South Lake Pain Institute

● **Julio Paez, M.D.** ● **Julie Saranita, D.O.**

Welcome to South Lake Pain Institute

We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

You will need to bring your insurance card and a photo ID with you for each appointment. Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your insurance card, your appointment will need to be rescheduled. You will be asked to fill out new registration forms annually so we may update your information.

All co-pays and past due balances are expected at time of service, unless a prior agreement has been made with our billing department.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

*Please bring **ALL** medications prescribed by our physicians in this office. Also a **list of ALL** your current prescriptions, and a **list of ALL** over-the-counter medications with you at each visit.*

Our Office Policy for a missed appointment is:

- If it is an appointment for a new patient, the appointment **will not** be rescheduled without a **valid reason**.
- Two **(2)** no-show appointments will result in dismissal from the practice.
- **$150.00** will be charged if you failed to cancel your appointment within twenty four **(24)** hours before your scheduled New Patient Appointment.

We understand that appointments sometime need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment.

Welcome to our practice and thank you for choosing **South Lake Pain Institute, Inc.** for all your ***Pain Management*** needs.

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NEW PATIENT DEMOGRAPHIC FORM

Name:		DOB:	Sex: □ Male □ Female
Social Security #:		Marital Status: □ Single □ Married □ Widowed □ Divorced	
Race:	Ethnicity:	Language:	
Address:			
Home Phone:	Work Phone:	Cell No:	Email:
Occupation:	Employer:	Phone:	
Is this a **work** related injury: □ Yes □ No		Is this injury related to a **car accident**?: □ Yes □ No	
Referring Physician:	Address:	Phone:	
Pharmacy:	Address:	Phone:	
Emergency Contact (Name)		Relationship to patient:	
Home Phone:		Work Phone	Cell No
Primary Care Physician, (if different from above):			
Primary Insurance Information:		Member ID number:	Effective Date:
If your insurance policy/ policies are under another subscriber, please give their information: ***Subscriber Name:*** ***Relationship:*** ***DOB:*** ***SS#:***			
Secondary Insurance Information, if applicable:		Member ID number:	Effective Date:
Tertiary Insurance Information, if applicable:		Member ID number:	Effective Date:

_____ _____

Signature Date

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PLEASE SHADE YOUR AREA OF PAIN

Name: _____ DOB: _____ Date: _____

FOR OFICE USE ONLY

Weight:

Height:

BP:

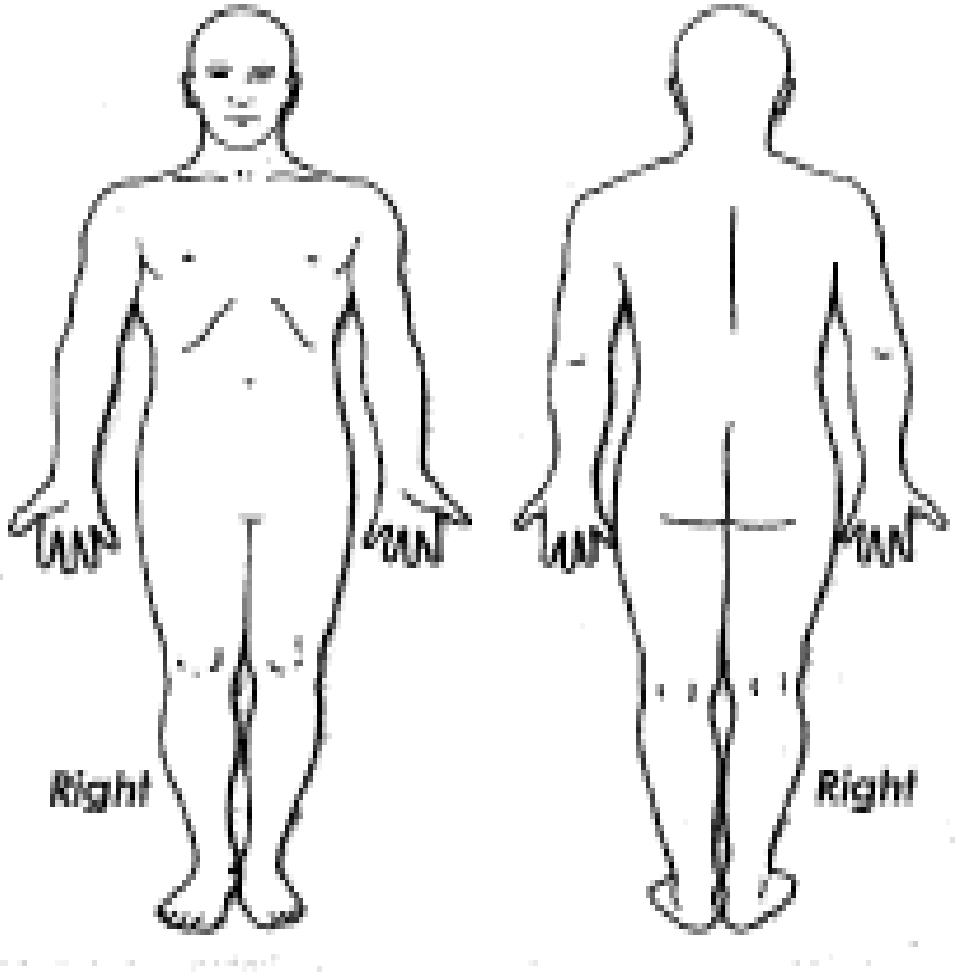
HR:

Temp:

Resp:

Ref Doc:

PCP



Please list all past and current treating Physicians

Physician Name	**Phone Number**
_____	_____
_____	_____
_____	_____
_____	_____

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NEW PATIENT CONSULTATION

Date: _____ Referring Physician: _____

Name: _____

DOB: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

HISTORY OF PRESENT PAIN PROBLEM

When did your pain start? _____

Location of your pain: _____

Description of your pain: _____

What event led to your present problem?

□ Cancer □ Operation □ Car Accident □ Work Related Injury □ Other Injury _____

Circle the words that describe your pain: □ Aching □ Tender □ Throbbing

□ Burning □ Shooting □ Sharp □Numb □ Lacinating

Is your pain (circle one)? Continuous Interminent (Comes and Goes)

If your pain is interminent, how long does the pain last? _____

What makes your pain better? (Circle all that apply)

Sitting Standing Lying Flat Walking Twisting Coughing Sneezing Other: _____

What makes your pain worst? (Circle all that apply)

Sitting Standing Lying Flat Walking Twisting Coughing Sneezing Other: _____

Rate your pain by circling the number that best describes your pain:

Agonizing None

10 9 8 7 6 5 4 3 2 1 0

Does your pain interfere with your sleep? □ Yes □ No

How many work days did you miss in the last month due to pain? _____

Do you have any: (Circle all that apply)

□ Numbness □ Tingling □ Extremity Weakness □ Bowel / bladder incontinence

Are you more depressed? □ Yes □ No Are you more anxious? □ Yes □ No

What procedures have you had done to treat / diagnose your pain? (Check all that apply)

□ Tens unit □ Cortisone joint injections □ Epidurals □ Physical Therapy □ Chiropractic Care □ Other _____

List **ALL** treatments, current and past for the pain management:

Treatment	Date	Doctor's Name Specialty
_____	_____	_____
_____	_____	_____

What test have been performed? (Check all that apply)

□ X rays □ CT Scans □ MRI □ EMG / NCS □ Bone Scan □ Other

ALLERGIES TO MEDICATION: _____

What reaction do you have when you take? Symptoms / Side Effect

_____

Please list **ALL** medications you are taking (Please include **ALL** the following information).

Name	Dosage (Strength)	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List **ALL** previous **PAIN** medications you have tried:

_____

MEDICAL PROBLEMS: Please list **ALL** ongoing or previous medical problems

_____

_____

PAST SURGICAL HISTORY:

Type of Operation	Date
_____	_____
_____	_____
_____	_____

FAMILY HISTORY: Please list **ALL** medical problems in **immediate family** and their relationship to you.

_____

SOCIAL HISTORY: ***(You must answer ALL of the following)***

Do you smoke? □ No □ Yes How much? _____ How long? _____
Have you ever smoked? □ No □ Yes When did you quit? _____
Do you drink? □ No □ Yes How much per day? _____ Type of drink? _____
Have you tried any illicit drugs? □ No □ Yes What drugs? _____ How often? _____
Do you have a history of: Drug Abuse? □ No □ Yes Alcohol Abuse? □ No □ Yes
Are there any substance abuse issues in the household? □ No □ Yes
Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated
Highest level of education completed (Check one):
□ High School □ Technical □ Vocational □ College □ Highest Degree: _____
Employment Status (Check One): Occupation: _____
□ Full Time □ Part Time □ Retired □ Unemployed □ Disabled
Have you ever been involved in a lawsuit? □ No □ Yes Reason: _____
Do you see a Psychiatrist or Psychologist? □ No □ Yes ***(If yes, please give name below)***
Name of Physician: _____ Phone: _____

Patient's Signature: _____ Date: _____

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FOR AUTO CASES ONLY

Name:	DOB:	
Date of accident / Injury:	Location in the vehicle: □ Driver □ Passenger □ Front □ Back	
Type of Vehicle Involved:	Type of Other Vehicle involved:	
Were you waiting a seatbelt? □ Yes □ No	# of days after accident did the pain start?	Were you taken to ER? □ Yes □ No Did you go by: □ Ambulance □ Self □ Other
What tests were performed in the hospital? □ X-rays □ MRI □ T Scan □ Other *If other, please explain:		
What medications were given at the hospital?	Any referrals given at the hospital? □ Yes □ No	Other Treating Physicians:
Did you lose consciousness? □ Yes □ No	Pain immediate after accident? □ Yes □ No *If yes, Where?	Any lacerations: □ Yes □ No *If yes, Where?
Do you have headaches: □ Yes □ No *How many times per week? *How long do they last?	Pre-existing status: History of pain prior to accident? □ Yes □ No History of treatment prior to accident? □ Yes □ No Previous MVA? □ Yes □ No Previous Work Related Injury? □ Yes □ No Previous Slip and Fall Injury? □ Yes □ No	
Previous Other Injury? Yes / No Details of Accident:	Previous treatments □ Chiropractor □ Physical Therapy □ Massage □ Ice □ Heat □ Medications □ EMG □ NCS □ Procedures □Surgery	
Signature:	Date:	

PLEASE READ AND SIGN

Authorization to Treat: I hereby grant permission to the physicians and staff to perform any necessary procedures to treat the medical conditions for which I am seeking assistance. I understand that, except in an emergency situation, the staff will discuss with me my treatment options and that I will have the opportunity to accept or refuse specific treatments at that time.

Assignment of Benefits: I certify that the information I have given is correct. I hereby authorize payment to ***South Lake Pain Institute, Inc.*** of the benefits payable to my physician(s). In applying for payment under Title XVIII of the Social Security Act, I request payment of authorized benefits be made on my behalf to those who accept this assignment. I further understand that I am responsible for any charges not covered or payable by this assignment. Even though ***South Lake Pain Institute, Inc.*** accepts assignment of insurance company payments, insurance carriers occasionally send payments checks to the patient for services rendered by the physician. I agree to forward such payments I receive to ***South Lake Pain Institute, Inc.*** as soon as I receive them.

Charges for Services: The charges for ***South Lake Pain Institute, Inc.*** are for the physician's professional fees and services. These charges do not include hospital facility fees. The facility fees will be billed separately by the facility.

Payment for Services: As a courtesy to you, we will file claims with your insurance company. Monthly statements are mailed to patients if they are responsible for some portion of the bill. Patients who have no insurance coverage, or a copay or deductible are aware that payment is due at the time of the service. Please call our office with any questions regarding your account.

Patient Responsibility for Payment: I understand that my insurance coverage is a contract between my insurance carrier and me, NOT between the insurance carrier and ***South Lake Pain Institute, Inc.*** Ultimately, all fees are my responsibility. Should timely payments not be made on my account, I understand that a **10%** (ten percent) late payment fee may apply if my account should exceed **60** (sixty) days past due. I understand that all copays and previous balances must be paid prior to seen provider. If balances are not paid, appointment may be rescheduled. ***South Lake Pain Institute, Inc.*** reserves the right to refuse treatment and/or services to me until my account is brought current.

I authorize ***South Lake Pain Institute, Inc.*** to retain the services of an attorney or collection agency to assist with the collection. Any expenses incurred by **South *Lake Pain Institute, Inc.*** for such action shall become an additional liability for which I assume responsibility. I understand that if my insurance requires a referral that is my responsibility to have a referral at time of visit from the Primary Care Physician (PCP) or current treating physician. I understand, that I am required to notify the office if I am not able to keep my scheduled appointment.

I understand that I will be charged **$75.00** for a follow up office visit, **$300.00** for procedures, and **$150.00** for New Patient appointments if I fail to cancel / re-schedule within **24** (twenty four) hours. I understand that I will be charged **$35.00** as an additional fee for any returned checks. I understand that I will be charged for copies of all medical records. The fee for copies is **$1.00** per page up to **25** pages and **$0.25** per page thereafter. These fees are to be paid prior to records being sent. I am required to give the office at least **30** (thirty) days' notice if requesting records. I understand that there is also a fee for medical forms. The cost of these forms will be discussed after reviewed.

Patient Name_____ Patient Signature: _____
DOB: _____ Date: _____

PATIENT'S CONSENT FOR PROVIDER TO DISCLOSE PHI TO AUTHORIZED PERSONS

1. **Authorization to Disclose PHI (Protected Health Information):**
   I hereby authorize, South Lake Pain Institute, Inc. to disclose any and all of my medical and protected health information (PHI) to the persons indicated below:

   Persons to Whom Disclosure May be Made:

   Provider may disclose my PHI to the following names:

Name	**Relationship, if any:**
_____	_____
_____	_____
_____	_____

2. **Purpose of Disclosure:**
   The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or to know the status of my health.

3. **Expiration of Authorization:**
   This authorization shall continue until I revoke this authorization in writing, which I may do at any time by sending a letter addressed to the Privacy Officer to any office where I am treated by Provider.

4. **Conditioning of Treatment:**
   Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this consent.

5. **Re-disclosure by Recipient:**
   I understand that once Provider disclose my PHI to the persons listed herein, my Provider has no control as to whether those persons may re-disclose my PHI, which may no longer be protected by Federal or State Law

6. **Acknowledge of Reading and Agreement:**

   _____ _____ _____
   Patient SS# Patient DOB Date

   _____ _____
   Printed Patient Name / Representative Patient Signature / Representative

   If a Representative Signs, state the Representative Authority: _____

Authorization for the Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive maybe re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations authorized to use or disclose the information:

   _____

   _____

2. Persons/organizations authorized to receive the information:

   South Lake Pain Institute, Inc. **352-394-0833 Phone**
   2440 Hooks Street **352-394-0367 Fax**
   Clermont, FL 34711

3. Specific Description of information that may be used/disclosed:

   _____

ITEMS 4-6 ONLY APPLY IF THE PRACTICE IS REQUESTING THE INFORMATION FOR ITS OWN USES AND DISCLOSURES.

4. ***The information will be used/disclosed for the following purposes:*** ***Continuing care***

5. *I understand that this Authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign or my revocation of this Authorization will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.*

6. *The person/organization authorized to use/disclose the information will receive compensation for doing so.*
   *Yes_____ No__**X**__*

7. I understand that I may inspect or copy the information used or disclosed.

8. I understand that I may revoke this Authorization at any time by notifying the person/organization providing the information in writing, except to the extent that:
   (a) Action has been taken in reliance on this authorization; or
   (b) If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest acclaim under the policy.

9. This authorization expires on_____.

   Patient SSN _____ Patient DOB_____ Date_____

   Printed name of patient/ patient's representative _____ Relationship _____

   Signature of patient /patient's representative _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES PURSUANT TO 45 C.F.R. § 164.520

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking for it.

Contact Person

You may contact our Privacy Officer at the following phone number for any questions:

Wanda Vicente (352)-394-0833 X-113

Effective Date

The effective date of this revised Notice of Privacy Practices is 03/28/2017.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received from the Group a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this Group's privacy practices and my rights regarding privacy of my protected health information.

_____ _____

PATIENT SIGNATURE **DATE**