INSTRUCTIONS:

“DOWNLOAD” DIGITAL NP FORMS



2. “FILL UP” the np forms



3. Save documents named “np forms (your name)”



4. Send to “ hello@excelpainandspine.com ”



5. Print the filled-up documents pages 2- 13 and bring documents on the appointment date.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Last Name: |       | First name:New Patient Questionnaire |       | Middle name: |       |  |
| Address: |       | Sex: |       | Date of Birth: |       |  |
|  |  |  |  |  |  |  | YES  | NO |  |  |
| Referring Physician: |       |  | Are you on blood thinner? | [ ]  | [ ]  |  |  |
| Family Physician: |       |  | If yes, which one? |       |  |
| PAST MEDICAL HISTORY |  | When did your pain begin? |       |  |
|  |  | YES | NO |  | Was there an inciting event? |       |
| Diabetes (high blood sugar): | [ ]  | [ ]  |  | Fill out part of the body that is in pain below. |
| Bleeding Disorder: | [ ]  | [ ]  |  |  |  |
| Cancer: | [ ]  | [ ]  |  |  |  |  |  |  |
|  | Other Medical Condition: |  |  |  |  |  |  |
|       |  |  |  |  |  |
|       |  |  |  |  |  |
|       |  |  |  |  |  |
|       |  |  |  |  |  |
|  | Medication Allergies and Reaction: |  |  |  |  |  |  |
|       |  |  |  |  |  |
|       |  |  |  |  |  |
|       |  |  |
|       | How would you rate your pain? |  |
| Current Medication/Dose/How often taken | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |  |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |  |
|       | No pain |  | Worst Pain Imaginable |  |
|       | What makes you pain better?(i.e sitting, lying down, heat cold, |
|       | Standing, etc) |       |
|       |  |  |       |
|       |  | What makes your pain worse? (i.e movement, walking |
|  | Bending over, weather, etc) |       |
|  | Other Symptoms or Concerns: |  |  |       |
|       |  |       |
|       |  |       |
|       |  |  |  |  |  |  |
|       |  |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Family History |  | PREVIOUSLY TRIED MEDICATIONS: | YES | NO |
|  | Similar pain | Arthritis | Cancer |  |  | Cymbalta/duloxetine: | [ ]  | [ ]  |
|  | [ ]  | [ ]  | [ ]  |  |  | Amitriptyline/Elavil: | [ ]  | [ ]  |
|  | Depression | Bleeding disorder | Substance abuse |  |  | Nortriptyline/Pamelor: | [ ]  | [ ]  |
|  | [ ]  | [ ]  | [ ]  |  |  | Effexor or Venlafaxine: | [ ]  | [ ]  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | Membrane Stabilizers | YES | NO |
| Social History |  | YES | NO |  | Gabapentin: | [ ]  | [ ]  |
| Do you use tobacco products?  |  | [ ]  | [ ]  |  | Lyrica/Pregabalin: | [ ]  | [ ]  |
| Do you drink alcohol? |  | [ ]  | [ ]  |  | Topamax/Topiramate: | [ ]  | [ ]  |
| Do you use illegal drugs? |  | [ ]  | [ ]  |  |  |  |  |  |
|  |  |  |  |  |  | Muscle Relaxants | YES | NO |
| Previous Surgeries and Date of Surgery |  | Tizanidine/Zanaflex: | [ ]  | [ ]  |
|       |  | Flexeril/Cyclobenzaprine: | [ ]  | [ ]  |
|       |  | Robaxin/Methocarbamol: | [ ]  | [ ]  |
|       |  | Baclofen: | [ ]  | [ ]  |
|       |  |  |  |  |  |
|       |  | NSAIDS | YES | NO |
|       |  | Advil/Motrin/Ibuprofen: | [ ]  | [ ]  |
|  |  |  |  |  |  | Celebrex: | [ ]  | [ ]  |
| PREVIOUSLY TRIED PROCEDURES: |  | Mobic/Meloxicam: | [ ]  | [ ]  |
|  |  |  |  | YES | NO |  | Tylenol/Acetaminophen: | [ ]  | [ ]  |
| Physical Therapy: | [ ]  | [ ]  |  |  |  |  |  |
| If yes where: |  |  | Opiods | YES | NO |
|  |  | Hydrocodone: | [ ]  | [ ]  |
| Chiropractic Care: | [ ]  | [ ]  |  | Oxycodone: | [ ]  | [ ]  |
| Massage Therapy: | [ ]  | [ ]  |  | Tramadol: | [ ]  | [ ]  |
| Heat/Ice Pool Therapy: | [ ]  | [ ]  |  | Butrans/Belbuca: | [ ]  | [ ]  |
| TENS unit: | [ ]  | [ ]  |  | Morphine: | [ ]  | [ ]  |
| Brace/Orthotic: | [ ]  | [ ]  |  |  |  |  |  |
|  |  |  |  |  |  | Any other information you would like for our team to  |
| PREVIOUSLY TRIED PROCEDURES |  | know? |       |
|  | YES | NO |  |       |
| Epidural Steroid Injection: | [ ]  | [ ]  |  |       |
| Facet joint/Medial branch nerve block |  |  |       |
| Radiofrequency Ablation (RFA): | [ ]  | [ ]  |  |  |  |  |  |
| Joint Injections: | [ ]  | [ ]  |  | Patients e-signature/signature: |       |
| Trigger point injection: | [ ]  | [ ]  |  |  |  |  |  |
| Spinal Cord Stimulation: | [ ]  | [ ]  |  | Date:  |       | Time: |       |
| Surgery: | [ ]  | [ ]  |  |  |  |  |  |
|  |  |  |  |  |  | Provider e-signature/signature: |       |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | Date: |       | Time: |       |
|  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- |
| ID#: |       |  | DATE: |       |
| Over the last 2 weeks, how often have you been |  |  |  |  |  |
| Bothered by any of the following problems? |  | Not at all | Several days | More than half the days | Nearly every day |
|  (mark the box to indicate your answer) | 0 | 1 | 2 | 3 |
| Little interest or pleasure in doing things | [ ]  | [ ]  | [ ]  | [ ]  |
| Feeling down, depressed, or hopeless | [ ]  | [ ]  | [ ]  | [ ]  |
| Tourble falling or staying asleep, or sleeping too much | [ ]  | [ ]  | [ ]  | [ ]  |
| Feeling tired or having little energy | [ ]  | [ ]  | [ ]  | [ ]  |
| Poor appetite or overeating | [ ]  | [ ]  | [ ]  | [ ]  |
| Feeling bad about yourself or that you are a failure or have let yourself or your family down | [ ]  | [ ]  | [ ]  | [ ]  |
| Trouble concentrating on things, such as reading the newspaper or watching television | [ ]  | [ ]  | [ ]  | [ ]  |
| Moving or speaking so slowly that other people could have noticed or the opposite being so fidgety or restless that you have been moving around a lot more than usual | [ ]  | [ ]  | [ ]  | [ ]  |
| Thoughts that you would be better off dead or of hurting yourself | [ ]  | [ ]  | [ ]  | [ ]  |
|  |  |  |  |  |  | Add columns |       |       |       |
|  |  |  |  |  |  | TOTAL: |       |  |  |
| (Healthcare professional: For Interpretation of TOTAL please refer to accompanying scoring car). | Not difficult | Somewhat difficult | Very difficult | Extremely difficult |
| If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home , or get along with other people? | [ ]  | [ ]  | [ ]  | [ ]  |
|  |  |  |  |  |  |  |  |  |  |
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A2663B 10-04-2005



New Patient Demographics- Please provide the Following Information:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date: |       |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| PATIENT: |  |  |  |  |  |  |  |  |  |
| Name (Last,First, MI): |       |
| Social Security Number: |       | Birthdate: |       |
| Street Address: |       |
| City: |       | State: |  |       | Zip Code: |       |
| Home Phone: |       | Cell Phone: |       |
| Work Phone: |       | Email: |  |       |
|  |  |  |  |  |  |  |  |  |  |
| Gender: |       | Age: |       | Height: |       | ‘ |       | “ | Weight: |       | lbs |
|  |  |  |  | SINGLE | MARRIED | WIDOWED | SEPARATED | DIVORCED |  |  |
| Marital Status: | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |  |  |
| Spouse’s Name: |       | Spouse’s Phone Number: |       |
|  |  |  |  |  |  |  |  |  |  |
| PHARMACY: |  |  |  |  |  |  |  |  |  |
| Name: |       |
| Address: |       |
|  |  |  |  |  |  |  |  |  |  |
| Referring Physician Name: |       | Phone Number: |       |
|  |  |  |  |  |  |  |  |  |  |
| EMPLOYMENT: | EMPLOYED | DISABLED | RETIRED | FULLTIME STUDENT | PART-TIME STUDENT | UNEMPLYED |
|  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Patient Employer: |       |
| Business Address: |       | Phone Number: |       |
|  |  |  |  |  |  |  |  |  |  |
| INSURANCE: |  |  | Y | N |  |  |  |  |  |  |
| Do you have medical insurance? | [ ]  | [ ]  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| PRIMARY INSURANCE NAME: |       | ID #: |       |
| Group #: |       | Subscriber: |       |
|  |  |  |  |  |  |  |  |  |  |
| SECONDARY INSURANCE NAME: |       | ID#: |       |
| Group#: |       | Subscriber: |       |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  | Y | N |  |  |  |  |  |  |
| Workers Compensation: | [ ]  | [ ]  |  |  |  |  |  |  |
| Claim #: |       | Adjuster: |       |
| Phone #: |       | Fax #: |       | Date of Injury: |       |
| Claims Mailing Address: |       |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

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## HIPAA 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 review it carefully. Effective date of this notice is November I, 2020 and will remain in effect until it is amended or replaced by us.



When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

* You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
* We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

* You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

* You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not. Ask us to limit what we use or share
* You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care. Get a list of those with whom we've shared information
* You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
* We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

* You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

* If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
* We will make sure the person has this authority and can act for you before we take any action. File a complaint if you feel your rights are violated
* You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence

Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gqv/ocr/privaqy/hipaa/complaints/.

* We will not retaliate against you for filing a complaint.

### Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

* Share information with your family, close friends, or others involved in payment for your care
* Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we don’t share your information unless you give us written permission:

* Marketing purposes
* Sale of your information

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Our Uses and Disclosures.

How do we typically use or share your health information?

* We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

* We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services. Run our organization

* We can use and disclose your information to run our organization and contact you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. Example: We use health information about you to develop better services for you.

Pay for your health services

* We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work. Administer your plan

* We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

* We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacv/hipaa/understanding/consumers/index.html.

Help with public health and safety issues We can share health information about you for certain situations such as:

* Preventing Disease
* Helping with product recalls
* Reporting adverse reactions to medications
* Reporting suspected abuse, neglect, or domestic violence
* Preventing or reducing a serious threat to anyone's health or safety

Do research

* We can use or share your information for health research. Comply with the law
* We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

* We can share health information about you with organ procurement organizations.
* We can share health information with a coroner, medical examiner, or funeral director when an individual dies. Address workers' compensation, law enforcement, and other government requests We can use or share health information about you:

• For workers' compensation claims

* For law enforcement purposes or with a law enforcement official
* With health oversight agencies for activities authorized by law
* For special government functions such as military, national security, and presidential protective services Respond to lawsuits and legal actions
* We can share health information about you in response to a court or administrative order, or in response to a subpoena. Our

Responsibilities

* We are required by law to maintain the privacy and security of your protected health information.
* We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. • We must follow the duties and privacy practices described in this notice and give you a copy of it.
* We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www,hhs.gqv/ocr/privacy/hipaa/understan<ing/consumers/noticepp.html. Changes to the Terms of this Notice

* We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.
* Effective date of this notice is November I, 2020 and will remain in effect until it is amended or replaced by us.

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## Consent to Medical Treatment

Excel Pain and Spine maintains personnel and facilities in order to assist my physicians in providing me with medical care, and I authorize Excel

Pain and Spine providers and personnel to perform on me the care ordered by my physicians. I consent to receive services by telemedicine (using Interactive audio, video, or data communications to carry out consultations, evaluations, screenings, diagnosis, treatment, monitoring or other communications benefiting a patient) if appropriate for my condition, and I understand the risks, benefits and alternatives of doing so, I choose to receive services even if my insurance plan may not cover or continue to cover specific service, including the specific services rendered during the admission. I understand that I have the right to be informed by my providers of the nature and purpose of any proposed operation or procedure and any available alternative methods of treatment together with an explanation of the risks associated with each of them. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to the recognized standards of medical practice, and I acknowledge that Excel Pain and Spine and its personnel are not responsible for providing me this information. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of examinations and or treatments provided by Excel Pain and Spine.

## Consent to Recording or Filming

I authorize Excel Pain and Spine, the attending physician, or other Excel Pain and Spine authorized persons to record, photograph or film me for treatment, quality improvement or education purposes. Such recording, filming or photographs will be released only as permitted by law or authorized by me.

## Assignment of Insurance Benefits. Patient Financial Resnnsibility and Credit Report Authorizations

I guarantee payment of all charges made for or on account of the patient. I assign my right and my insurance benefits payments or other payment sources directly to Excel Pain and Spine and/or the physicians providing services in conjunction with Excel Pain and Spine. This assignment includes, but is not limited to, radiology reading, pathology services, emergency room visits or EKG readings. I understand I will receive separate bills for certain Excel Pain and Spine and physician services. I understand I am financially responsible to Excel Pain and Spine and physicians for charges not covered by this insurance assignment, I further understand Excel Pain and Spine can obtain my credit report for collection purposes and I am responsible for any collections, attorney fees and costs. I have provided all Medicare information and insurance cards to Excel Pain and Spine. I agree that in the event benefits paid under this assignment or any other amounts paid by me/us or my/our behalf exceeds the amount due Excel Pain and Spine, my physicians, or those entitles for services in connection with this treatment, and such excess amount may be applied to any other indebtedness that l, my spouse, or any child for whom I am financially responsible, may have with Excel Pain and Spine or any other facility entity related to Excel Pain and Spine.

## Authorization to Disclose Information and Privacy Act

I authorize Excel Pain and Spine, and its affiliates to use or disclose my protected health information for the purposes of treatment, payment or healthcare operations. This consent shall cover any of my protected health information that Excel Pain and Spine may maintain or receive. I

authorize the release of medical and related information about my treatment to the Professional Standards Review Organization responsible for reviewing the medical care furnished to me. This authorization will expire six years from the date shown below; however, I reserve the right to revoke this authorization at any time by contacting Excel Pain and Spine at 813-701-5804.



I authorize Excel Pain and Spine and my physicians to disclose any medical information related to my services or treatment to my insurance company, governmental or charitable agencies and their agents, my employer and professional review organizations with whom I may have insurance coverage or who may be assisting in the payment of my bill and my medical care. I also authorize Excel Pain and Spine and my physicians to release any medical information to any licensed physician or medical facility to which I may be referred or transferred for further medical care. In addition, I authorize Excel Pain and Spine and my physicians to release any medical information necessary to prove Excel Pain and Spine's damages in any legal proceeding brought about to enforce any unpaid balance on any of my accounts. This authorization will expire two (2) years from the date shown below, and I understand that I or my legal representative may revoke this authorization at any time, unless legal action has already been taken, or in In the event of my death, the release of medical information is necessary to verify any charges incurred by me.

### Authorization tv Release Medicare and Medicaid Informatign

I certify that the information provided by me in applying for payment under Titles V, Will and/or XIX 01 the Social Security Act is correct. I understand that health care services paid for under Medicare, Medicaid and Maternal and Child Health programs are subject to review by professional organizations, which may recommend denial of payment if my medical condition does not warrant continued Excel Pain and Spine care. I authorize Excel Pain and Spine to assist me in the processing of any benefits application, including Medical Assistance, Aid to Families with Dependent Children, or Special Assistance, initiated for the patient within six months of the date of this authorization. Excel Pain and Spine may have access to and copy any records or information to which I would be entitled. The doctrine of informed consent has been explained to me, I acknowledge that this consent is voluntary and that it may be revoked by me at any Mme except to the extent that action has already been taken in reliance on it. Unless otherwise revoked, this consent shall be valid for one year from the date of authorization, or until final determination of any benefits application as described above, whichever is later.

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## for Underinsured Patients or Uninsured Patients

I authorize Excel Pain and Spine and its affiliates, to use or disclose my protected healthcare information for the purpose of helping me find a healthcare provider and/or locate a payment source for my visit.

## Release of Responsibilitv/Liabilitv For Valuables

I understand that Excel Pain and Spine has a policy for safekeeping of patient valuables requiring all money, credit cards and/or items of value including jewelry to be given to a family member to hold or leave at home. If I choose not to deposit such items of value with my family member, I absolve Excel Pain and Spine Florida from responsibility for their loss, damage of disappearance.

## Payment Guaranty

(Patient and/or responsible party/parties) agree to pay all charges for services rendered by Excel Pain and Spine and my physicians or other providers during treatment related to services provided by Excel Pain and Spine. This guarantee includes charges not covered by my insurance regardless of the reason insurance coverage is denied. I agree to pay the reasonable cost of the attorney services in addition to the unpaid charges. I consent and authorize Excel Pain and Spine and its agents or subcontractors to contact outside sources including for the purpose related to my account, including evaluating and assessing my credit worthiness, my charity eligibility and the viability of collecting any amounts due for treatments I receive, whether at this time or on subsequent visits. I understand and agree that Excel Pain and Spine may assign my accounts as it deems necessary for the purposes of collecting any amounts I owe, including to collection agencies and attorneys. I consent and authorize Excel Pain and Spine and third-party agents of Excel Pain and Spine to contact me at any telephone associated with me, including a wireless number, and to use pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account.

I affirm that my signature on this form indicates that I have disclosed any and all current Insurance coverage/s that may pay for this visit. Further, any failure on my part to Identify my insurance/s may result in additional charges for which I will be responsible. My signature also indicates that if I have no insurance coverage I will cooperate and participate in any efforts to help me qualify for any applicable coverage. Failure to do so may render me ineligible for any financial assistance discounts.

I have read the request and authorization in Its entirety and agree to be bound by all the terms and conditions herein. Witness my (our) hand(s) and seal(s) below,

|  |  |
| --- | --- |
|       |       |
| Patient |  |  |  |  | Responsible Party |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|       |       |
| Witness |  |  |  |  | Relationship to patient |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

----------------------------------------------------------------------------------------------------------------------------------------------------------------

|  |  |  |
| --- | --- | --- |
| I have been provided access to Excel Pain and Spine of Privacy Practices |  |  |
|  |  |  |  |  |  |  |
|       |       |  |       |
| Patient Signature ( or authorized representative) | Date |  | Time |
|  |  |  |  |  |  |  |
| Excel Pain and Spine Representative |       | Date/time |       |

771 cypress Village Blvd. sun City Center, FL 33573 • Phone: 813-701-5804 • Fax: 813.291.7615 •Excelpainandspine.com

PATIENT SELF-DETERMINATION QUESTIONNAIRE - YOUR RIGHT TO DECIDE

While you cannot remove all uncertainty about your future health care needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance. Please let us know if you have any Of the following:

Declaration to Decline Life Prolonging Procedures (such as do not resuscitate or "DNR")

 [ ] I have [ ] I have NOT made a Living Will

Durable Power of Attorney

 [ ] I have [ ] I have NOT appointed a Durable Power of Attorney for Health Care Decisions

Health Care Surrogate

 [ ] I have [ ]  I have NOT designated a Health Care Surrogate

If you have a living will and/or an assigned health care surrogate, we will gladly make a copy of your documents/will and place it in your chart if you desire.

PATIENT PRIVACY QUESTIONNAIRE

Please list the family members or Other persons, if any, whom we may inform your general medical condition and your diagnosis (including treatment, payment and health care operations):

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |       | Name: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Address: |       | Address: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone Number: |       | Phone Number: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Relationship: |       | Relationship: |       |

Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |       | Phone#: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |       | Phone#: |       |

Please indicate your understanding that all correspondence from our office will be sent in a sealed envelope marked "CONFIDENTIAL":

[ ] Click/Mark here to indicate that this statement was read.

Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? [ ] ( Yes) or [ ] ( No)

Please print the phone number where you want to receive calls about your appointments:

|  |  |  |  |
| --- | --- | --- | --- |
| PATIENT NAME: |       | DATE OF BIRTH: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| LEGAL REPRESENTATIVE: |       | RELATIONSHIP TO PATIENT: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| E-SIGNATURE/SIGNATUREOF PATIENT OR REPRESENTATIVE: |       | DATE: |       |

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|  |  |
| --- | --- |
| Patient Name: |       |

MEDICAL RECORDS RELEASE FORM

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Birth: |       | Phone Number: |       |

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that, by initializing this form, I am specifically authorizing the release of this information.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Initials: |       |  | Date: |       |  |  |

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below:

EXCEL Pain and Spine

Phone: (813) 701-5804

Fax: (813) 291-7615

Documents@excelpainandspine.com

www.excelpainandspine.com

[BRANDON](https://maps.app.goo.gl/JXGLudx8wSnkyutm6): 414 W Robertson Street Brandon, FL 33511
[DAVENPORT:](https://maps.app.goo.gl/QiFZD8ptZyGDkwZ57) 2310 North Blvd W Suite A Davenport, FL 33837

[ELLENTON:](https://maps.app.goo.gl/Ujow15qEEMV9iSaQ7) 7032 US-301 North Ellenton, FL 34222

[LAKELAND:](https://maps.app.goo.gl/3PHgP1cwREsPC6GF7) 1417 Lakeland Hills Blvd Suite 201 Lakeland, FL 33805

[NEW PORT RICHEY](https://maps.app.goo.gl/kVvWyLAGzKsyUS21A): 2202 Duck Slough Blvd, Suite 102, New Port Richey, FL 34655

[SARASOTA:](https://maps.app.goo.gl/mbrFPfRM8YrzvoF97) 5250 17th Street #7, Sarasota, FL 34235

[SUN CITY CENTER:](https://maps.app.goo.gl/TAJ5Z5525bmEZKiP7) 771 Cypress Village Blvd. Sun City Center, FL 33573
[ST. PETERSBURG](https://maps.app.goo.gl/FEQQGajrXnh8t3bz7): 6606 10th Avenue North St. Petersburg, FL 33710

[TAMPA:](https://maps.app.goo.gl/7YCmDwmEKTQPA1vu7) 620 S MacDill Ave., Suite B, Tampa, FL 33609
[THE VILLAGES](https://maps.app.goo.gl/1bhaXnaJnmdvRrW98): 11950 CR 101, Suite 205, The Villages, FL 32162

[WAUCHULA:](https://maps.app.goo.gl/oHTGhCHzv95xF67Y7) 326 South 6th Ave Wauchula, FL 33873

[WESLEY CHAPEL:](https://maps.app.goo.gl/sXVXZ3SuchDnC5n66) 26851 Tanic Drive, Suite 102, Wesley Chapel, FL 33544
[WINTER HAVEN](https://maps.app.goo.gl/WcpH3gMuLJzopTcN9): 1740 6th Street NW, Winter Haven, FL 33881

I do give permission for these records to be faxed to the above entity. Please forward:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| [ ]  | Office Visits | [ ]  | Initial History and Physical |  | [ ]  | Imaging Reports |
|  |  |  |  |  |  |  |  |  |  |
| [ ]  | Lab Reports | [ ]  | Correspondence |  |  | [ ]  | Insurance information |

|  |  |
| --- | --- |
| Other (Please Specify): |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patients Signature: |       | Date: |       |  |

|  |  |  |  |
| --- | --- | --- | --- |
| PATIENT NAME: |       | DATE OF BIRTH: |       |

Please answer each question as honestly as possible by putting the corresponding number in the box to the right (ie, if "Seldom" write if "Sometimes" write etc). There are no right or wrong answers

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SCORE | COLOR | INITALS OF REVIEW |  | Never | Seldom | Sometime | Often | Very Often |
|  |  |  |  | 0 | 1 | 2 | 3 | 4 |
| How Often do you have mood swings? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| How often have you felt a need for higher dosed of medication to treat your pain? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| How often have you felt impatient with you doctors? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| how often have you felt that things are just too overwhelming that you can’t handle them? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| How often is there tension in you home? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 6. How often have you counted pain pills to see how many are remaing? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 7. How often have you been concerned that people will judge you for taking pain medication? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 8. How often do you fee bored? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 9.How often have you taken more pain medication than you were supposed to? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| How often have you worried about being left alone? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| How often have others expressed concern over you use of medication? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| How often have any of your close friends had a problem with alcohol or drugs? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| How often have other told you that you had a bad temper? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| How often have you felt consumed by the need to get pain medication? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| How often have you run out of pain medication eary? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| How often have others kept you from getting what you deserve? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| How often in you lifetime, have you had legal problems or been arrested? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| How often have you attended an AA or NA meeting? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| How often have you been in argument that was so out of control that someone got hurt? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| How often have you been sexually abused? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| How often have others suggested that you have a drug or alcohol problem? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| How often have you had to borrow pain medications from you family or friends? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| How often have you been treated for an alcohol or drug problem? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Has any relative had a problem with: (please mark the box for each item below)Alcohol: [ ]  Addiction: [ ]  Mental illness [ ]  |  |  |  |  |  |
| Green = less than 9  | Yellow = 10-21 | Red= 22 and over |

Please include any additional information you wish about the above answers. Thank you

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|  |  |  |  |
| --- | --- | --- | --- |
| PATIENT NAME: |       | DATE OF BIRTH: |       |

OSWESTRY PATIENT QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may

|  |  |
| --- | --- |
| PAIN INTENSITY | 6. STANDING |
| [ ] I can tolerate the pain I have without having to use pain killers | [ ]  I can stand as long as I want without extra pain |
| [ ]  The pain is bad but I manage without taking pain killers | [ ]  I can stand as long as I want but it gives me extra pain |
| [ ]  Pain killers give complete relief from pain | [ ]  Pain prevents me from standing for more than one hour |
| [ ]  Pain killers give moderate relief from pain | [ ]  Pain prevents me from standing for more than 30 minutes |
| [ ]  Pain killers have no effect on the pain and I do not use them | [ ]  Pain prevents me from standing for more than 10 minutes |
| PERSONAL CARE (e.g. Washing, Dressing) | [ ]  Pain Prevent me from standing at all |
| [ ]  I can look after myself normally without causing extra pain | 7. SLEEPING |
| [ ]  I can look after myself normally but it causes extra pain | [ ]  Pain does not prevent me from sleeping well |
| [ ]  It is painful to look after myself and I am slow and careful | [ ]  I can sleep well only by using medication |
| [ ]  I need some help but manage most of my personal care | [ ]  Even when I take medication, I have less than 6 hrs sleep |
| [ ]  I need help every day in most aspects of self-care | [ ]  Even when I take medication, I have less than 4 hrs sleep |
| [ ]  I don't get dressed, I was with difficulty and stay in bed | [ ]  Even when I take medication, I have less than 2 hrs sleep |
| 3. LIFTING | [ ] Pain Prevents me from sleeping at all |
| [ ]  I can lift heavy weights without extra pain | 8. SOCIAL LIFE |
| [ ]  I can lift heavy weights but it gives extra pain | [ ]  My social life is normal and gives me no extra pain |
| [ ]  Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table | [ ]  My social life is normal but increases the degree of pain |
| [ ]  Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned | [ ]  Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc. |
| [ ]  I can lift very light weights | [ ]  Pain has restricted my social life and I do not go out as often |
| [ ]  I cannot lift or carry anything at all | [ ] Pain has restricted my social life to my home |
| 4. WALKING | [ ]  I have no social life because of pain |
| [ ]  Pain does not prevent me walking any distance | 9. TRAVELLING |
| [ ]  Pain prevents me walking more than one mile | [ ]  I can travel anywhere without extra pain |
| [ ]  Pain prevents me walking more than h mile | [ ]  I can travel anywhere but it gives me extra pain Pain is bad, |
| [ ]  Pain prevents me walking more than % mile | [ ] Pain is bad, but I manage journeys over 2 hours |
| [ ]  I can only walk using a stick or crutches | [ ]  Pain restricts me to journeys of less than 1 hour |
| [ ]  I am in bed most of the time and have to crawl to the toilet | [ ]  Pain restricts me to short necessary journeys under 30 minutes |
| 5. SITTING | [ ]  Pain prevents me from traveling except to the doctor or hospital |
| [ ]  I can sit in any chair as long as I like | 10. EMPLOYMENT/ HOMEMAKING |
| [ ]  I can only sit in my favorite chair as long as I like | [ ]  My normal homemaking/ job activities do not cause pain |
| [ ]  Pain prevents me from sitting more than one hour | [ ]  My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me |
| [ ]  Pain prevents me from sitting more than 1/2 hour | [ ]  I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming) |
| [ ]  Pain prevents me from sitting more than 10 minutes | [ ]  Pain prevents me from doing anything but light duties |
| [ ]  Pain prevents me from sitting at all | [ ]  Pain prevents me from doing even light duties |
|  | [ ]  Pain prevents me from performing any job or homemaking chores |