pharmacy Name	Address	City/State/Zip
Pharmacy Phone Number	Pharmacy Fax	

8200 SW 117th Avenue, Suite 312, Miami, FL 33183
Phone: 305 595 PAIN (7246) www.superiorpainsolutions.com Fax: 305 595 7242

Patient Rights-Disclosure of Information

Welcome to Superior Pain Solutions.

We would like you to know that Dr. Reynolds is a specialist in the management of pain. He is board certified by the American Board of Pain Management and American Board of Anesthesiologist, and licensed in the State of Florida The goal of Superior Pain Solutions is to improve quality of life with minimization of dependence of opioid pain medication through the use of a multimodality treatment plan. The treatment plan offered in this office may be different than the treatment plan offered in the past by other physicians. The initial consultation at our office will be used to determine the appropriate plan of treatment, which may include procedures, physical therapy, massage therapy, psychological evaluation, medications, and/or a referral to another specialist. In order to receive treatment, we ask you to follow the treatment plan determined by our physicians.

A patient's rights occur at many different levels, and in all specialties. The American Medical Association (AMA) outlines fundamental elements of the doctor-patient relationship in their Code of Medical Ethics. These rights include the following:

- The right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives.
- The right to make decisions regarding the health care that is recommended by the physician.
- The right to courtesy, respect, dignity, responsiveness, and timely attention to health needs.
- The right to confidentiality: see **Notice of Privacy Practices.**
- The right to continuity of health care.
- The basic right to have adequate health care.

Patients often have certain responsibilities for ensuring their rights. According to the AMA, physicians should also serve as advocates for patients and promote these basic rights. Every time a patient visits a doctor, both parties are seeking answers to these questions:

- Diagnosis: What is wrong with the patient?
- Prognosis: What does the diagnosis mean for the patient?
- Caring and management component: What can be done for the patient?
- Research dimension: What can the doctor learn from this patient?
- Public health dimension: How can others benefit from the treatment process of this patient?
- Educational opportunities: What can the patient and the professionals learn from this experience and teach others?

Notice of Privacy Practices is available to patients by Superior Pain Solutions by request and also on our website www.superiorpainsolutions.com. Patients may ask at anytime for a copy of the Notice of Privacy Practices. Superior Pain Solutions is HIPPA compliant. For more information about HIPAA please visit the federal government website link that follows: http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

If you have a suggestion, please place this in writing and hand to the receptionist or mail it to the office. We encourage all patients to be actively involved in their care, so please speak up and ask questions of anyone in this organization.

By signing the document below, you are acknowledging that you have read and understand the information stated above.

Patient Signature	Patient Printed Name	Date

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Patient Information Release Authorization & Consent

Use and Disclosure of Health Information Protected under HIPAA

Superior Pain Solutions is committed to fulfilling all the requirements of the Health Insurance Portability and Accountability Act (HIPPA) of 1996.

Patient Name: _____

Section A: ***AUTHORIZATION***
Pursuant to the information obtained in the Notice of Privacy Practices, I authorize Superior Pain Solutions to release any of my medical or insurance information necessary to process my medical claims and coordinate or manage my health care.

I understand that I may revoke this authorization any time by notifying Superior Pain Solutions in writing. But, if I do revoke this authorization, my revocation will not have an effect on any actions Superior Pain Solutions took before they received my revocation**. T**his authorization may be revoked by signing a Revocation Authorization form and returning it to Superior Pain Solutions. To request a Revocation Authorization form, you may ask the reception desk or contact our office. Superior Pain Solutions will not base condition for treatment or payment for health care services on your completing and signing this authorization.

I authorize Superior Pain Solutions to release and reconcile any of my medication history necessary to coordinate and manage my health care or transfer of care.

Section B: ***CONSENT***
In the event a family member or care giver attends my office visit and is in the exam room at the time of evaluation and/or treatment, I give Superior Pain Solutions and it's physicians or employees my permission to discuss freely my condition, treatment, diagnosis or insurance/payments issues with that person.

Please fill in the blank with the appropriate information if we may use this as way to communicate with you or write NO if not. May we leave a message on your:

EMAIL: _____

HOME Phone: _____

WORK Phone: _____

CELL Phone: _____

With whom may we discuss or release information about your care, treatment, or diagnosis?

_____ Relationship_____

_____ Relationship_____

The patient or the patient's representative has read and agrees to the following statements by signing below:

_____ _____

Patient Signature Date

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Financial Policy

Patient Name: _____

Superior Pain Solutions is dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. The following information is provided for your consideration. It contains information concerning payment for our services. If our office participates with your insurance company, it is your responsibility to:

- Bring your insurance card to every visit.
- Be prepared to pay your co-pay and deductible in full (if applicable) at each visit.
- Credit cards and cash are accepted as payments. We do not accept checks.

Referrals: If your plan requires a referral for treatment, the referral must be presented at or prior to your visit. If you do not have your referral, your visit may need to be rescheduled or you will be financially responsible for the visit. This is the policy of your insurance carrier and not a Superior Pain Solutions policy. It is the patient's responsibility to confirm that any necessary referrals or pre-authorizations are obtained and our front office will help with this during the scheduling process.

Superior Pain Solutions has made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, Superior Pain Solutions will file your insurance claim, if you choose to assign the benefits to Superior Pain Solutions. We will bill your insurance company, and you are only responsible for a co-payment at the time of service. Although it is our policy to verify your benefits, please understand that you are responsible for any services not covered by your insurance. When scheduled for a procedure, payment for your co-pay and deductible is expected in full prior to the procedure. Not all insurance companies cover all services. In the event your insurance plan determines a service to be 'not covered,' you will be responsible for the complete charge. Payment will be due upon receipt of a statement from our office. If the patient is a minor (18 years and younger), or dependent, then the parent or legal guardian must sign below. The parent or guardian of an unaccompanied minor is responsible for any payment due at time of service. They are responsible for bringing any necessary referrals and insurance verification. If you do not have insurance coverage, or have coverage with a company that we do not participate with, payment is expected in full at the time of your visit. If you have any questions about your specific insurance coverage issues, the front office staff will be pleased to help you contact your insurance company member services department to determine coverage and estimate costs.

Cancellations of office appointments should be made at least 24 hours before scheduled time. Less than 24 hours cancellations will be assessed a no-show recorded in the chart. If a patient has three or more no-shows in the chart, then a fee of $35 may be assessed for each additional missed appointment; we do reserve the right to refuse scheduling for patients with a history of no-shows.

Requests for forms to be completed will be charged a reasonable administrative fee for the service. A quote will be given by the front office staff and the amount must be paid in advance. Some forms will require an office visit with the physician to be correctly filled out.

Questions about financial arrangements should be directed to our office manager or billing personnel. Please sign that you have read and agree to this policy.

_____ _____

Patient Signature Date

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Assignment of Benefits Form

Patient Name: _____

Consent for Treatment:

I hereby give consent to Superior Pain Solutions to perform medical procedures, which are appropriate for my conditions, symptoms, illness, or injuries.

Assignment of Benefits:

I hereby assign to Superior Pain Solutions all medical and surgical benefits of any and all insurance policies, including health insurance and personal injury protection to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment directly to Superior Pain Solutions for all services, items, and/or supplies rendered to me and/or my dependents regardless of my insurance benefits, if any.

Authorization to Release Information:

I hereby authorize Superior Pain Solutions to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of this page to be used to process insurance claims for the period of lifetime or the claim is paid. This order will remain in effect until revoked by me using certified mail.

I have requested medical services from Superior Pain Solutions on behalf of myself and/or my dependents, and understand that by making this request, I remain directly and personally responsible to Superior Pain Solutions for all charges submitted by them which pertain to me and that nothing in this authorization and assignment can be construed to waive these obligations.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

Assignment of Cause or Action:

In the event that any insurance company which is obligated by contract, statute, or law to make a payment to Superior Pain Solutions for professional services refuses to make such payment, I hereby assign and transfer to Superior Pain Solutions the ability to prosecute any such action in my name and/or their name to compromise, settle, or otherwise resolve said claim as they see fit.

This assignment and authorization may be revoked by me using certified mail.
A photocopy of this authorization and assignment shall be as binding as the original.

_____ _____

Patient or legal guardian Date

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Controlled Substances Therapy Agreement

Patient Name: _____

The purpose of this agreement is to protect access to controlled substances and to protect Superior Pain Solutions' ability to prescribe these substances. This agreement between Superior Pain Solutions and you, referred to as 'the patient' hereafter, is intended to clarify the way controlled substances may be used to manage pain.

The long-term use of such substances as opiates (narcotic analgesics, pain pills), benzodiazepine tranquilizers, and other sedatives are controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder (psychological dependence/physical dependence) developing or of relapse occurring in a person with a prior addiction. The percent of this risk is not certain. Because these drugs have the potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by the patient and the physician, to consider the initial and/or continued prescription of controlled substances to treat pain.

The patient agrees to be responsible for the controlled substances prescribed to them. The patient agrees not to sell, lend, or in any way give my medication to any other person. Prescriptions may not be replaced due to loss, misplacement, destruction, or theft. It is expected that the patient will take the highest possible degree of care in regard to medication and prescription. These items should not be left where others might see or otherwise have access to them. It is the responsibility of the patient to keep themselves and others safe from harm, this includes, but not limited to, operating heavy equipment or motor vehicle, working in unprotected heights or being responsible for another individual. If there is any question of impairment of the patient's ability to safely perform any activity, the patient will not attempt to perform the activity until his/her ability to perform the activity has been evaluated or the patient has stopped the medication long enough for the side effects to resolve. The patient understands that driving a motor vehicle may not be allowed while taking a controlled substance in some states; and it is the responsibility of the patient to comply with laws of the state while taking these medications.

The patient understands strong medications, which may include opiates and other controlled substances may be described for pain relief. The patient understands there are potential risks and side effects with taking any medications, including the risks of addiction. Overdose of opiate medication may cause injury or death by stopping breathing. Other possible complications include, but are not limited to, constipation which could be severe enough to require medical treatment, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function. These drugs should not be stopped abruptly, as an abstinence syndrome may occur (flu-like syndrome such as nausea, vomiting diarrhea, aches, sweating, and chills). The patient understands that opioid withdrawal is quite uncomfortable and maybe a life threatening condition. Alcoholic beverages should be avoided or be used with extreme caution and sparingly after approval of your pain physician while taking these medications. The patient understands that if she is pregnant or becomes pregnant while taking opioid medications, her child would be physically dependent on these opioids, and withdrawal can be life threatening for a baby.

The patient will not use any illegal substances (cocaine, heroin, marijuana, crystal methamphetamine, ecstasy, ketamine, etc.) while being treated with controlled substances. Violation of this policy will result in the cessation of the prescribing of any controlled substances and possible termination of care at the clinic. Unannounced, random toxicology (drug) screens and pill counts may be requested by Superior Pain Solutions to determine compliance with this agreement. The patient's cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder. Refusal of such testing may subject the patient to an abrupt rapid wean schedule in order for the medication to be discontinued or prompt termination from care.

Before the decision to initiate opioid therapy, certain patients may be subject to a voluntary psychological evaluation by a psychiatrist and this may be reevaluated thereafter while being maintained on controlled substances therapy. Based on psychological evaluation, it may be decided that he patient is no longer a candidate for continued therapy on the controlled substance regiment.

Opioid medication can only be prescribed by a Superior Pain Solutions' physician. The patient agrees not to take any pain medication or mind altering medication from any other physician without first authorizing it with Superior Pain Solutions. The patient agrees to take the medications as prescribed by Superior Pain Solutions, and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early refills, escalating doses without authorization and losing prescriptions may be signs of misuse of the medication, and may be reasons for the doctor to discontinue prescribing these medications. Unauthorized changes in medications cannot be tolerated. Early refills will generally not be given. Prescriptions may not be phoned in after hours, on weekends or holidays. Patient agrees all controlled substances must be obtained from one pharmacy; this pharmacy must be on file at Superior Pain Solutions. Should the patient decided to change this pharmacy, then it is the responsibility of the patient to inform the office. The prescribing physician has permission to discuss treatment details with dispensing pharmacist and other medical professionals for the purposes of maintaining accountability. Timely request for refills of medications are solely the patient's responsibility. The patient agrees to adhere to the Superior Pain Solutions' prescribing policy.

The above statements have been read by the patient. The patient by signing this form voluntarily is in agreement to be treated with the aforementioned controlled substances for the treatment of pain.

_____ _____

Patient or legal guardian Date

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Medical Information Release Form

I authorize:

A. To release information to: Superior Pain Solutions
8200 SW 117th Avenue, Suite 312
Miami FL 33185

B. Information to be released: Last three office notes.
Current medications list.
XRY, MRI, CT reports (actual films or images are not required).

_____

C. Purpose of request for records: Continued Medical Care

D. This consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken; and if not earlier revoked, it shall be terminated one year from the date of consent without express revocation.

E. The requestor may be provided with a copy of this authorization form upon request.

Patient's Name: _____ Date of Birth: _____

Patient's Signature: _____ Date: _____

Contact Number: _____

PLEASE NOTE: Fill out only if this applies to you.

Special Authorization: Check applicable areas and sign below:

☐ Alcohol ☐ Drugs ☐ Mental Health ☐ HIV/AIDS

Note: If this release pertains to alcohol, drug, mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: _____ Date: _____

Initials of staff member requesting information: _____

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Pain Initial Assessment Questionnaire

Patient Name:_____ Date of Birth:_____

Referring Physician:_____ Today's Date:_____

What is your MAIN complaint?_____

_____

How long have you been experiencing this pain? _____

Onset of pain: ☐ Gradual ☐ Sudden ☐ Injury (at work) ☐ Injury (not at work)

How do you believe your pain started? _____

_____

Please indicate you level of pain on a scale of 0-10, with 0 being no pain and 10 being the worst pain imaginable:

Your average pain: _____ Your pain WIHOUT medication:_____

Please circle each word that best describes your average pain over the last month:

☐ Piercing ☐ Stabbing ☐ Burning ☐ Grinding ☐ Throbbing ☐ Cramping
☐ Aching ☐ Stinging ☐ Squeezing ☐ Sharp ☐ Itching ☐ Tingling

Does your pain travel down the arms? ☐ YES ☐ NO legs: ☐ YES ☐ NO Is this new? ☐ YES ☐ NO

Do you have any weakness in your arms or legs? ☐ YES ☐ NO Is this new? ☐ YES ☐ NO

Any bowel or bladder leakage? ☐ YES ☐ NO Is this new? ☐ YES ☐ NO

Does your pain limit your activities? ☐ YES ☐ NO

Extent of Symptoms? ☐ Weakness ☐ Muscle spasms ☐ Walking difficulties ☐ Limitations of self care

Please circle each word that makes your pain worse:

☐ Flexion ☐ Extension ☐ Lying Flat ☐ Sitting ☐ Standing ☐ Walking
☐ Lifting ☐ Twisting ☐ Sneezing ☐ Coughing ☐ Activity

Initial Treatments: Have you used:

☐ NSAIDS ☐ Muscle Relaxants ☐ Narcotics ☐ Oral Steroids ☐ TENS Units
☐ Injections ☐ Physical Therapy ☐ Stretching ☐ Heat ☐ Ice

When did you last attend physical therapy? _____

Do you exercise? ☐ YES ☐ NO How many times a week? _____

Please list conditions of your past medical history:_____

_____

_____

_____

Have you or are you currently seeing a psychiatrist/psychologist to help you deal with pain or depression? ☐ YES ☐ NO

Have you ever been hospitalized for a addiction or psychiatric illness? ☐ YES ☐ NO

If yes, what reason? _____

Date/Hospital? _____

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Infection History: ☐ None ☐ Tuberculosis ☐ Hepatitis ☐ HIV/AIDS

Please list all your previous surgeries: Date of Surgery/ Surgeon/ Surgery

_____

_____

_____

_____

_____

Family History: Please list any significant family history to include pain problems and any issues with addiction.

_____

_____

_____

Social History: Do you drink alcoholic beverages ? ☐ Never ☐ Currently ☐ Quit this year

How many drinks per week?_____ ☐ Not Applicable

Number of years drinking alcohol? _____ ☐ Not Applicable

Tobacco History: ☐ Current occasional smoker ☐ Current everyday smoker ☐ Former smoker ☐ Never smoker

If yes, how many cigarettes a day?_____

If yes, please tell us for how many years? _____

Do you use any illegal drugs? ☐ Never ☐ Currently ☐ Quit less than three year ☐ Only in the remote past

Number of years abusing drugs?_____ ☐ Not applicable

Are you currently: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Living Arrangements: ☐ House ☐ Shared house ☐ Apartment/Condo ☐ Homeless ☐ ☐

Employment: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student

Please list all your current medications.

Date	Medication	Dose	Frequency	Why started?

Please list all your allergies to medications, foods and environmental substances: ☐ No Known Allergies

_____

_____

Do you have a reaction to iodine or betadine ☐ YES ☐ NO ☐ DON'T KNOW

Do you have a reaction to contrast dyes (For x-ray) ☐ YES ☐ NO ☐ DON'T KNOW

Do you have a reaction to latex? ☐ YES ☐ NO ☐ DON'T KNOW

Have you filed any claims:

Worker's Compensation? ☐ YES ☐ NO

Personal injury lawyers? ☐ YES ☐ NO

Social Security/Disability? ☐ YES ☐ NO

Please list the **most recent tests** (X-ray, CT Scan, MRI, EMG/Nerve Conduction, Myelogram, Bone scan) with date and indicate where it was performed to the best of your memory (partial information is better than none please).

_____

_____

_____

_____

_____

_____

_____

Review of Systems: Please circle all that apply.

Constitutional: Pain Weight gain Weight loss Chills Fever Night sweats Malaise Fatigue

Eyes: Eye pain

ENT: Jaw pain Ear pain Facial pain Tinnitus Vertigo Dizziness Verigo Epistasis Tooth Pain

Cardiovascular: Chest pain Chest pressure Palpitation Tachycardia Dyspnea Reduced exercise tolerance

Respiratory: Cough Wheezing Dyspnea Hemopysis

Gastrointestinal: Nausea Vomiting Abdominal pain Constipation Diarrhea Dysphagia Heartburn

Genitourinary: Pelvic pain Flank pain Genital pain Urinary incontinence

Musculoskeletal: Neck pain Back pain Shoulder pain Arm pain Leg pain Hip pain Knee pain

Dermatologic: Rash Itching Easy bruising Hair changes Excessive sweating Skin changes

Neurological: Seizures Syncope Tremor Confusion Numbness Weakness

Psychiatric: Suicidal thoughts Depression Anxiety Panic Insomnia Substance use concerns

Endocrine: Cold intolerance Heat intolerance Polydipsia Polyuria Proptosis Sexual Dysfunction

Hematological: Easy bruising Prolonged bleeding Bleeding Gums Recurrent infections Anemia

Allergy/Immunology: Hives Eye redness Nasal discharge

By signing below, I verify that the above stated information is correct.

_____ _____

Patient Signature Date

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Drug Abuse Screening Test - DAST - 10

Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior*. 1982;7(4):363-371.
Yudko E, Lozhkina O, Fouts A. A comprehensive review of the psychometric properties of the Drug Abuse Screening Test.
J Subst Abuse Treatment. 2007;32:189-198.

Patient Name:_____

These Questions Refer to the Past 12 Months

1 Have you used drugs other than those required for medical reasons?	☐ Yes ☐ No
2 Do you abuse more than one drug at a time?	☐ Yes ☐ No
3 Are you unable to stop using drugs when you want to?	☐ Yes ☐ No
4 Have you ever had blackouts or flashbacks as a result of drug use?	☐ Yes ☐ No
5 Do you ever feel bad or guilty about your drug use?	☐ Yes ☐ No
6 Does your spouse (or parents) ever complain about your involvement with drugs?	☐ Yes ☐ No
7 Have you neglected your family because of your use of drugs?	☐ Yes ☐ No
8 Have you engaged in illegal activities in order to obtain drugs?	☐ Yes ☐ No
9 Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	☐ Yes ☐ No
10 Have you had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, bleeding)?	☐ Yes ☐ No

By signing below, I verify that the above stated information is correct.

_____ _____
Patient Signature Date

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