Date of Appointment:	Time of Appointment:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security#:	Home phone #: ( )

Cell Phone ( )	City:	State:	ZIP Code:

Email:	Employer:	Employer phone #: ( )

Please Select the Appropriate Box	Referring Dr.	Telephone #:
❑Auto Accident ❑Work Comp ❑Other	Date of Injury:	

INSURANCE INFORMATION

Primary Insurance:
Secondary Insurance:

Policyholder:	Birth date: / /	Address (if different):	Home phone #: ( )

Primary Policy Number:	Secondary Policy Number:	Social Security #:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Patient/Guardian signature *Date*

ATTORNEY INFORMATION

Attorney Name:

Mailing Address:	City:	Zip code:	Office Number #: ( )

Contact Person:	Fax Number: ( )

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO PAY AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the______________________Insurance Co. to pay by check made out and mailed directly to:

New Day Pain and Wellness, LLC
110 Southern Oaks Dr.
Plant City, FL 33563

I hereby authorize to the above captioned doctor, the medical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for the all professional services that were rendered.
This payment shall not exceed my indebtedness to the above-named assignee, and I have agreed to pay, IN CURRENT MANNER, any balance of said professional service charges over and above the insurance payment.

With this form I give my consent and authorization to release any necessary medical information required to process this claim.

Signed:________________________Date:______________________

New Day Pain & Wellness
Interventional Pain Specialist

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO____
NAME OF FACILITY

ADDRESS_________________________________

CITY______________FL__________ZIP __________

I HEREBY AUTHORIZE THAT MY MEDICAL RECORDS BE RELEASED TO:

New Day Pain & Wellness
342 E. Bloomingdale Ave.
Brandon, FL 33511
Phone (813) 938-6627
Fax (866) 357-5209

New Day Pain & Wellness
110 Southern Oaks Dr.
Plant City, FL 33563
Phone (813) 938-6627
Fax (866) 357-5209

I AUTHORIZE A COPY OF THE SIGNATURE TO ALWAYS SERVE AS AN AUTHORIZATIONFOR RELEASE OF MEDICAL RECORDS.

______________________________ ____________________

Patient Signature **Date**

______________________________ ____________________

Social Security Number **Date of Birth**

Disclosure of Policies

HIPAA Policy:

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

Privacy Notice:

I have been provided with a copy of the **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures. I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Authorization to Release Information:

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Financial Policy:

New Day Pain and Wellness participates with many forms of health insurance, such as HMO's, PPO's, Workman's Compensation and Medicare. However, few insurance carriers cover all medical costs and a balance on your account may result from co-payments, co-insurance, deductibles, or non-covered services. The patient is responsible for full payment of any and all balances deemed "patient responsibility" by their insurance carrier. We will file medical insurance claims as a courtesy to our patients.

Motor Vehicle and Worker's Compensation: In order for our office to submit your claims for you, you must provide us with the following information: insurance company name, address and telephone number, as well as your claim number, date of accident and claims adjuster's name. In the event that your insurance denies or terminates your benefits, you will be responsible for full payment for services rendered. Please note for all Workers' Compensation patients, your initial appointment must be scheduled by your nurse case manager or Worker's Compensation adjustor. Authorization must be received prior to the initial office visit. Motor Vehicle patients, please note prior to your initial office visit your auto benefits must be confirmed and verified by our office.

Payment Policy:

All co-payments, co-insurance, and deductibles are paid at the time of service to help control costs of medical care. Payments may be made by cash, check, Visa, MasterCard, American Express, and Discover. For larger amounts, such as surgical fees not covered by insurance, New Day Pain and Wellness will work with you to arrange a payment plan. Self pay patients and Surgical Pre-pay patient's payments will only be accepted via credit card, cash payment, and/or money orders.

Treatment of Patients:

Throughout your treatment at New Day Pain and Wellness, the medical providers may order diagnostic testing to help determine your diagnosis or create a better treatment plan for you, the patient. These tests include lab work, x-rays, MRI's, CT scans, Bone Scan's, etc. Failure to schedule or obtain the recommended diagnostic studies in a timely manner or to schedule a follow up appointment to review the diagnostic tests in a timely manner; will constitute as a breach of our recommendations and is Against Medical Advice (AMA). Therefore, New Day Pain and Wellness employees and medical providers will not be held responsible for lack of patient responsibility and purposeful disregard of our medical recommendations. Non- compliance may result in an adverse complication to the patient's medical result/ outcome.

Code of Conduct:

Requirements: In an effort to provide and maintain a safe and healthy environment for employees, visitors, patients and other occupants I have been informed that unacceptable, disruptive behaviors and/or communications (mail, telephonic, electronic, voicemail) of any form will not be tolerated and/or permitted within New Day Pain and Wellness facilities. The following behaviors are prohibited and will be resolved as indicated through proper public law enforcement assistance; destruction of property, verbal or gesturing threats and/or implications of violence, possession of any/all weapons, cursing/profanity, physical assault or threats and/or other derogatory verbal or non verbal remarks. No hostile communication or gestures regarding an individuals' race, ethnicity, language or sexuality is permitted within New Day Pain and Wellness facilities. Appropriate attire, shoes must be worn. Nudity and/or inappropriate exhibition and/or exposure will not be tolerated and removal from the premises will be requested.

HIPPA Policy and Privacy Notice

I have received and read a copy of New Day Pain & Wellness Notice of Privacy Practices (Notice).

By initialing I have read and understand the above_______

Authorization to Release Information

I consent to the use or disclosure of my protected health information by New Day Pain & Wellness for the purpose of diagnosing or providing treatment to me, obtaining payment for my Health care bills or to conduct health care operations of New Day Pain & Wellness.

By initialing I have read and understand the above_______

Financial Agreement & Payment Policy

I understand that I am financially responsible for services rendered by New Day Pain & Wellness providers. I also understand that few insurance carriers cover all costs for services rendered. New Day Pain & Wellness will submit claims to your insurance carrier. I will be responsible for the balance on my account that my insurance company does not cover. I will pay any co-payments, co-insurance, and deductibles at the time of service at New Day Pain & Wellness.

By initialing I have read and understand the above_______

Authorization for treatment

Throughout your treatment at New Day Pain & Wellness the medical providers may order diagnostic testing (lab work, bone scan's, x-rays, MRI's, CT scans. etc) that will help determine your diagnosis and future treatment. Failure to schedule or obtain the recommended diagnostic studies or failure to schedule a follow up visit in a timely manner to review the diagnostic studies and discuss the results will constitute as a breach of our recommendations. New Day Pain & Wellness employees and medical providers will not be held accountable for your lack of responsibility and purposeful disregard of our medical recommendations.

By initialing I have read and understand the above______

I hereby authorize the medical staff of New Day Pain & Wellness to render medical services and treatments as deemed necessary. I understand that failure to comply with our medical recommendations is against medical advice. (AMA)

By initialing I have read and understand the above_______

Code of Conduct Policy

I have read and understand New Day Pain and Wellness Patient Code of Conduct.

By initialing I have read and understand the above_______

By signing, I have read, understand and agree to comply with ADA policies so noted in the Notice of Privacy Practices {Notice).

Signature ____________________________________Date ___/___/___

Printed Name____

If patient is a minor {under 18):

Minor's Name _______________________Guardian's Name (printed)_____________________

Signature____________________________ Relationship______________________

Date ___/___/___

Consent for the Release of Protected Health Information to Personal Representatives

I, ____________________, give my written consent for New Day Pain and Wellness to share information regarding my protected health information and care to the following listed persons: I understand that these persons will be treated as personal representatives of myself.

Personal Representatives that New Day Pain and Wellness may share my Protected Health Information with:

Name: ___________________________ Relationship: ________________________

Name: ___________________________ Relationship: ________________________

Name: ___________________________ Relationship:_________________________

_____**Do not discuss my Protected Health Information with anyone other than myself at any time.**

New Day Pain and Wellness may leave a message:

At Home At Work

Patients' Signature _____________________ Date:_________

Form Fee Agreement

Please note: The completion of informational/insurance forms represents an administrative service to our patients above and beyond the provision of medical care. Recent changes in health care have resulted in the tremendous increase in the volume of information requests to our practice. The time and effort involved in providing this detailed information results in significant costs, especially when multiplied over the large number of patients our practice serves. The refusal of insurance companies and requesting agencies to cover the costs requires us to institute a policy of charges for the completion of the forms as follows:

NO Charge:

- Workers Compensation requested Disability and Work Status forms
- Auto Insurance Carrier requests for Work Status and Treatment Plans

$35.00:

- Disabled Parking Applications
- Credit Card deferment forms
- Private Disability Insurance Forms
- Family Medical Leave Act {FMLA) forms

$150.00- $300.00

- For completion of any dictated letter describing medical care and limitations
- For any narrative report detailing diagnosis, treatment, and future medical care including work capacity statements. <u>Functional Capacity Evaluation testing may be necessary prior to, or in addition to the narrative report.</u> The fee for the FCE test is determined by the facility that the testing is completed at.

I have read and understand the above. By signing I agree to comply with the Form Fee policy of ADA. Fees subject to change without notice.

Patient Name (printed) ___________________Signature ______________________Date________

Please complete this form

Patient Name: ____

Today's Date: ___/___ /___ DOB: ___/___ /___

(please circle): M F Right handed Left handed HEIGHT: _____WEIGHT: _____

Pain: _____ BP: _____ HR: _____ RR: _____ Temp: _____ O2 Sat: _____

RACE/ETHNICITY (please circle): WHITE HISPANIC AFRICAN AMERICAN PACIFIC ISLANDER OTHER

PRIMARY CARE______________________________

PREFERRED LANGUAGE (please circle): ENGLISH SPANISH OTHER

What is your chief complaint today?

How long have you've been affected by this pain? ___days ___weeks ___years ___date

How did the pain begin? ___gradually ___suddenly

Since the pain began, how has the pain changed? ___decreased ___increased ___stayed the same

Have you been treated for this pain in the past? Yes / No

If yes, by whom? (list all doctors, physical therapists, Hospital ER, etc.)

Are you taking any medications for this pain? Please list.

Have you had any diagnostic testing for this pain? (MRI, CT, X-Ray) Please indicate facility and date.

New Day Pain & Wellness
Interventional Pain Specialist

Rate your pain by circling the number that best describes your pain at its worst

No pain - 0 1 2 3 4 5 6 7 8 9 10 - Pain as bad as you can imagine

Rate your pain by circling the number that best describes your pain on average

No pain - 0 1 2 3 4 5 6 7 8 9 10 - Pain as bad as you can imagine

---

Please circle the symptoms you've been experiencing.

Headache	Tingling in Arms	Buzzing in Ears
Neck Pain	Tingling in Legs	Loss of Balance
Neck Stiffness	Numbness in Toes	Fainting
Dizziness	Numbness in Fingers	Diarrhea
Back Pain	Shortness of Breath	Stomach Upset
Back Stiffness	Fatigue	Constipation
Nervousness	Light Sensitivity	Cold Sweats
Chest Pain	Loss of Memory	Fever
Sleep Disruption	Ringing Ears	Other

Please circle the description of the pain you've been experiencing.

Aching	Tiring/Exhausting	Cramping
Numbness	Shock-like	Shooting
Spasming	Squeezing	Tingling/Pins & Needles
Throbbing	Hot/Burning	Dull

How often does the pain affect you? ___Constant ___Intermittent

When does the pain get worst? ___Mornings ___During the Day ___Evenings ___Middle of the night

What makes your pain better?

What makes your pain worse?

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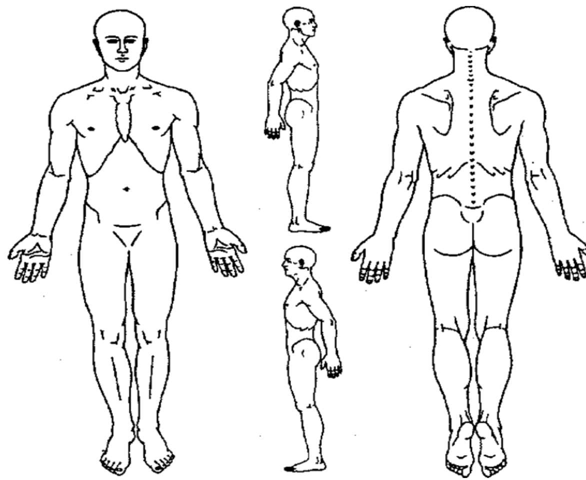
Interventional Pain Specialist

Is your condition preventing you from participating in certain activities? Yes / No - Please list.

Have you had any previous injuries? (Previous auto accidents, fractures, surgeries, etc.) Please list the year.

Official use only:



Plan:

CURRENT MEDICATIONS (name, strength and dose):

1.	2.	3.
4.	5.	6.
7.	8.	9.

PHARMACY NAME ____

ADDRESS/CROSS STREETS_________________________________

PHONE# ____

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PAST MEDICAL HISTORY: (please circle all that apply)

Arthritis	heart attack	Osteoporosis
Asthma	hepatitis a, B, or C	Pacemaker
bleeding disorders/blood clots	high blood pressure	renal disease
Cancer	high cholesterol	Rheumatoid
COPD	HIV/aids	Stroke
Diabetes	liver disease	thyroid disease
GERD	neurologic disorders	
GI disorders	other	

ALLERGIES (please circle): Aspirin Codeine Latex Penicillin Sulfa None Other:

____

Reaction:____

LIST ALL PREVIOUS HOSPITALIZATIONS AND/OR SURGERIES: □ NONE

1. YEAR
2. YEAR
3. YEAR
4. YEAR
5. YEAR

FAMILY HISTORY

Have any direct relatives had any of the following disorders? If so, list your relative

□Diabetes____________________ □High Blood Pressure________________

□Rheumatoid Arthritis_________________ □Difficulty with anesthesia ________________

□Bleeding Problems ___________________ □None known

SOCIAL HISTORY (please circle): Smoking Qty Drinking Qty Drugs Type/Qty

MARITAL STATUS (please circle): Single Married Divorced Widow Separated Student

EMPLOYMENT STATUS (please circle): Employed Unemployed Disabled Retired Occupation______________________________

REVIEW OF SYSTEMS

Have you ever had any of these symptoms? If no, mark NONE		NONE	YEAR	Details/Comments
1. GI	□Heartburn, Ulcers □Nausea, Vomiting □Blood in Stool	□	____	______________
2. ENDO	□Thyroid Disease □Heat or Cold Intolerance	□	____	______________
3. CON	□Weight Loss □Loss of Appetite □Fatigue	□	____	______________
4. EYE	□Blurred Vision □Double Vision □Vision Loss	□	____	______________
5. ENT	□Hearing Loss □Hoarseness □Trouble Swallowing	□	____	______________
6. CV	□Chest Pain □Palpitations	□	____	______________
7. RS	□Chronic Cough □Pneumonia □Shortness of Breath	□	____	______________
8. GU	□Painful Urination □Blood in Urine □Kidney Problems	□	____	______________
9. SK	□Frequent Rashes □Skin Ulcers □Lumps □Psoriasis	□	____	______________
10. NEU	□Headaches □Dizziness □Seizures □Numbness	□	____	______________
11. PSY	□Depression/Anxiety □Drug/Alcohol Addiction □Sleep Disorder	□	____	______________
12. HEM	□Easy Bleeding □Easy Bruising □Anemia	□	____	______________

13. Are you HIV Positive? □Yes □No

14. Have you ever had Hepatitis A, B, or C? □Yes □No If yes what type?

15. Are you pregnant? □Yes □No

16. Are you Claustrophobic? □Yes □No

New Day Pain & Wellness
Interventional Pain Specialist

Patient Assessment

The physicians at New Day Pain and Wellness are concerned about your health and want to make sure that we are evaluating those factors which may impact your wellbeing. The following questions are intended to give the physicians at New Day Pain and Wellness information about your general health.

Please circle the correct answer or fill in the blanks.

1. Have you been on medicine to treat osteoporosis? Yes No

    If yes, has it been prescribed within 12 months? Yes No

    What medicine are you taking to treat your osteoporosis?

2. Do you take Calcium and Vitamin D? Yes No

3. Have you ever had a fracture of your arm, hip, or spine? Yes No

4. Have you fallen more than twice or fallen and hurt yourself in the past year? Yes No

5. Have you had the influenza vaccination for the current flu season? Yes No

6. Have you ever had the pneumococcal vaccine? Yes No

7. Do you have an Advanced Care Plan? Yes No

8. Have you used or smoked tobacco products in the last 24 months? Yes No

    If yes, are you a tobacco smoker? Yes No

9. Do you consume alcoholic beverages? Yes No

    If yes, how much per setting? ________ Per week?__________

Please understand that smoking and consuming alcoholic beverages can impair your general health as well as your health.

Are you interested in quitting? Yes No

Print name:____

Patient signature:____________________________________ Date:________________