KISSIMMEE OFFICE:
1381 E. Osceola Parkway
Kissimmee, FL 34744

PALM TREE
INTERVENTIONAL
PAIN MANAGEMENT
Pain Relief Starts Here
Tel. (407) 906-1328 Fax. (866) 425-8143

ST. CLOUD OFFICE:
2801 17th Street Ste. 202
St. Cloud, FL 34769

# NEW PATIENT FORM:

Name: _____ Date:_____/_____/_____

DOB:_____/_____/_____ EMAIL: _____

**HISTORY:** REF: ____PCP___NEURO___ORTHO _____

What pain is bothering you today? (chief complaint): _____

How long have you been having this pain? _____

Did your pain start after an event or accident? YES or NO If yes, what? _____

Describe your pain (circle all that apply): a spasm, aching, burning, cold, cramping, dull, numb, pressure, sharp, shock-like, shooting, squeezing, stabbing, stinging, tenderness, tingling

Does the pain radiate anywhere? YES or NO If yes, where? _____

**How severe is your pain w/ meds? _____ / 10 How severe is your pain w/o meds? _____ / 10**

When during the day do you have your pain? _____

What makes your pain better? _____

What makes your pain worse? _____

**Have you tried physical therapy? YES or NO If yes, did it help your pain? YES or NO**

**Dates Attended:** _____

Have you tried injections? YES or NO If yes, did it help your pain? YES or NO When?_____

Have you tried surgery? YES or NO If yes, did it help your pain? YES or NO When?_____

What pain medications are you taking? _____

**Have you tried and/or failed NSAIDS to control pain? YES or NO**

**If yes, which ones? (Circle all that apply): Ibuprofen Naproxen Aspirin Meloxicam Diclofenac**

Do you have any recent imaging (within the last two years)? YES or NO

Do you have constipation? YES or NO or SOMETIMES

Circle for what applies:

Smoking Status: NEVER SMOKED or FORMER SMOKER or CURRENT SMOKER

Alcohol Status: CURRENT ALCOHOL DRINKER or NOT A CURRENT ALCOHOL DRINKER

CURRENT MEDICATION LIST (please add dosages):

_____

_____

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY:

_____

_____

ALLERGIES:

_____

SURGICAL HISTORY:

_____

_____

FAMILY HISTORY:

_____

_____

Name: _____ Date: ____/____/____ DOB: ____/____/____

**OPIOID RISK TOOL :**

| | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| 1. How often do you have mood swings? | o | o | o | o | o |
| 2. How often have you felt a need for higher doses of medication to treat your pain? | o | o | o | o | o |
| 3. How often have you felt impatient with your doctors? | o | o | o | o | o |
| 4. How often have you felt that things are just too overwhelming that you can't handle them? | o | o | o | o | o |
| 5. How often is there tension in the home? | o | o | o | o | o |
| 6. How often have you counted pain pills to see how many are remaining? | o | o | o | o | o |
| 7. How often have you been concerned that people will judge you for taking pain medication? | o | o | o | o | o |
| 8. How often do you feel bored? | o | o | o | o | o |
| 9. How often have you taken more pain medication than you were supposed to? | o | o | o | o | o |
| 10. How often have you worried about being left alone? | o | o | o | o | o |
| 11. How often have you felt a craving for medication? | o | o | o | o | o |
| 12. How often have others expressed concern over your use of medication? | o | o | o | o | o |
| 13. How often have any of your close friends had a problem with alcohol or drugs? | o | o | o | o | o |
| 14. How often have others told you that you had a bad temper? | o | o | o | o | o |
| 15. How often have you felt consumed by the need to get pain medication? | o | o | o | o | o |
| 16. How often have you run out of pain medication? | o | o | o | o | o |
| 17. How often have others kept you from getting what you deserve? | o | o | o | o | o |
| 18. How often, in your lifetime, have you had legal problems or been arrested? | o | o | o | o | o |
| 19. How often have you attended an AA or NA meeting? | o | o | o | o | o |
| 20. How often have you been in an argument that was so out of control that someone got hurt? | o | o | o | o | o |
| 21. How often have you been sexually abused? | o | o | o | o | o |
| 22. How often have others suggested that you have a drug or alcohol problem? | o | o | o | o | o |
| 23. How often have you had to borrow pain medications from your family or friends? | o | o | o | o | o |
| 24. How often have you been treated for an alcohol or drug problem? | o | o | o | o | o |

# PCS-EN

Name: _____ Age: _____ Sex: M(__) F (__) Date: _____

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

---

**<u>Please use the 0-4 scale to rate your feelings:</u>**

**0 – not at all 1 – to a slight degree 2 – to a moderate degree 3 – to a great degree 4 – all the time**

When I'm in pain…

1. _____ I worry all the time about whether the pain will end.
2. _____ I feel I can't go on.
3. _____ It's terrible and I think it's never going to get better.
4. _____ It's awful and I feel that it overwhelms me.
5. _____ I feel I can't stand it anymore.
6. _____ I become afraid that the pain will get worse.
7. _____ I keep thinking of other painful events.
8. _____ I anxiously want the pain to go away.
9. _____ I can't seem to keep it out of my mind.
10. _____ I keep thinking about how much it hurts.
11. _____ I keep thinking about how badly I want the pain to stop.
12. _____ There's nothing I can do to reduce the intensity of the pain.
13. _____ I wonder whether something serious may happen.

Total: _____

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## CONTROLLED SUBSTANCE AGREEMENT:

The words we and our refer to the facility and the words I, me, or my refer to you, the patient. We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of chronic pain, which is strictly regulated by both state and federal agencies. Some patients have an excellent response to morphine and morphine-like drugs (opioids). These patients experience a notable decrease in their pain without interfering side effects, such as sedation and nausea. This favorable response allows these patients to increase their function. Unfortunately, not all patients have a favorable response to morphine and morphine-like medications and may experience significant side effects that prevent further use of this type of pain medicine. Additionally, these drugs do not decrease all pain syndromes. Your doctor has no way of knowing which side affects you may experience or how much pain relief you may experience. Furthermore, these medicines may cause unintended psychological effects such as a false sense of well-being and improved ability to cope with problems. Sometimes patients who experience these psychological effects may use these medicines in a way other than prescribed. There exists significant misunderstanding regarding the use of opioid analgesics. The following definitions are important for you to understand.

Physical dependence is a pharmacologic property of certain drugs, such as caffeine and opioid, that cause biochemical changes in the body such that abruptly stopping these drugs will result in a withdrawal response.

Addiction is a psychological and behavioral syndrome in which there is drug craving and drug seeking behavior, for purposes other than those intended by your physician. For example, addictive behavior would include increasing your usual dose of opioid (without prior discussion with our doctor) for psychological benefit to self-medicate during a stressful situation.

Tolerance is a pharmacologic property of certain drugs defined by the need for increasing the dose to maintain effect.

The risk of addiction in patients who do not have a prior addiction history (to any substance) is extremely low. The risk of addictive behavior is much higher in patients who have a prior history of addiction. If you do develop an addiction problem your doctor will help you with this. Your doctor may decide that you should not continue on the particular drug or may decide that you may continue on the medicine, but only with very careful treatment guidelines.

## INFORMED CONSENT:

I understand that the use of opioid analgesics can be safe and effective treatment for my chronic pain. I also understand that there exists a risk of developing an addiction disorder; however, I also understand that this is extremely rare in patients who have no prior addiction history. I have truthfully advised my doctor that I have no history of addiction to any narcotic medication, controlled substances, illicit drugs, alcohol, gambling or any other type of addiction.

All controlled substances must come from the physician whose signature appears below or, during his/her absence, by the covering physician, unless specific authorization is obtained for an exception. I understand that I must tell the physician whose signature appears below or, during his/her absence, the covering physician, all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death. I will not seek prescriptions for controlled substances from any other physicians, healthcare provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physicians' knowledge. I also understand that it is unlawful to obtain or attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to physicians, or his/her staff, or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff all controlled substances that I have been prescribed).

All controlled substances must be obtained at one pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed.

You may not share, sell, or otherwise permit others; including spouse or family members, to have access to any controlled substances that you have been prescribed. You may not dispose or throw away any of your medications that you receive from our doctor for any reason; but rather, you will return any unused portion to your doctor or to your designated pharmacy. You may be subject to random pill counts. You will be notified by phone, at random, to come into the office and bring your medication in the bottles provided by the pharmacy. Once you have been contacted, you will have a 6 hour window to arrive. Your participation will be mandatory. Failure to participate will result in a breach of the Controlled Substance Agreement and will result in, but not limited to, discontinuation of opioid therapy, discharge from practice and/or referral to law enforcement.

I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescription of my medication, and I authorize my doctor to provide this information to any person or facility that he/she deems appropriate and necessary. My doctor may fax this contract to any physician involved in my care, pharmacy, ER, hospital, or any person or facility that he/she deems appropriate and necessary, even if such disclosure may be adverse to my interest (e.g. law enforcement personnel).

Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from this facility. Also, if your prescribed medication does not appear in the urine or serum toxicology specimen you may also be discharged from the practice.

I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below or, during his/her absence by the covering physician, as set forth in Section 1 above. I will not use, purchase or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substance (e.g. alcohol and prescribed drugs), which impair my driving ability, may result in DUI charges.

Medications or written prescriptions may not be replaced if they are lost, stolen, misplaced, and/or destroyed.

Prescriptions should be taken as prescribed. I understand that I will not increase my dose unless I discuss this with my doctor first. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol); refills on controlled substances will not be given.

I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribe by this physician and other physicians at the facility and that law enforcement officials may be contacted.

I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. A copy of this documentation has been given to me.

Patient Printed Name: _____

Patient Signature: _____ Date:_____

Physician Signature: _____ Date:_____

Dr. Jason Song, MD, PhD

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## HIPAA Release of Information AUTHORIZATION FORM:

I, _____ hereby authorize **Palm Tree Interventional Pain Management**, its affiliates, its employees, and agents to release to _____ my personal health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, member id number) except the following information about me:

_____

[Describe information not to be disclosed, if any]

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

The authorization is valid from the date of my/my representative's signature below and shall not expire.

I understand that I have a right to revoke this authorization by providing written notice to **Palm Tree Interventional Pain Management**. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization.

Name of Patient: _____

Signature of Patient: _____

Date: _____ / _____ /_____

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## FINANCIAL POLICY:

In order to establish optimal relations and avoid misunderstanding, we developed the following financial policy to inform all patients of our position regarding finances.

This office accepts the following forms of payment: Cash, Credit Card
*Checks will only be accepted to pay for balances by mail*

**ALL PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED**

Payment of fees:

- If you are a self-pay patient, the total amount charged is due at your first visit.
- Payment arrangements can be made for subsequent visits.
- All co-pays or co-insurance amounts are due at the time of service.
- All past-due balances will be collected in full at the subsequent visit.
- We will as a courtesy file your claim if it is with an insurance company we contract with.

Patient Responsibility:

- It is the patient's responsibility to inform the office if you have a new insurance, address, or phone number.
- You must inform us if your insurance has changed prior to our appointment. We will not verify your insurance while you wait. You must be rescheduled until it can be done.
- It is your responsibility to be familiar with your own insurance policy guidelines and follow them.

Miscellaneous:

- Patients with outstanding balances will receive three (3) monthly statements of intent to collect. If after the third statement your balance has not been satisfied, you will not be permitted to make further appointments until the account is current and/or possible discharge from the practice.
- We may take further action such as utilizing a collection agency.
- We understand temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

Returned checks will be subject to an additional fee of $35.00 to you, the patient.

I, _____, have read, understand, and will adhere to the financial policy as stated here. I understand that ultimately, I am responsible for payment not covered by my insurance contract.

Patient Signature: _____ Date: _____ / _____ / _____

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I received a copy of the Notice of Privacy Practices which summarizes the way my protected health information may be used and disclosed by the practice and stated my rights with respect to my protected health information. I understand that the practice has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event the practice changes this Notice, a revised Notice will be posted in the practice and that I may obtain a current Notices of Privacy Practice at any time from the Privacy Officer.

PROVIDE APPROPRIATE SIGNATURE(S) BELOW:

Signature of Patient: _____

Printed Name: _____

Date: _____ / _____ / _____

Signature of Legal Representative if patient is legally incompetent or incapacitated:

x_____

Name of Legal Representative: _____

Relationship to Patient: _____

Date: _____ / _____ / _____

Signature of Witness: _____

Printed Witness Name: _____

Date: _____ / _____ / _____

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Patient Name: _____

DOB: _____/_____/_____

## Updated Emergency Contact

The ideal emergency contact can talk to medical professionals about medical history, allergies, chronic conditions, and current medications. In some cases, they even make medical decisions for their loved one. If we cannot get a hold of you, regarding a time sensitive matter, we may reach out to your emergency contact in an attempt to reach you.

Name of Contact: _____

Phone Number: ( _____ ) - _____ - _____

Relation (Check One):

[ ] Child [ ] Brother

[ ] Spouse [ ] Sister

[ ] Caregiver [ ] Father

[ ] Friend [ ] Mother

[ ] Guardian [ ] Other: _____

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Please choose a **FLORIDA** pharmacy.

This may be changed upon request, at future appointments.

- Must be in the state of Florida

## We are not affiliated with Walmart

- Must be compliant with ePrescriptions

(Examples: Prescriptions Unlimited, Publix, Walgreens, CVS, Winn Dixie)

Pharmacy Name: _____

Pharmacy Address: _____

In compliance with state law, we are now electronically prescribing ALL medications directly to your pharmacy. Please allow prescriptions 48 hours to be sent to your pharmacy. We ask that you wait 48 hours before contacting our office concerning medications, as Dr. Song is the sole provider to send the medication to the pharmacy. We ask that you consider this time frame when scheduling your follow up appointments for medication refills. It is advised to schedule 2-3 days prior to needing a refill on medication.

Thank you for your cooperation.

I, _____, understand the above statement and will comply.

Patient Signature: _____ Date: _____

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## CANCELLATION/ NO SHOW POLICY:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly full appointment book.

If an appointment is not canceled at least 2 business days in advance you will be charged $50 for standard office visits and $100 for procedures. This will not be covered by your insurance company.

If you are more than 15 minutes late for your scheduled appointment, your appointment will be canceled and you will have to reschedule.

Signature:_____ Date:_____

## AUTHORIZE AUTOMATED REMINDER OF APPOINTMENT:

I hereby authorize Palm Tree Interventional Pain Management to use their automated appointment reminder service to remind me of all my scheduled appointments. I understand that my signature on this form authorized Palm Tree Interventional Pain Management to utilize the automated appointment reminder service for all my scheduled appointments.

Signature:_____ Date:_____

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## Urine Drug Screen Policy & Protocol:

1. We conduct randomized urine drug screens on all patients.
2. Some patients will have to complete a urine drug screen more frequently from time to time depending on our clinical assessment of each patient.
3. In addition to random urine drug screens, patients could be subjected to random medications counts.
4. Our urine drug screen process is to provide better compliance, safety, and care for our patients.

### MEDICATION TREATMENT CONTRACT SUMMARY:

This summary is not a substitute for reading the medication treatment contract.

### The Following are violations of Medication Treatment Contract:

1. Taking pain medication (including tramadol/ultracet/medical marijuana) other than those prescribed by this practice (including other physicians, friends, family, strangers, other patients or medication previously prescribed by this practice or by other physicians).
2. Using illegal drugs.
3. Tampering in any way with your urine specimen.

Signature:_____ Date:_____

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**RELEASE OF INFORMATION TO INSURANCE COMPANY(IES)**

**ASSIGNMENT OF BENEFITS:**

I hereby authorize Palm Tree Interventional Pain Management to release information acquired during the course of my examination and treatment to the Insurance company(ies) and its agents or any other third party carrier as necessary to secure payment of any benefits due to me. I hereby assign payment of said benefits to include Medicare benefits directly to Palm Tree Interventional Pain Management. I understand that I am responsible for all charges regardless of insurance status as well as any associated cost for collection should such action become necessary. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof.

Signature:_____ Date:_____

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**MEDICAL RECORDS RELEASE FORM:**

Patient Name:_____ Date of Birth: _____/_____/_____

Address: Street Number:_____

City, State, and Zip code:_____ Phone Number:_____

**RECORDS REQUESTED FROM:**

Name of Person or Facility:_____

Practice Address: Street Number:_____

City, State, and Zip Code:_____

Phone Number:_____ Fax Number:_____

**RECORDS TO USE OR DISCLOSURE TO:**

Name of Person or Facility:_____

Practice Address: Street Number:_____

City, State, and Zip Code:_____

Phone Number:_____ Fax Number:_____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by recipient and no longer protected. I understand that specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon authorization.

The authorization will expire in six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Signature:_____ Date:_____

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Advance Beneficiary Notice (ABN) Form

Patient Name: _____ DOB: ____/____/____ Date: ____/____/____

**Note: You need to make a choice about receiving future health care items and services.**

Your insurance company may not pay for all of your health care costs. Your insurance company only pays for covered items and services when your insurance company's rules are met. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. **There may be a good reason your doctor recommended it.**

The purpose of this form is to help you make an informed choice about whether or not you want to receive future items or services, knowing that you may have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain if you do not understand why your insurance company might not pay for some items or services.
- Ask us how much these items or services will cost you.

**PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE.**

☐ **Option 1: Yes, I want to receive future items and services.**
I understand that my insurance company will not decide whether to pay unless I receive items or services. Please submit my claim to my insurance company. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance company is making its decision. If my insurance company does not pay, you will refund me any payments I made to you that are due to me. If my insurance company denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal my insurance company's decision.

☐ **Option 2: No, I have decided not to receive future items and services.**
I will not receive future items or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance company will not pay.

_____ _____
**SIGNATURE** of patient or person acting on patient's behalf **DATE**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance company, your healthy information on this form may be shared with your insurance company. Your insurance company will keep your health information confidential.

# PRIVACY STATEMENT

We are committed to protecting your privacy and developing technology that gives you the most powerful and safe online experience. This Statement of Privacy applies to our Practice's Web site and governs data collection and usage. By using this website, you consent to the data practices described in this statement.

## Collection of your Personal Information

This Practice collects personally identifiable information, such as your e-mail address, name, home or work address or telephone number. This Practice also collects anonymous demographic information, which is not unique to you, such as your ZIP code, age, gender, preferences, interests and favorites.

There is also information about your computer hardware and software that is automatically collected by this website. This information can include: your IP address, browser type, domain names, access times and referring Web site addresses. This information is used for the operation of the service, to maintain quality of the service, and to provide general statistics regarding use of this Web site.

Please keep in mind that if you directly disclose personally identifiable information or personally sensitive data through public message boards, this information may be collected and used by others.

This Practice encourages you to review the privacy statements of Web sites you choose to link to from the website so that you can understand how those Web sites collect, use and share your information. This Practice is not responsible for the privacy statements or other content on any other Web sites.

## Use of your Personal Information

This Practice collects and uses your personal information to operate the Web site and deliver the services you have requested. This Practice also uses your personally identifiable information to inform you of other products or services available from this Practice and its affiliates. This Practice may also contact you via surveys to conduct research about your opinion of current services or of potential new services that may be offered.

This Practice does not sell, rent or lease its customer lists to third parties. This Practice may share data with trusted partners to help us perform statistical analysis, send you email or postal mail, provide customer support, or arrange for deliveries. All such third parties are prohibited from using your personal information except to provide these services and they are required to maintain the confidentiality of your information.

This Practice does not use or disclose sensitive personal information, such as race, religion, or political affiliations, without your explicit consent.

This Practice will disclose your personal information, without notice, only if required to do so by law.