

The New Age of Pain Medicine



It is our pleasure to welcome you to ProActive Pain Care.

In order to assure that your first visit with us goes smoothly, we have enclosed forms to be completed prior to your appointment. These forms are necessary to assist in your care. Mailing this packet to you in advance affords you the opportunity of filling it out at home at your convenience rather than doing so in the office where all the information needed may not be as accessible. This will save you time in the office, streamline the process and avoid the inconvenience of filling out these forms at the last minute. To expedite the registration process, we kindly ask that you bring the completed forms to our office at least one day prior to your scheduled visit. This will insure that all information is entered in our computer system prior to your visit and will expedite your registration process and afford our staff the necessary time to request additional records as needed. We understand that this may be an inconvenience however it is our goal to insure that you receive the highest level of care. For your convenience our office has an after-hours mail drop to the right of our front door. If you are unable to return the packet prior to the day of your visit, kindly arrive 30 minutes prior to your scheduled appointment.

When you arrive for your initial visit and are being checked in, a member of our staff will ask for your insurance card(s) and Driver's License to scan, take your photo and have you electronically sign our HIPPA Privacy Compliance Notice. This information is collect to protect you as the patient from fraudulent activity.

Please be sure to bring the completed packet to our office at least one day prior to your scheduled appointment along with any recent (within the last 18 months) MRI, CT Scan (Cat Scan), X-ray or Physical Therapy reports. If you do not have copies, of your reports, please contact the rendering physician or facility and have them faxed to our office at 239-221-3998 prior to your appointment.

27160 Bay Landing Drive
Suite 200
Bonita Springs, FL 34135

Office 239.676.5665
Fax 239.221.3998

info@ProActivePainCare.com

ProActivePainCare.com

Again, we welcome you to our practice. If you have access to a computer, please visit our website at www.ProActivePainCare.com to find out how ProActive Pain Care can help you. Our aim is excellence in patient care and to assist our patients in any way we can.

Sincerely,
Scheduling Staff for ProActive Pain Care

Enclosures.



27160 Bay Landing Drive, Suite 200
Bonita Springs, FL 34135
Office 239.676.5665 Fax 239.221.3998
Info@ProActivePainCare.com

Michael Martinez, MD
Board Certified in Anesthesiology
Board Certified in Pain Medicine

PATIENT DEMOGRAPHIC INFORMATION

First Name	Middle Name	Last Name	Email Address
SSN	DOB	Drivers License # & State	
Address		City, State, Zip	Phone # (including Area Code)
Northern Address		City, State, Zip	Phone # (including Area Code)
Patient Cell Phone # (including Area Code)		Preferred Contact Phone # (including Area Code)	
Patient Occupation		Employer Phone # (including Area Code)	
Employer Address			

EMERGENCY CONTACT INFO

Spouse Name	Spouse DOB
Spouse Cell Phone # (including Area Code)	Spouse Work Phone # (including Area Code)
Spouse Employer & Address	
Other Emergency Contact Name, Relationship & Phone # (including Area Code)	

HEALTH INSURANCE INFORMATION

Primary Insurance Name	
Insurance Subscriber	Relationship to Subscriber
Policy Number	Group Number
Claims Mailing Address	
Phone # (including Area Code)	
Secondary Insurance Name	
Insurance Subscriber	Relationship to Subscriber
Policy Number	Group Number
Claims Mailing Address	
Phone # (including Area Code)	



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PLEASE BRING THE FOLLOWING TO YOUR APPOINTMENT ON: _____

* ALL PRESCRIPTION MEDICATION IN THEIR ORIGINAL CONTAINERS * INSURANCE CARD * ID CARD

* IMAGING FILMS/REPORTS (MRIs, X-RAYS, CT SCANS, PHYSICAL THERAPY REPORTS, ETC.)

PATIENT HEALTH HISTORY— _____, CHART # _____

For us to obtain a complete medical history, please, fill out every item as this information is very important.

Full Name _____ DOB _____ Male _____ Female _____

Social Security Number _____

Primary Physician _____ Primary MD Phone Number _____

Pharmacy Name & Address _____ Pharmacy Phone Number _____

Your Insurance Company's Preferred Lab & Phone Number _____

Is this a Workmen Comp Case NO YES Date of Injury _____

Recent Auto Accident NO YES (COMPLETE AUTO DISCLOSURE FORM) Date of Accident _____

Past Injuries/Falls—Please, list and provide dates _____

Are you CURRENTLY taking ANY medication now including prescriptions, over-the-counter or herbal medication?

NO YES (IF YES, PLEASE LIST BELOW AND INCLUDE DOSAGES) Bring ALL medications with you in their original bottles.

MEDICATION NAME	DOSAGE	TAKEN HOW OFTEN

Please, check if you are allergic to IODINE SHELLFISH LATEX

MEDICATION ALLERGIES	TYPE OF REACTION

SURGERIES—Have you had Bone, Joint or Muscle surgeries? NO YES

TYPE OF SURGERY/PROCEDURE	DATE OF SURGERY/PROCEDURE

_____, CHART # _____



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Please, list any specialists that have previously evaluated you for your pain:

Neurologist	Pain Physician
Neurosurgeon	Psychiatrist
Orthopedic Surgeon	Rheumatologist
Osteopathic Physician	Rehab/Physiatrist

TESTS: If you have had any of the following, please describe where, when and the results of your tests.

Please, bring a copy of the films/reports with you.

TEST	YES	NO	DATE	WHERE WAS IT DONE/FINDINGS
X-Rays				
CT/MRI				
EMG/NCS (Nerve Conductive Studies)				
Myelogram				
Discogram				

TREATMENTS: If you have had any of the following, please describe where, when and if it was helpful.

Please, bring a copy of the reports with you.

TREATMENT	WHEN	WHERE did you have the treatment	RESULTS of the treatment(s)/Was the treatment helpful?
Acupuncture			
Alternative/Herbal			
Massage Therapy			
Braces/Splints/Assistive Devices			
Chiropractor			
Heat/Ice Therapy			
Injection Therapy			
Nerve Blocks			
Over-the-Counter Meds			
Prescription Meds			
Occupational Therapy			
Physical Therapy			
TENS Unit			
Traction			
Biofeedback			
Counseling			
Other			

_____, CHART # _____



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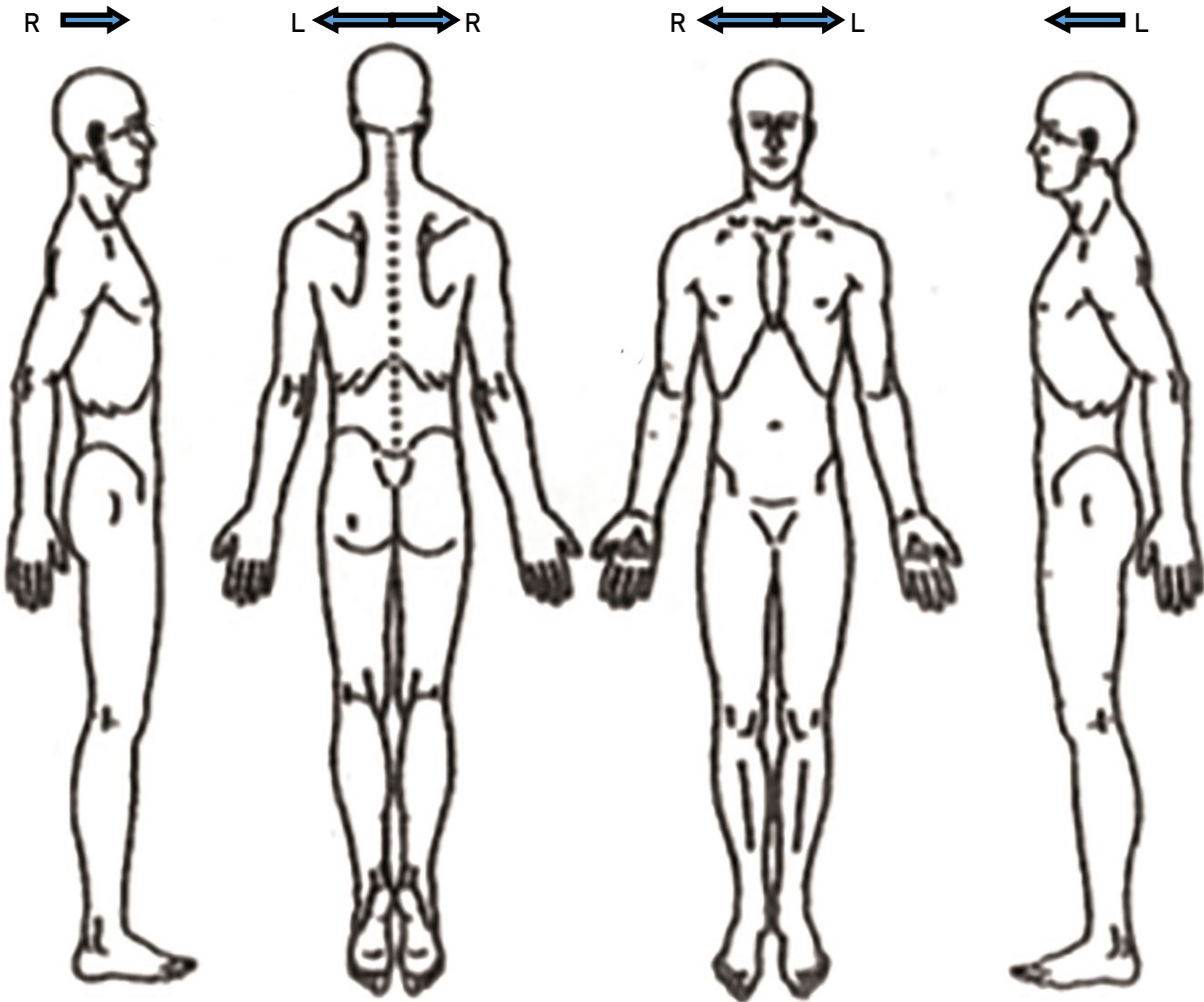
Board Certified in Pain Medicine

What is the MAIN reason you are here today to see the Physician?

Please, circle the types of pain you are having: Burning Stabbing Aching Sharp

How long have you experienced this pain? _____ Hours _____ Days _____ Months _____ Years

Please, mark the body below in the location(s) you are having pain:



Patient/Legal Guardian Signature

Date

Admitted by

_____ CHART # _____



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MEDICAL HISTORY

Do any of these Medical Issues apply to you? If so, please put an "X" in the box to the right of the issue.

Make any necessary comments in the box below the category.

HEENT			
Headaches		Dizziness	
Double Vision		Loss of Vision	
Corrective Lenses/Contacts		Pain in Eyes	
Earaches		Discharge from Ears	
Deafness/Hearing Loss		Frequent Nose Bleeds	
Sinus Problems		Smelling Sense change	
Sore Throat		Swallowing Difficulty	
Taste Difficulty		Hoarseness	
Comments:			

RESPIRATORY			
Trouble breathing		Shortness of Breath	
Asthma		COPD/Emphysema	
Sputum Production		Coughing up Blood	
Sleep Apnea		Orthopnea	
Wheezing		Respiratory Infections	
Comments:			

CARDIOVASCULAR			
Chest Pain		Poor Circulation	
Blood Clots		Irregular Heart Beat	
Thumping in the Chest		Limb Swelling	
Limb Pain on Walking		Ankle Swelling	
Feet Swelling		Varicose Veins	
PND		Phlebitis	
Comments:			

GENITOURINARY			
Incontinence		Blood in Urine	
Kidney Stones		Difficulty in Urination	
Comments:			



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GASTROINTESTINAL			
Abdominal Pain		Indigestion	
Gastroesophageal Reflux Disorder		Heart Burn	
Nausea or Vomiting		Vomiting of Blood	
Frequent Constipation		Frequent Diarrhea	
Stomach Ulcer		Painful Bowel Movement	
Chronic Bloating		Blood in Stool	
Hemorrhoids/Piles		Jaundice	
Comments:			

MUSCULOSKELETAL			
Muscle Pain		Muscle Cramp	
Muscle Twitches		Muscle Wasting	
Muscle Weakness		Muscle Pain or Tenderness	
Loss of Muscle Bulk		Neck Pain	
Shoulder Pain		Back Pain	
Joint Pain		Joint Stiffness	
Joint Swelling		Morning Stiffness	
Abnormal Joints		Limitation of Joint Movement	
Fractures		Arthritis	
Swollen Joints		Night Cramps	
Atrophy		Posture Abnormalities	
Comments:			

NEUROLOGICAL			
Seizures		Blackouts	
Trouble with Memory		Trouble Concentrating	
Gait Disturbance		Headache	
Stroke		Loss of Strength	
Fainting Spells		Memory Loss	
Involuntary Movements		Poor Coordination	
Numbness		Spasticity	
Weakness		Tremors	
Comments:			

_____, CHART # _____

FORM 01/2019—NEW PATIENT PACKET



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PSYCHIATRIC			
Anxiety		Depression	
Mood Swings		Nervousness	
Sleeping Difficulty			
Comments:			

ENDOCRINE			
Excessive Thirst		Heat or Cold Intolerance	
Excessive Urination		Thyroid Problem	
Diabetes		Polyuria	
Comments:			

HEMATOLOGIC			
Bleeding Disorder		Anemia	
Easy Bruising		Blood Transfusions	
Comments:			

SKIN			
Itching		Rashes	
Boils			
Comments:			



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AUTHORIZATION FOR USE/DISCLOSURES OF PROTECTED HEALTH INFORMATION

Patient Name

Chart #

Description of information to be used/disclosed:

Release of medical information and/or billing information

Person(s) or class of persons authorized to use/disclose the information:

ProActive Pain Care

***** Family member or friend to whom the information may be used or disclosed:

Purpose for the use or disclosure:

Continuation of treatment and Release of Medical Information and/or Billing Information

This information used or disclosed pursuant to this authorization:

_____ May / _____ May not / include information related to HIV/AIDS

_____ May / _____ May not / include information related to mental health

_____ May / _____ May not / include information related to substance abuse or alcoholism

Expiration: This authorization (put "X") in applicable box:

<input type="checkbox"/>	DOES NOT EXPIRE
<input type="checkbox"/>	Expires on (date)
<input type="checkbox"/>	Expires on the occurrence of (describe expiration event):

Important Notice: You have the right to revoke this authorization. Your revocation must be in writing to:

ProActive Pain Care, 27160 Bay Landing Drive, Suite 200, Bonita Springs, FL 34135

We will not condition the provision of health care services on whether you sign this authorization, unless your authorization is needed to provide information relating to health care related research or the health care is needed to provide health information to a third party.

You have a right to a copy of the signed authorization.

PATIENT/LEGAL GUARDIAN SIGNATURE

DATE

_____, CHART # _____



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CONTROLLED SUBSTANCE AGREEMENT

_____, CHART # _____

To be prescribed opioid medications or other controlled substances, *you must agree to the following statements:*

- I understand that the goal of using these medications is to reduce the intensity of my pain but that total pain relief is unlikely.
- I understand that the use of opioid medications is associated with a number of risks, some of which are outlined below in Part 1 of this document.
- I understand that I have a responsibility to protect myself and others from harm, and that taking the medications outside the manner in which they are prescribed can lead to dependence/abuse/death. I will not operate automobile or other dangerous equipment if there is any question as to whether my judgement, reflexes or coordination are impaired by my medications.
- I will not use any illegal drugs (such as cocaine, speed, PCP, etc.)
- I will not share or trade my medications with anyone else.
- I will not sell my medications.
- I will not obtain prescriptions for controlled substances (opioids, sedatives, sleeping pills, etc.) from another doctor or clinic.
- I will discontinue all pain medications or other controlled substances prescribed by another physician or clinic unless specifically told to do otherwise by Dr Martinez.
- I will keep my medication in a safe place, away from children, friends or pets. I understand that accidental ingestion of these medications by anyone else could be fatal.
- I understand that it is my responsibility to take my medications as prescribed. If I run out of my medications early, I realize that I will be without my medications until the next scheduled visit and I will most likely go through withdrawal, which can be very unpleasant.
- I agree to obtain all my medications from the same pharmacy.
- If I need to change my pharmacy, I agree to notify this office and have my old pharmacy forward my records to the new pharmacy.
- I agree to have my pharmacy confirm all my current and past prescription fills with this office.

_____, CHART # _____



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CONSENT FOR USE OF OPIOID MEDICATIONS AND CONTROLLED SUBSTANCES

_____, CHART # _____

- I agree to have blood/urine test to determine compliance with my pain medicine regimen. My Physician has the right to order a random drug screen test and it will be sent to a participating lab.
- I agree to unannounced "call-ins" where I can be called and asked to come into the office, bringing all medications with only 24 hours notice. I will inform the office of all medications I am currently taking. Should any other physicians including dentists prescribe any other medications for any reason, I will notify Dr Martinez by calling the office and speaking to the nurse or leaving a message on the next working day.
- I understand that it is my responsibility to keep my appointments and that missing an appointment may result in doing without my medications for a period of time long enough to induce withdrawal.
- I agree to have laboratory testing as needed, to ensure safe use of my medications. These tests may include, but are not limited to, tests of renal and liver function.
- I understand that refills of opioids and other controlled substances are made only at the time of an office visit. Controlled substances will not be refilled after regular office hours, on weekends or on holidays.
- I will give my physician and the staff permission to contact any other physician that I may see, to discuss my pain medication usage.
- I give my physician or his staff permission to contact my pharmacy to obtain information related to my medication usage.
- I understand that treatment with controlled substances will be discontinued if any of the following occur and/or my physician concludes:
 - ⇒ Medications have not produced effective relief and/or side effects are unacceptable.
 - ⇒ There is any evidence of improper use of controlled substance as defined above.
 - ⇒ I give away or sell my medications.
 - ⇒ I lose or misplace my medications or prescriptions.
 - ⇒ I do not take the medications as prescribed.
 - ⇒ I obtain opioids or other controlled substances from any other source.
 - ⇒ I abuse any other substance (narcotics, alcohol, marijuana, cocaine, etc.)
 - ⇒ I fail to abide by the statements in this consent form.
 - ⇒ I fail to follow this treatment plan.

I understand that management of pain with controlled substances may delay the diagnoses of potentially life-threatening illnesses (e.g. cancer), and thus reducing the chance of survival.

By signing below, I indicate that I have read this entire document and understand it. I consent to the use of opioids in an attempt to control pain and improve the quality of my life. I understand that my treatment with opioids and other medications will be carried out according to the rules above. I understand that if I do not follow the conditions outlined in this consent form, I can endanger my health as well as my life.

PATIENT SIGNATURE _____ DATE _____ WITNESS SIGNATURE _____ DATE _____ WITNESS NAME PRINTED _____

_____, CHART # _____



ProActive Pain Care
 27160 Bay Landing Drive
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Opioid Risk Tool

Mark each that apply Total if Female Total if Male

1. Family History of Substance Abuse	Alcohol	[]	1	3
	Illegal Drugs	[]	2	3
	Prescription Drugs	[]	4	4
2. Personal History of Substance Abuse	Alcohol	[]	3	3
	Illegal Drugs	[]	4	4
	Prescription Drugs	[]	5	5
3. Age (Mark box if 16-45)		[]	1	1
4. History of Preadolescent Sexual Abuse		[]	3	0
Psychological Disease	ADHD	[]	2	2
	Obsessive Compulsive Disorder	[]		
	Bipolar	[]		
	Schizophrenia	[]		
	Depression	[]	1	1
TOTAL		[]		

Patient Name: _____ Date: _____ Chart #: _____



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LABORATORY DRUG SCREENING CONSENT

I, _____, request that payment of authorized benefits is made on my behalf to the laboratory LabCorp, Quest Diagnostics or any laboratory used for drug screening purposes. I authorize any holder of medical or other information about me to be released to the insurance company, LabCorp, Quest Diagnostics, or other utilized laboratory, HCFA, and their agent's information to determine these benefits or any benefits for related services. I understand that I am financially responsible for all services performed by the above mentioned laboratories, whether or not they are paid by insurance. I hereby authorize LabCorp, Quest Diagnostics or other utilized laboratory to release the minimum necessary private health information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I, the undersigned, authorize LabCorp, Quest Diagnostics or other utilized laboratory or any agents thereof, to notify me by telephone, answering machine, mail, etc., regarding billing and collection information.

PATIENT CONSENT AND AGREEMENT FOR OFF-LABEL PAIN TREATMENT

REASON FOR THIS CONSENT AND AGREEMENT: All prescription drugs in the United States have a label approved by the United States Food and Drug Administration. This label provides an indication and dosing for the drug, but neither patient nor physician is legally bound to follow them. Pain treatment is virtually impossible unless the physician prescribes one of more medications that are not intended for a specific indication or dosage not listed on the drug label.

CONSENT AND AGREEMENT: The undersigned acknowledges that pain control cannot be achieved without off-label use of one or more drugs. The undersigned, furthermore, accepts all risks and complications that may occur from off-label use, since the benefit of pain control cannot otherwise be achieved. The undersigned agrees to waive all liability against the physician and clinic that provide pain treatment.

SPECIFIC OFF-LABEL USES: Any and all off-label use of drugs are covered by this consent including, but not limited to the following:

1. The uses of antidepressants, anti-epileptics, muscle relaxants, tranquilizers, and nutraceuticals for pain relief.
2. The administration of sustained release preparations of morphine and oxycodone used more frequently than every 12 hours.
3. Maximal dosage of opioids is to be determined by therapeutic effect rather than any arbitrary published maximal dosing level.
4. Topical use of morphine, methadone, naloxone, carisoprodol, and ketamine.

I, the undersigned, agree to the above and release the physician and clinic of all liability for off-label use of drugs.

PERMISSION TO PHOTOGRAPH

I agree to allow ProActive Pain Care to digitally reproduce my image into my file as a means of identification. I understand that this is for my personal protection so that others may not impersonate me.

By signing this consent form, I declare that I have read the above consents: Laboratory Drug Screening, Off-Label Pain Treatment and Permission to Photograph. Furthermore, by signing below, I consent to the items listed on this form.

PATIENT SIGNATURE

DATE

_____, CHART # _____



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PATIENT INFORMATION AND FINANCIAL RESPONSIBILITY POLICY

WELCOME to our practice. Our ultimate goal is to treat the source of your pain when possible to minimize its impact on your life and help you return to a more functional and productive lifestyle. The following statement is to educate you with information relevant to our office policies, your treatment and financial responsibility. We ask that all patients read and sign our Policy Statement prior to seeing a medical care provider. If you have any questions or concerns about our policies, please do not hesitate to ask our business office personnel.

TREATMENT PLAN: Your Physician will discuss your treatment plan in detail. Patients are encouraged to participate in the progress of their treatment. Increasing your knowledge of your diagnosis and the treatment received will aid in learning how to cope with your pain and improve your day to day activities. A clinical chart is maintained with Physician dictation describing your diagnosis, treatment plan, the progress with treatment, dates of and fees for our services. Copies of Physician's dictation are available for a small fee.

PRESCRIPTION ISSUES: All medication refill issues will be addressed at scheduled appointments. Medications will not be dispensed between appointments. Patients experiencing reactions to medications and/or questions regarding prescribed medications may leave a message on the Nurse's answering line. All messages received are reviewed by our Nursing staff and addressed with Physicians. Phone messages are returned during or by the end of regular clinic hours the day they are received.

APPOINTMENTS: It is important that you arrive on time for your scheduled appointment. Failure to arrive on time may result in your appointment being rescheduled and a fee assessed. In the event of an emergency, we advise you to call 911 or go to the nearest emergency facility. Scheduling changes may be made by calling (239) 676-5665. If you are unable to meet your appointment, we ask that you call and provide us with 24 hours notice; failure to provide 24 hours notice, will result in assessed fees as outlined below.

\$50.00 for failure to provide 24 hours notice resulting in a missed non/procedure appointment.

\$50.00 for not arriving on time for a non/procedure appointment, resulting in a rescheduled appointment.

\$75.00 for failure to provide 24 hour notice resulting in a missed procedure appointment.

\$75.00 for not arriving on time for a scheduled procedure, resulting in a rescheduled procedure.

ProActive Pain Care reserves the right to adjust these fees from time to time.

FEES: We accept assignment with most major insurance companies and participating provider plans. However, you must understand that regardless of your medical insurance coverage. You are responsible for payment of your account and are expected to pay your co-pay and any patient level balance due at the time of each visit.

Fees for services, along with unpaid deductibles and co-payments, are due at the time of service and will be collected at check-in. We do not accept post-dated checks. Failure to pay your co-payment at time of service will result in a \$25.00 fee being added to your account.

Your insurance policy is a contract between you, your insurance company and/or your employer. We are not a party to that contract. Therefore, it is your responsibility to insure that your claims are paid. If your insurance company does not pay your balance in full within 30 days, we ask that you work with our billing staff by calling your insurance company to facilitate payment. Our staff will work with you to resolve any claim payment issues.

Returned checks will be subject to \$35.00 collection charge and may result in our office requiring payment by cash, credit card or money order for future visits.

Unpaid balances over 90 days may be subject to collections via Small Claims Court, attorney, and/or collection agency with applicable collection fees. All collection fees are the responsibility of the patient.

_____, CHART # _____



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We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate with our Business Office about any such problems so that we can assist you in the management of your account.

INSURANCE

Private/Government Insurance: As a courtesy, our billing office will file a claim with your private or government carrier. You are responsible for the following:

Providing our office with accurate and correct insurance information and notifying our billing office of any changes to your insurance coverage prior to your visits. Failure to notify us in advance of any changes to your insurance coverage will require that we bill you for payment of our charges.

If your insurance is unable to process and pay your claim due to missing information from you, you will be responsible for payment of the charges.

Workers Compensation: We will file an insurance claim with your employer’s workers compensation carrier. If your employer denies your claim, and you have provided us with health insurance information, we will file your claim to your health insurance carrier. Involvement of legal counsel will not mitigate your responsibility for your charges. You are ultimately responsible for payment of services provided to you.

Auto Insurance: We will file a claim to your auto insurance carrier. Once benefits have been exhausted, we will then bill your health insurance. If you do not have health insurance coverage, you will be responsible for unpaid balances and any future treatment. Involvement of legal counsel will not mitigate your responsibility for payment as we do not accept letters of protection from attorneys.

THANK YOU. We are committed to providing you with the highest quality health care and hope you find your visit beneficial and our staff friendly and compassionate.

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to ProActive Pain Care, the medical and/or surgical benefits I am entitled from my insurance company(s) and/or Medicare. This authorization is in effect for all future claims until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above Policies as outlined in this document. I understand that I am financially responsible for all charges incurred for my medical treatment including laboratory test charges and x-ray charges incurred on my behalf for care rendered. These charges will be in addition to charges for the care that the personnel of ProActive Pain Care provide. I further understand I may receive separate bills for each of these services, and that I am financially responsible for any services not covered by third party payors, including but not limited to my health insurance and/or managed care plans. I have had the opportunity to ask and have my questions answered to my satisfaction.

PATIENT ACKNOWLEDGEMENT: I HAVE BEEN PROVIDED WITH A COPY OF THIS NOTICE. Failure to read this notice does not negate my responsibilities as outlined above.

PATIENT/LEGAL GUARDIAN SIGNATURE

DATE

_____, CHART # _____

FORM 01/2019—NEW PATIENT PACKET



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HIPPA Notice of Patient Privacy Practices & Acknowledgement

- ProActive Pain Care is structured as an organized healthcare arrangement, which allows for the sharing of protected health information among groups and services listed in the Notice to carry out services for Treatment, Payment or Healthcare Operations.
- *Your protected health information may be released:*
 - ⇒ To other healthcare professionals for the purpose of providing you with quality healthcare. Providing this health information will assist in coordinating the care you need, such as prescriptions, blood work, x-rays or other diagnostic tests.
 - ⇒ To your insurance provider for the purpose of P APC receiving payment for providing you with needed healthcare services.
 - ⇒ In connection with our healthcare operations, P APC might share your health information to perform an evaluation of our quality of services provided to you at your office visits. P APC might share health information among outside agencies for review and certification or licensing of our services provided.
 - ⇒ To public or law enforcement official in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
 - ⇒ To other healthcare providers in the event you need emergency care.
 - ⇒ To a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
 - ⇒ Only after receiving written authorization from you for treatment, payment or healthcare operations. You may revoke your permission to release protected health information at any time. It must be in writing with effective date and be specific to the health information being protected. P APC is not required to agree to your request if action has already been taken or if your authorization was obtained as a condition for obtaining insurance coverage and the law gives the insurer the right to contest a claim.
- You may be contacted by P APC by phone, mail or by leaving a message on an automated answering device to remind you of appointments, to schedule appointments, verify insurance or demographic information or inform you of test results. You have the right to request a more confidential way of providing this information at the time of your initial appointment. P APC will honor all reasonable requests.
- *You have the right:*
 - ⇒ To request a restriction on the use of your protected health information. However, P APC may choose to refuse your restriction if it is in conflict with providing you with quality healthcare or in the event of an emergency situation.
 - ⇒ To receive confidential communication about your health status. P APC might disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, your location or your general health condition or death. P APC will also use our professional judgment and our experience with common practice to make reasonable decisions when releasing your health information that is directly relevant to the person's involvement in your health care.
 - ⇒ To review and photocopy any/all portions of your health information. P APC has the right to assess a fee for the photocopying of the health information.
 - ⇒ To request an amendment to your health information. It must be in writing and explain why the information should be amended. P APC can deny the amendment and if so, a written explanation will be provided.
 - ⇒ To know who has accessed your protected health information and for what purpose other than for treatment, payment, healthcare operations, and other activities or those disclosures directly authorized by you. P APC requires that the request for accounting of the disclosures be in writing.
 - ⇒ To possess a copy of this Statement of Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- P APC is required by law to protect the privacy of its patients. It will keep protected any and all patient health information and will provide patients with a list of duties or practices that protect health information upon written request.
- P APC will abide by the terms of the notice currently in effect.
- You have the right to complain to P APC if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your written complaint to: ProActive Pain Care, 27160 Bay Landing Drive, Suite 200, Bonita Springs, FL 34135.
- All complaints will be investigated. No personal issue will be raised for filing a complaint with ProActive Pain Care.
- You may also submit a written complaint to: Region IV, Office of Civil Rights, US Dept of Health and Human Svcs, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street SW, Atlanta, GA 30303-8909.

By electronically signing this form, you are acknowledging that a staff member of ProActive Pain Care has explained how your protected health information will be handled in various situations and a copy of this statement will be provided upon request.

PATIENT/LEGAL GUARDIAN SIGNATURE

DATE

_____, CHART # _____

FORM 01/2019—NEW PATIENT PACKET



27160 Bay Landing Drive, Suite 200
Bonita Springs, FL 34135

Office 239.676.5665 Fax 239.221.3998
Info@ProActivePainCare.com

Michael Martinez, MD

Board Certified in Anesthesiology

Board Certified in Pain Medicine

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PLEASE FAX MEDICAL RECORDS TO: 239-221-3998

To:

I hereby authorize the above name Facility/Physician to release my medical records to ProActive Pain Care. I also give permission for the following to be disclosed: acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV); behavioral health services/psychiatric care; treatment for alcohol and/or drug abuse.

Please, send the following specific information:

- 1) Office visit notes from the Patient's last two appointments
- 2) Diagnostic Reports
- 3) MRI/CT or X-ray reports
- 4) Medication Flow Sheet
- 5) Other _____

The medical facility, its employees, officers, and physicians are released from legal responsibility or liability for the release of the medical record to the extent indicated and authorized herein. I understand that the medical record maintained by the doctor may contain medical and administrative information from other healthcare providers.

PATIENT/LEGAL GUARDIAN SIGNATURE

DATE

PATIENT DOB

RELATIONSHIP TO PATIENT, IF NOT SIGNED BY PATIENT.

_____, CHART # _____



27160 Bay Landing Drive, Suite 200
Bonita Springs, FL 34135
Office 239.676.5665 Fax 239.221.3998
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Michael Martinez, MD

Board Certified in Anesthesiology

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To Our Valued Patients,

The practice of Pain Management has been forced to undergo some changes over the past year. Due to the increasing problems of controlled substance abuse and diversion, the state of Florida has seen a tremendous increase in prescription drug related deaths. Along with this increase, the rate of abuse has also increased ten-fold.

The State of Florida has passed a new law (Senate Bill 2722) to attempt to control prescription drug abuse. In conjunction with this law, the Florida Board of Medicine has implemented new guidelines to monitor pain management patients and clinics. These new laws and guidelines went into effect October 1, 2010. Our practice fully supports these guidelines and will abide by them. This is being done for the welfare of the citizens of our community and state.

Please be aware that these new guidelines include:

1. More frequent urine drug testing
2. Restrictions on the number of prescriptions that physicians may write
3. No phoning-in to pharmacies of controlled substances
4. A face-to-face encounter for every controlled substance prescription written
5. Psychological evaluations may be necessary for ongoing care in certain patients
6. Appointments for controlled substance prescriptions will be more frequent

It is imperative that these measures be implemented to insure that we physicians may continue to care for our patients. We understand your potential frustration with these guidelines. There are many more guidelines that this practice must follow to meet the requirements of the Department of Health.

If you have any questions, we will be happy to sit down and discuss them with you. We thank you in advance for your understanding.

Sincerely,

Michael Martinez

Michael D Martinez, MD