Superior Pain Solutions
Live Your Life Again!

Registration Form

Patient Information		
Patient's Last Name	First Name	Middle Name
Date of Birth	Social Security Number	Male/Female
Home Street Address/Apt #		City/State/Zip
Home Phone Number	Cell Phone Number	Name of Emergency Contact
Email Address		Emergency Contact Phone Number
Referring Physician Name	Referring Physician Phone Number	Referring Physician Fax
Address		City/State/Zip
Primary Care Physician (PCP) Name	PCP Phone Number	PCP Fax
Address		City/State/Zip
Pharmacy Name	Pharmacy Phone Number	Pharmacy Fax
Address		City/State/Zip

8200 SW 117th Avenue, Suite 312, Miami, FL 33183
Phone: 305 595 PAIN (7246) www.superiorpainsolutions.com Fax: 972 466 9536

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 any time for a copy of the Notice of Privacy Practices. Superior Pain Solutions is HIPAA 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

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 (HIPAA) 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: _____

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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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 prescribed 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

Medical Information Release Form

I authorize:

A. To release information to: Superior Pain Solutions
8200 SW 117th Avenue, Suite 312
Miami FL 33183

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: _____

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Pain Initial Assessment Questionnaire

Patient Name:_____

Referring Physician:_____

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, _____

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

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 an addiction or psychiatric illness? YES NO

If yes, what reason? _____

Date/Hospital? _____

Infection History: None Tuberculosis Hepatitis HIV/AIDS

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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 every day 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

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

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 Epistaxis Tooth Pain

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

Respiratory: Cough Wheezing Dyspnea Hemoptysis

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 NOT able 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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