SOUTHWEST FLORIDA NEUROSURGICAL ASSOCIATES

SOUTHWEST FLORIDA REHAB & PAIN MANAGEMENT ASSOCIATES

12700 Creekside Lane, Suite 101 • Fort Myers, Florida 33919 • (239) 432-0774 • FAX (239) 432-9404
632 Del Prado Blvd. N. • Cape Coral, Florida 33909 • (239) 772-5577 • FAX (239) 772-9961

Dear Patient:

Thank you for choosing our practice to assist in your healthcare needs. We appreciate the confidence you and your personal physician have placed in us. Please read the following instructions and information and let us know immediately if you have any questions.

FORMS: Enclosed you will find a Patient Information form along with a Pain Questionnaire. Please fill out these forms and bring them with you at the time of your appointment.

INSURANCE: Please bring your insurance cards so we can copy them for your chart. We will file your primary insurance claim for you. If your insurance requires prior authorization, please ensure it is taken care of before the day of your appointment as ***you cannot be seen without it*** and your appointment will have to be rescheduled.

PAYMENT: It is the policy of this office to advise patients that they are responsible for all bills incurred. Please be prepared to ***pay any copay or coinsurance amounts due at the time of service***. Please note: A $10.00 processing fee will be charged for each copay not paid at time of service. Our office ***does not file supplemental insurances***. We accept cash, check and most major credit cards.

FILMS: You are responsible to ensure that your **ACTUAL films, NO CD's** (all x-rays, CT scans, MRI scans, etc., relating to your problem/injury) are here for your appointment. If your films are being delivered to the office, please call the day before your appointment to make sure they have arrived. We regret that ***your appointment will have to be rescheduled if your films are not at our office at the time of your appointment***.

MOTOR VEHICLE ACCIDENT: If you are being seen as a result of a motor vehicle accident and your insurance benefit does not pay 100% or benefits are exhausted, you will be responsible for all or part of your first appointment. If you are to have surgery, you can instruct your attorney to provide us with a Letter of Protection. A Letter of Protection simply gives permission to your attorney to pay expenses incurred at this office when a settlement has been reached on your behalf. It does not release you of your responsibility to pay any unpaid balance.

LOCATIONS: Please refer to the "Office Locations" section on the homepage of our website, www.swfna.com. This will provide you with directions to the office at which your appointment has been scheduled.

If you have any questions regarding the above information and instructions, please contact our office. If you would like to learn more about our practice, please visit our website at: www.swfna.com.

Sincerely,

Southwest Florida Neurosurgical Associates
Southwest Florida Rehab & Pain Management

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CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: ______________________________ Date of Birth: ____________

Please Check One of the Following:

______ I REQUEST THAT ALL OF MY PROTECTED HEALTH INFORMATION BE DISCLOSED ONLY TO ME AND NO OTHER FRIENDS OR FAMILY.

OR

______ I GIVE MY PERMISSION TO THE EMPLOYEES OF SOUTHWEST FLORIDA NEUROSURGICAL ASSOCIATES AND/OR SOUTHWEST FLORIDA REHAB AND PAIN MANAGEMENT TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING FAMILY MEMBERS OR FRIENDS.

NAME: ______________________________ RELATION: ______________

NAME: ______________________________ RELATION: ______________

NAME: ______________________________ RELATION: ______________

NAME: ______________________________ RELATION: ______________

WHAT TYPE OF MESSAGE MAY WE LEAVE FOR YOU?

In an effort to better serve you, Southwest Florida Neurosurgical Associates and/or Southwest Florida Rehab and Pain Management would like to know what type of message we may leave on your answering machine/voicemail when contacting you. It is the policy of Southwest Florida Neurosurgical Associates and Southwest Florida Rehab and Pain Management to call you at any phone number you provide to us. Please let us know what type of message we may leave on your answering machine/voicemail by answering the following questions by circling **YES** or **NO**.

When we contact you by calling you at any telephone number you have provided us:

May we leave a detailed message on your answering machine/voicemail? **YES** or **NO**

If no, we will leave a message with just enough information for you to call us back.

*****Please Note: We will ALWAYS leave a detailed message on your answering machine/voicemail or with anyone who answers your telephone when we are contacting you to remind you of an appointment at our office.*****

I understand I may revoke or change this consent at anytime by filling out another consent form to replace this one.

______________________________ ______________________

Patient/Guardian/or Legal Representative Signature Date

______________________________ ______________________

Printed Name if not signed by Patient Relationship

_

Internal Use Only: Please post the above information in the patient's off-bill comments.

Date Received: ____________________ Posted By: ______________________________

DATE REVOKED/CHANGED______________

If revoked/changed see new consent form

Revised July 3, 2007

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PLEASE PRINT CLEARLY DATE ____________________

NAME ______________________________________ HOME PHONE ____________________
LAST FIRST MI

SEX: M F AGE: _____ BIRTHDATE: ____/____/____ SOCIAL SECURITY #: ____________________

MARITAL STATUS: ____________ SPOUSE'S NAME: ____________________

PHARMACY NAME: ____________________ PHARMACY PHONE: ____________________

HOME ADDRESS: ____________________

CITY: ____________ STATE: ________ ZIP: ________ IS ADDRESS: PERMANENT ____ TEMPORARY ____

OTHER ADDRESS IF ABOVE IS TEMPORARY: ____________________

PATIENT'S EMPLOYER: ____________________ WORK PHONE: ____________ YEARS EMPLOYED: _____

DRIVER'S LICENSE #: ____________________ STATE: ________ EMAIL: ____________________

INSURANCE INFORMATION **(Please present your insurance card(s) for copying)**

MEDICARE #: ____________________ MEDICARE SUPPLEMENT: ____________________

HEALTH INSURANCE: ____________________ POLICY #: ____________ GROUP #: ____________

POLICY HOLDER'S NAME: ____________________ RELATIONSHIP TO PATIENT: ____________________

BIRTHDATE:_____/_____/_____ SOCIAL SECURITY #: ____________________

IF VISIT IS RELATED TO WORK COMP OR AN ACCIDENT, PLEASE COMPLETE BELOW

WORK COMP: EMPLOYER NAME: ____________________ PHONE: ____________________

ADDRESS: ____________________ DATE OF ACCIDENT: ____________________

ACCIDENT: AUTO ACCIDENT: ____________ OTHER (STATE TYPE): ____________________

INSURANCE CARRIER: ____________________ POLICY #: ____________________

CLAIM #: ____________ DATE OF ACCIDENT: ____________ POLICY HOLDER'S NAME: ____________________

BIRTHDATE: _____/_____/_____ SOCIAL SECURITY #: ____________ RELATIONSHIP TO PATIENT: ____________

ARE YOU REPRESENTED BY AN ATTORNEY? ______ ATTORNEY'S NAME: ____________ PHONE #: ____________

IF PATIENT IS A MINOR, PLEASE COMPLETE BELOW

MOTHER'S NAME: ____________________ EMPLOYER: ____________________

HOME ADDRESS: ____________________ PHONE #: ____________________

MOTHER'S SOCIAL SECURITY #: ____________________ WORK PHONE #: ____________________

FATHER'S NAME: ____________________ EMPLOYER: ____________________

HOME ADDRESS: ____________________ PHONE #: ____________________

FATHER'S SOCIAL SECURITY #: ____________________ WORK PHONE #: ____________________

PLEASE COMPLETE

REFERRING DOCTOR: ____________________ PHONE #: ____________________

REASON FOR VISIT: ____________________

EMERGENCY CONTACT (not living with you): NAME: ____________________

EMERGENCY PHONE #: ____________________

LETTER OF PROTECTION AUTHORIZATION

I authorize my attorney, ______________________________, to provide to Sypert Institute, P.A. a letter of protection. I understand that this will authorize my attorney to protect the medical provider's unpaid bill and pay the same from any settlement I might receive. This does not relieve me from the responsibility to provide my medical provider(s) with insurance information so the insurance can be filed. NOTE: All managed care copays must be paid at time of service.

____

PATIENT'S SIGNATURE

MEDICARE/CHAMPUS AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for medical provider(s) services to the medical provider(s) furnishing the services and authorize such medical provider(s) to submit a claim to Medicare for payment.

SIGNED ____ DATE__________________________

PATIENT'S SIGNATURE (OR PARENT IF MINOR)

AUTHORIZATION TO RELEASE INFORMATION

I authorize any holder of medical or other information about me to release same to the insurance carrier for the purpose of payment of services.

I hereby authorize payment directly to my medical provider for all medical care benefits otherwise payable to me; this is not to be construed as an assignment of benefits unless the medical provider has a contractual agreement with the insurance company. I understand that I am responsible for any insurance deductibles and coinsurance, and I am financially responsible for my medical bills regardless of insurance coverage.

SIGNED ____ DATE__________________________

PATIENT'S SIGNATURE (OR PARENT IF MINOR)

PATIENT — PLEASE NOTE:

This office will prepare and file your insurance for you. If you choose to file your own, please check all data before forwarding to your insurance company. Our office will expect payment in full on the date services are rendered if you are filing your own claim. There will be a $25.00 charge for each special form you request us to complete, such as disability forms, family medical leave, etc.

I understand that if my insurance carrier controverts or rejects my claim that I/we (am/are) responsible for all charges billed by this office.

Managed Care Patients: There will be a $10.00 processing fee billed to your account each time you do not pay your required co-payment at time of service.

NOTE: You will be charged a NO SHOW FEE of $25.00 for failure to notify our office in advance of any appointment cancellation. This charge will be your responsibility as insurance does not cover this fee.

For, and in consideration of, services rendered to the above named patient, I/we jointly and severally promise to pay to the Sypert Institute, P.A. (dba as Southwest Florida Neurosurgical Associates and/or Southwest Florida Rehab & Pain Management Associates) all its charges for services rendered to and for the above named patient. I/we understand the Sypert Institute, P.A. may elect to accept or not to accept assignment of insurance benefits as it deems advisable. Any other arrangements made by me (insurance company, lawyers, etc.) does not involve the Sypert Institute, P.A. and does not change my (our) responsibility to pay for services.

All patients (excluding contracted third party payors) are assessed a 1% monthly billing fee on any balance over 120 days.

I have read and understand all of the above.

_______________________________ _______________________________

(PATIENT) (GUARANTOR)

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Notice of Privacy Practices

Effective April 14, 2003, all medical practices must follow certain guidelines as it pertains to the "Protected Health Information" (PHI) of their patients. PHI is defined as information about the patient, including demographic information, that may identify the patient, and relates to the patient's past, present, or future physical or mental condition and related health care services.

This short form has been created to provide you an overview explaining how we will handle your PHI and actions you can take if you feel we have not handled your PHI properly. A more detailed explanation of this Notice of Privacy Practices is available on our website at www.swfna.com.

How we handle your Protected Health Information:
We will ask each patient to sign consent from allowing Southwest Florida Neurosurgical Associates and/or Southwest Florida Rehab and Pain Management to use your PHI for three purposes only. Those purposes are for medical treatment, information required for payment of services rendered, and for conducting our operational activities. No other use of your PHI will occur without your written consent, unless it is to comply with state and federal laws.

Complaints regarding Protected Health Information:
If you feel we have improperly distributed your PHI or believe your HIPAA privacy rights have been violated by Southwest Florida Neurosurgical Associates and/or Southwest Florida Rehab and Pain Management, you may file a complaint by notifying our privacy contact listed below. Additionally, you also may file a complaint to the Secretary of Health and Human Services. We will not retaliate against any patient for filing a complaint.

If there are any questions with regard to this notice, they may be directed to our Privacy Contact, Robert O'Grady at (239) 432-0774, x5218, or at bogrady@swfna.com.

______________________________ ______________________
Patient Signature Date

______________________________ ______________________
Southwest Florida Neurosurgical Associates
Southwest Florida Rehab and Pain Management
Date

SOUTHWEST FLORIDA REHAB AND PAIN MANAGEMENT ASSOCIATES

Pierre R. Hyppolite, M.D. • Robert D. Mehrberg, M.D.
Peter S. Schreiber, D.O • James P. Weiner, M.D.

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PAIN MANAGEMENT/NARCOTIC TREATMENT CONTRACT

I have agreed to use narcotics (morphine-like drugs) as part of my treatment for my chronic pain. I understand these drugs are very useful, but have a potential for misuse and are therefore closely controlled by the local, state and federal governments. Because my physician is prescribing such medication to help manage my pain, I agree to the following conditions, without reservations:

1. **I am responsible for my pain medication. I agree to take the medication only as prescribed.** I understand that increasing my dose without the close supervision of my physician could lead to drug overdose, causing severe sedation, respiratory depression and death.

2. **I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician at Southwest Florida Rehab and Pain Management Associates.**

3. I understand the side effects are related to narcotic medication. Common side effects are nausea and vomiting (similar to motion sickness), drowsiness and constipation. Less common side effects are mental slowing, flushing, sweatings, itching, urinary difficulty and jerkiness. These side effects would occur at the beginning of my treatment and often go away within a few days without treatment. It is my responsibility to notify my physician of any side effects that continue or are severe (i.e., sedation, confusion). I am also responsible for notifying my pain physician immediately if I need to visit another physician or emergency room due to pain or I become pregnant. I will also inform my other treating physician(s) when I see them of this agreement to avoid prescription duplication. Once you are stable on your pain medications, you should be able to drive a vehicle. If changes are made to your dosage, you should refrain from driving for 48-72 hours. You should never mix alcohol or illicit drugs with your prescribed medications as they can impair judgment. If at any time you do not feel competent to drive, then do not drive.

4. Since narcotics can cause constipation you should use a stool softener and/or a fiber supplement on a daily basis, and if necessary, a laxative/enema to maintain normal bowel function. If you have a problem with bowel function, notify your doctor immediately. You should never go five days without a bowel movement.

5. I understand the pain medication is strictly for my own use. Pain medicines **should never** be given to others.

6. I understand I must contact my pain physician before taking any other drugs. Medications like Valium, Ativan, Xanax, Fiorinal or Ambien. Certain muscle relaxants like Soma, antihistamines like Benadryl or Atarax, and alcohol may produce profound sedation, respiratory depression, blood pressure drop, and even death when taken with narcotic/pain medications. All mind altering drugs, including marijuana, cocaine, ecstacy, etc., are especially dangerous and deadly, and should not be used.

7. During the time my narcotic/pain medication is being adjusted, **I will return to the clinic at least one time per month or whenever instructed by my physician.** After I have been placed on a stable dose, I will return to Southwest Florida Rehab and Pain Management Associates for a medical evaluation **at least once every three months.**

8. **I understand that pain prescriptions will not be mailed.** I will pick up my refill prescriptions at Southwest Florida Rehab and Pain Management Associates every month or as designated by my physician. If I am unable to obtain my prescriptions monthly, I will be responsible for finding a local physician who can take over the writing of my prescriptions with consultations from my pain physician.

9. I am responsible for my narcotic/pain prescriptions. I understand that refill prescriptions:
• Can only be written for a one month supply for most medications and will be filled at the same pharmacy. The allowance of refills on prescriptions is at the discretion of my physician, but also dictated by the governing laws of the state.

• Request for prescriptions refills for pain medication need to be made Monday through Thursday, 8:00 am to 4:00 pm. Please do not wait until you have only one pill left before calling for a prescription refill as refill requests may take 72-96 hours to fulfill. No refill prescriptions will be written at night, on holidays or on weekends.

• **I am responsible for the safety of my medications. Refills will not be made for lost, stolen or misplaced medications.** If I run out of my medications early because I took more medicine than prescribed by my physician, not only will my refill be denied, but also I run the risk of dismissal from my physician's practice. Changes to type and amount of medication **can only** be done with the approval of my physician. I will be allowed to take less than prescribed if my medicine is not needed, but not more without the permission of my physician.

• Can only be filled by a pharmacy in the State of Florida, even if I am a resident of another state.

10. If my physician changes my pain medication, I will turn into the clinic the appropriate balance of medication, before picking up my new prescription. The type and quantity of the turned in medication will be entered into a journal and then properly disposed of by my physician's office staff. I will not dispose of or flush the medicine down the toilet on my own. Hoarding of old medications prohibited.

11. I understand that narcotic/pain medications, along with all medications, pose a danger to children and I will safeguard these in my home.

12. While physical dependence is to be expected after long-term use of narcotic pain medication, signs of addiction (and psychological dependence) shall be interpreted as a need for weaning and detoxification.

• Physical dependence is common to many drugs such as blood pressure medication, anti-seizure medicines and narcotics. It results in biochemical changes such that abruptly stopping these drugs can cause a withdrawal response.

• Addiction is a psychological and behavioral syndrome that is recognized when a patient abuses the drug to obtain mental numbness and euphoria. When the patient shows a craving behavior or "doctor shopping," when the drug is quickly escalated without correlation to pain relief and/or when the patient shows a manipulative or abusive attitude toward the physician to obtain the drug. If the patient exhibits such behavior, the drug will be tapered; such a patient is not a candidate for the narcotic medication and he/she may be referred to a narcotic detoxification program and/or be discharged from the practice.

•Tolerance is a pharmacological property of certain drugs and is defined as a need for higher doses to maintain the same drug effect.

A. I understand that if I participate in any illegal, deceitful or fraudulent activities I will be discharged from the practice and appropriate criminal/legal action will be invoked. This includes "dealing" prescription drugs and forging or altering prescriptions in any manner or form.

B. If it appears to the physician that there is no improvement to my daily function or quality of life from the prescribed medications, they will be discontinued. I will gladly taper the medicine as instructed by my physician.

C. I agree to submit to supervised/witnessed urine and bloodscreens at any time as determined by my physician or his designee to detect the use of both prescribed and non-prescribed medications, and I will be financially responsible for the test

D. I authorize the release of any information and hospital records by the pain physician or his/her designee to other healthcare providers, my family, my employer, my insurance company or other reimbursing agencies. I also authorize any pharmacy, hospital, medical clinic and physician to release medical information to my pain physician.

E. I understand that if in the opinion of my physician I did not follow the above conditions, my physician may determine that narcotic therapy is no longer appropriate for me. I will then be gradually taken off these medications and other therapies will be used, or I may be discharged from my physician's care. I also agree to hold Southwest Florida Rehab and Pain Management Associates, the Sypert Institute and my treating physicians free of any liability or responsibility should I violate any of the above conditions.

I, ______________________________, have read all pages of the pain management/narcotic treatment contract or it has been read to me and all my questions regarding the treatment of pain with narcotic/pain medicines have been answered to my satisfaction. I hereby give my consent to participate in narcotic/pain medication therapy.

PATIENT SIGNATURE: ______________________________ DATE: ______________

PHYSICIAN SIGNATURE: ______________________________

MY PHARMACY: ______________________________

PHARMACY ADDRESS: ______________________________

PHARMACY PHONE: (   ) ____________________ ____________________

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PAIN QUESTIONNAIRE

This information is confidential. Please fill out this sheet, providing as much reliable data as possible. Approximate dates are satisfactory. You may extend your description in the blank spaces.

Name ______________________________ Date ______________

Major Problem ______________________________

When did you first notice the pain you are experiencing? ______________________________

Did your pain follow a recent accident or injury? Yes ☐ No ☐ Explain ______________________________

____

What makes your pain better or worse? ______________________________

____

Have you had similar pain before? Yes ☐ No ☐ If so, when? ______________________________

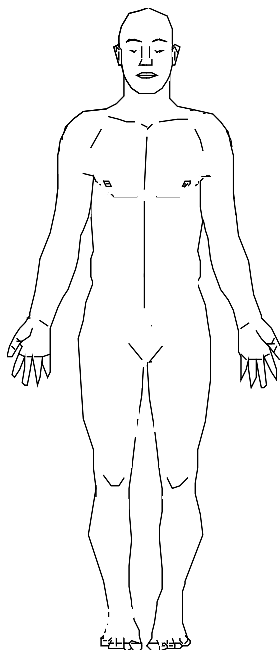
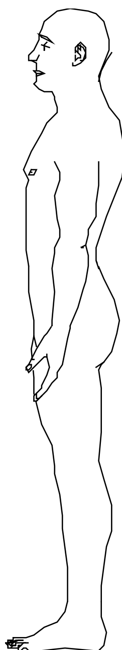
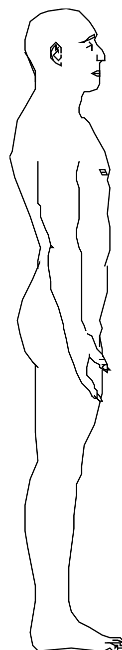
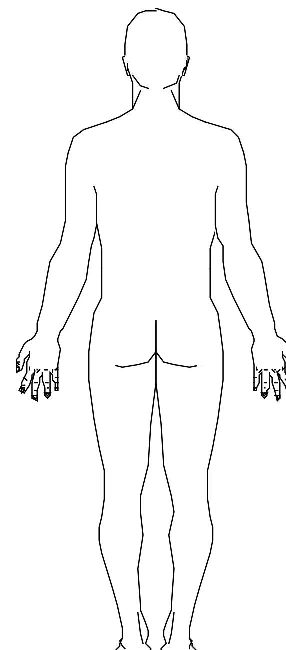
Describe ______________________________

____

Please describe your pain using the drawings below.

Mark the areas on your body where you feel your pain. Include all affected areas. Use the appropriate symbol indicated below:

Ache >>>>	Numbness ====	Pins & Needles oooo	Burning xxxx
Stabbing ////	Throbbing	Shooting ––––	

Please note your pain on the scale below:

NO PAIN — EXTREME PAIN (GO TO ER)

0 1 2 3 4 5 6 7 8 9 10

Pain Today __________ On a good day __________ On a bad day __________

Hospitalizations for this problem: ____________________

What type of treatment did you receive in the hospital? ____________________

____

What is your exercise program? #times/week

walk__________ weights__________ golf __________ swim__________ yoga__________

Previous pain treatments (check all that apply):

- ☐ Physical therapy (exercise, heat, ultrasound, etc.) Effect: ____________________
- ☐ Chiropractor Effect: ____________________
- ☐ Injections Effect: ____________________
- ☐ TENS Unit Effect: ____________________
- ☐ Accupuncture Effect: ____________________
- ☐ Psychological Pain Evaulation Effect: ____________________
- ☐ Medications (please list) Effect: ____________________

____

____

____

- ☐ Other Effect: ____________________

Last day worked after injury or problem: ____________________

List all days of work missed: ____________________

Name all doctors and chiropractors who have treated you for this: ____________________

____

Which medical tests have been done (x-rays, MRI, EMG, etc.)?

Test: ____________________ Results: ____________________

____________________ ____________________

REVIEW OF SYSTEMS

Do you have any problem with the following?

	CIRCLE		If YES, describe below
Head	YES	NO	______
Eye	YES	NO	______
Ears	YES	NO	______
Nose	YES	NO	______
Throat	YES	NO	______
Neck	YES	NO	______
Breasts	YES	NO	______
Heart	YES	NO	______
Blood Pressure	YES	NO	______
Anemia	YES	NO	______
Lungs	YES	NO	______
Shortness of Breath	YES	NO	______
Pain in Chest	YES	NO	______
Heart Burn	YES	NO	______
Foods	YES	NO	______
Liver or Gallbladder	YES	NO	______
Yellow Jaundice	YES	NO	______
Hernia/Rupture	YES	NO	______
Intestines or Colon	YES	NO	______
Hemorrhoids/Piles	YES	NO	______
Blood in Bowel Movement	YES	NO	______
Bladder	YES	NO	______
Kidneys	YES	NO	______
Prostate Gland	YES	NO	______
Joints	YES	NO	______
Skin	YES	NO	______
Diabetes	YES	NO	______
AIDS	YES	NO	______
Psychological Problems	YES	NO	______
Cancer	YES	NO	______
Arthritis	YES	NO	______
TB	YES	NO	______
Epilepsy	YES	NO	______

Describe below any other information you think may be useful to your doctor: ______________________________

____

____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY ______________________________

DATE ______________________________

PATIENT'S NAME: ______________________ PHONE: ______________

ALLERGIES TO MEDICATIONS & MEDICINE/REACTION

Allergy: Metal: Yes No

Iodine: Yes No

Top/IVP

Latex Allergy: Yes No

Weight: Height:

BP: Pulse:

MEDICINES

OSTEOPOROSIS SCREEN

Hormone Replacement

Calcium Replacement

Vitamin D Replacement

Fosamax

Last Dexa Scan

SURGICAL HISTORY

MEDICAL HISTORY

SOCIAL HISTORY

Do you drive? Yes No

Do you participate in sports? Yes NO

Drink alcohol? Never/Rarely Moderately/Daily

Smoke? No Yes ______/Day

Resident Status: Permanent/Seasonal

Marital Status: S M W D

Living Status: live alone? Yes No

FAMILY HISTORY

Diabetes:	Yes	No
Heart Disease:	Yes	No
Cancer:	Yes	No
Hypertension:	Yes	No
Arthritis:	Yes	No
THR/TKR:	Yes	No

INITIALS & DATE	PT. HIST REV.
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PHYSICIAN SIGNATURE: ______________________