**Patient Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  |  |  |
|  | Last | First | Middle |

|  |  |  |  |
| --- | --- | --- | --- |
| Home Address |  | | |
|  | Street |  |  |
|  |  |  |  |
|  | City | State | Zip |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone Number | ( ) | Cell Number: | ( ) |

|  |  |
| --- | --- |
| Email Address |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of Birth | / / | Age: |  | Social Security Number | - - |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Sex: |  | Male |  | Female | Race: |  | (W) |  | (B) |  | (H) |  | (A) |  | (I) |  | (O) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| |  |  |  |  | | --- | --- | --- | --- | | Patient’s Employer: |  | Occupation: |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| Employer’s Address: |  | Phone Number: | ( ) |

|  |  |  |  |
| --- | --- | --- | --- |
| Emergency Contact: |  | Phone Number: | ( ) |

|  |  |
| --- | --- |
| Relation: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Pharmacy Name |  | Phone Number: | ( ) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pharmacy Address |  |  |  |  |
|  | Street | City | State | Zip |

**Insurance Information:**

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a secondary insurance provider? Yes No

Who may we thank for your referral? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DESCRIPTION OF PAIN**

Where is your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your pain begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What caused your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times have you been hospitalized for your pain problem? When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times have you been to the emergency room for your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which Emergency Room: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What operations or other surgeries have you had in the past for any reason?

Treatments/Operations Date Results

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

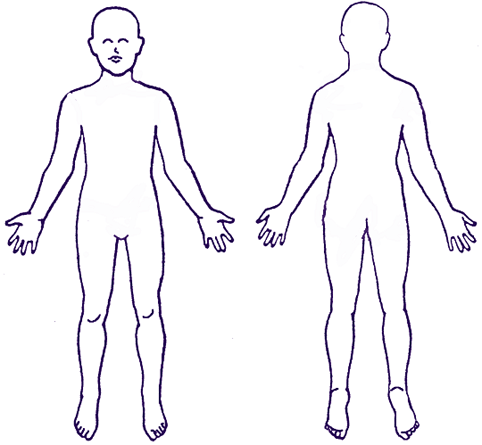
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate where you feel pain.

Please list all the medications you are now taking.

Medication Name Dose Per Day



\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Medications you have taken in the past:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Drug reactions or allergies you have had:

Name of Drug Reaction

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any of the following?

MRI CT Scan X-ray Other:\_\_\_\_\_\_\_\_\_\_

If so, please state the date and where you had them done: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Please list other medical problems that are not related to your current pain problem.

Problem Date Treatment

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you receiving workers compensation payments? \_\_\_\_Yes \_\_\_\_No

Has your workers compensation case been settled? \_\_\_\_Yes \_\_\_\_No \_\_\_\_NA

What degree of disability was awarded? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, what was the status of your case? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has there been any legal action related to your pain problem? \_\_\_Yes \_\_\_No

If yes, what sort of legal action? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the status of this legal action? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your attorney’s name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you were treated regularly at Advanced Pain Care, would transportation to the clinic be a problem for you? \_\_\_Yes \_\_\_No

If yes, what sort of problem?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your pain the result of: Auto Accident Injury at Work

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information provided and have completely answered all questions to the best of my ability. I certify this information is true and correct to the best of my knowledge. I will notify you of any change in my status or the above information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian/Health Surrogate (if applicable)

BILLING AUTHORIZATION

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the undersigned patient hereby agrees and directs Stanley R. Dennison Jr., MD, MBA and Advanced Pain Care, Inc. to mail or otherwise send billing statements and invoices and related correspondence for Stanley R. Dennison Jr., MD, MBA and medical services provided to patient directly to the patient and the patient’s attorneys and other professionals who contact Stanley R. Dennison Jr., MD, MBA or Advanced Pain Care, Inc., even if such statements or invoices are not requested. The undersigned patient agrees and directs Stanley R. Dennison Jr., MD, MBA and Advanced Pain Care, Inc. to send to patient and patient’s attorneys gross, total, balance and other statements and invoices, and patient agrees to cooperate with and assist Stanley R. Dennison Jr., MD, and Advanced Pain Care, Inc. in the collection of all of Stanley R. Dennison Jr., MD, MBA’s and Advanced Pain Care, Inc.’s statements and invoices. The undersigned patient specifically agrees that Stanley R. Dennison Jr., MD, MBA and Advanced Pain Care, Inc. are authorized to mail or otherwise send billing statements and invoices and related correspondence directly to the patient and patient agrees that these invoices and billing statements may be used for the purposes of collecting a debt from patient, patient’s attorneys or other third parties. The undersigned patient specifically waives any claim or defense against Stanley R. Dennison Jr., MD, MBA and Advanced Pain Care, Inc. and their respective agents and attorneys that the mailing or sending of the above-described invoices, statements and/or related correspondence violate any state or federal statute, including but not limited to Chapter 559, *Florida Statutes*, and the Fair Debt Credit Collection Act. The undersigned patient specifically agrees that he has agreed to the disclosure by Stanley R. Dennison Jr., MD, MBA and Advanced Pain Care, Inc. and their respective agents and attorneys of all such invoices, billing statements and related correspondence. The undersigned patient hereby agrees to indemnify and hold harmless Stanley R. Dennison Jr., MD, MBA and Advanced Pain Care, Inc. and their respective agents from any and all claims by patient or patient’s agents or any other third party for sending such invoices, billing statements and related correspondence, including any claims that such actions violate any state or federal statute, including but not limited to Chapter 559, *Florida Statutes*, and the Fair Debt Credit Collection Act. Patient agrees and hereby directs patient’s attorney to fully cooperate with and assist Stanley R. Dennison Jr., MD, MBA and Advanced Pain care, Inc. in collecting all such billing statements and invoices, including contacting third party payors to arrange for payment of Stanley R. Dennison Jr., MD, MBA ’s and Advanced Pain Care, Inc.’s statements and invoices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian/Heath Surrogate Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

**DOCTOR’S LIEN**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Accident: Auto: \_\_\_\_\_\_\_ W/C: \_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_

Amount to Date: **To be applied at a later date**

I hereby give a lien to Advanced Pain Care, Inc. for services rendered to me on any settlement, judgment, and verdict or otherwise as a result of the accident/injury which occurred on the above date. I authorize my attorney, to pay directly to Advanced Pain Care, Inc. such sums as may be due and owing to him for services rendered to me and to withhold such sums from any settlement, judgment, verdict or otherwise as are necessary to protect said Doctor accordingly.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Patient’s Signature

The undersigned, being attorney of record for above patient, does hereby acknowledge receipt of the above lien and does hereby agree to honor same in order to adequately protect Advanced Pain Care, Inc. under this lien be paid prior to the payment of any sums to the above patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Attorney’s Signature

**I understand that the lien amount at settlement time will include interest of 1 ½% per month accrued after ninety (90) days of the billing period from the date of my settlement.**

**DOCTOR-PATIENT AGREEMENT**

This agreement is made between Dr. Stanley R. Dennison Jr., M.D, MBA ./Advanced Pain Care, Inc., other medical physicians, physician assistants, their agents, employees, servants, or any of the foregoing, referred to hereinafter as the “Doctor” and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ referred to hereinafter as the “Patient.” It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representatives, guardians or any persons deriving their claims through or on behalf of the patient.

It is further understood that in the event of any controversy or dispute which might arise between the doctor and the patient, regardless of whether the dispute concerns the medical care rendered, or payment of fees, or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provide by the Florida Arbitration Code, Chapter 682, Florida Statutes. This arbitration shall be binding. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. Each party shall be entitled to the discovery provided for under Rules 1.280-1.390, Florida Rules of Civil Procedure. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court of competent jurisdiction in and for Hillsborough County, Florida. Request for arbitration by either party must be made within the time frame set forth in section 95.11 of the Florida Statutes dealing with medical malpractice.

This agreement shall remain in effect for all treatment and/or surgery provided the patient presently and at any future date.

In witness whereof, I (we) have set our hands this date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Doctor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Agent Patient Signature

Advanced Pain Care, Inc.

1921 West Dr. Martin Luther King Jr. Blvd Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tampa, FL 33607 ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(813) 873-0102 phone Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(813) 489-7017 fax

I hereby assign, instruct, and direct any and all benefits payable by Patient’s insurance or healthcare plan(s) as a result of charges incurred by Patient for services rendered by this Provider be made payable to:

Advanced Pain Care, Inc.

1921 West Dr. Martin Luther King Jr. Blvd

Tampa, FL 33607

and mailed to Provider address. Or, if my current policy prohibits direct payment to Provider, I hereby also instruct and direct you to make out the check for this claim payable to me and mail it to the temporary address as follows:

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c/o Advanced Pain Care, Inc.

1921 West Dr. Martin Luther King Jr. Blvd

Tampa, FL 33607

In the event \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ receives any check, draft, or other payment subject to this Agreement, such monies will be held in trust for Provider. Patient will immediately deliver said check, draft, or payment to Provider. Any violations of this agreement will, at Provider’s election, terminate Patient charge privileges with Provider and bring any balance owed by Patient to Provider immediately due and payable.

For the professional or healthcare expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the Provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Policyholder Patient /Guardian Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dated Witness

**Simple Agreement**

**Patient authorizes the Doctor to deposit checks received on patient’s account when made out to the Patient.**

Dated at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ this \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_\_\_\_

(Time) (Month) (Day) (Year)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Policy Holder Signature of witness

**Notice of Privacy Practices**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY.**

Our commitment here at Advanced Pain Care, Inc. is to serve our customers with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

* During treatment, we may find it necessary to acquire a laboratory analysis.
* During treatment, we may find it necessary to schedule you for a procedure.
* For payment purposes, we may use the services of a billing service.
* During health care operations, we may need a second opinion.

We here at Advanced Pain Care, Inc. are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, Information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer at (813) 876-7600.

I have read and understand the above and have been given a complete Notice of Privacy Practices for my records upon request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian/Health Surrogate (if applicable)

**Confidential Prescription Information – Authorization of Release**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_\_\_\_

Parent or Legal representative (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize all pharmacies and insurers as may have access to my medication history for the past two years as may exist in a privacy respecting database to release information to Advanced Pain Care, Inc. Optimizing our ability to care for you and lowering your risk of adverse reaction of medications and other treatment is the goal of obtaining your medication information. This consent grants permission to health care providers, pharmacists and the active staff of the above named prescription data management services to release a list of all medications for which these entities have medication records that may be of personal and private nature. Note that these databases may be incomplete if your pharmacy does not participate in database sharing. Neither will this list include over-the-counter medications and supplements/vitamins which you use. This list will not contain information on how well you utilized the prescriptions or why you may have stopped the prescription. To the degree you have supplied allergy information, this database should provide an allergy list but if you have developed an allergy which you have not told a participating pharmacy service about, it will not be listed. Thus, we still need you to bring us a list of ALL medications and supplements which you use and a complete list of your allergies, including the type and degree of allergic reaction you experienced. Please sign below indicating all prescription information is to be released.

The patient or legal representative my revoke this consent at any time by written notice to Advanced Pain Care, Inc. Returning a copy of this notice with a signature on the next line is sufficient: Authorization Revoked: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Revoking this release of information consent will not have any effect on any information already used or disclosed before the written notice is received. This authorization form expires on Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or when the above specified information has been transmitted/received, or not later than one year from the signed date of signature. The patient/legal representative may inspect and/or request a copy of all medical records by a copying charge will be assessed. The patient/legal representative may refuse to sign or to allow the above specified information to be released or transmitted with recognition that lack of information can affect diagnosis and treatment. The physician will not refuse to care for a patient without this information unless it is viewed by a physician to be critical information in which the physician may suggest an alternative provider.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient /Legal Representative Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

We, the staff of Advanced Pain Care, Inc. thank you for choosing us as your healthcare/health provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and building a successful provider-patient relationship with you and your family. We believe your understanding of our patients’ financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact Beverly Dennison at (813) 873-8700.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients. Please understand that payment for services is an important part of the provider-patient relationship.

In order to keep our costs reasonable we require payment at the time of service unless our staff has approved payment arrangements in advance. We make payment as convenient as possible by accepting (Cash, Money Order, MasterCard, Visa, and in-state checks). A $35.00 service fee will be charged for all returned checks. You may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

**Interest**

Interest will incur if a balance remains unpaid after 60 days.

**Insurance**

Please remember that your insurance policy is a contract between you and your insurance carrier. We have found that insurance companies may try to limit or dictate the services, or level of service a provider can offer to their patients. In order to avoid this intrusion in the doctor-patient relationship we do not contract with. This leaves the provider of service and the patient with a direct relationship and the opportunity to make the final decision as to which treatments are most beneficial for the patient.

We have found that insurance carriers will request needless and redundant information from a provider of service much more frequently than a patient. If you have insurance we will bill your carrier. Any requests for additional forms from your insurance company will gladly be accommodated for a fee. This includes records, reports, tests, etc. We will provide you with the additional information to submit to your insurance company so there can be no doubt in your mind that we are complying with their request.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, the guarantor is responsible for all out-of-network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

**Missed Appointments**

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance, a missed appointment fee may apply. These fees are typically $100.00 for initial evaluation and $75.00 for subsequent appointments. Repeated missed appointments without notification may cause you to be discharged from the facility so that we can provide care to other patients.

**Medical Records Fees**

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files, and or summaries.

**Timeliness of Appointments**

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs.

We realize that temporary financial problems may affect timely payment of your account. If this should occur please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

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Signature of Insured or Authorized Representative: Date:

**THIRD PARTY LIABILITY**

By signing below I acknowledge my understanding that if I receive treatment as a result of a third-party liability injury (for example: motor vehicle accidents, premises liability, or other general liability claims against third parties), the balance for services rendered is considered due in full at the time of the service unless a valid letter of protection from an attorney as a guarantee of payment or assignment of third party insurance payments (PIP, MedPay). Advanced Pain Care, Inc. cannot act as administrator to resolve financial arrangements. We may agree to bill a third party insurance company of an at-fault party involved in an accident as a courtesy to you. To bill your claim directly, you must provide us all necessary information to confirm coverage for these payments with the auto/third-party carrier. **We will not collect information about your personal medical insurance, No healthcare insurance will be billed while under a Letter of Protection.** Regardless of whether we submit your claim to third-party insurance, as the patient, you are ultimately responsible for payment.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information provided and have completely answered all questions to the best of my ability. I certify this information is true and correct to the best of my knowledge. I will notify you of any change in my status or the above information. Furthermore, I agree that this office **will not collect information about my personal medical insurance, and that No healthcare insurance will be billed while under a Letter of Protection.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian/Health Surrogate (if applicable)

**REQUEST AND AUTHORIZATION OF MEDICAL RECORDS**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hereby request and

(PATIENTS NAME)

D.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorize that my medical records be released to:

Stanley R. Dennison, Jr. M.D., M.B.A

Geoffrey Jones M.D.

Advanced Pain Care, Inc.

If records are to be faxed, I understand that possible transmission errors may occur although every precaution will be taken to prevent this from happening. I hereby release Advanced Pain Care, Inc from any liability should this occur.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

**AUTHORIZATION FOR ALL PATIENTS**

I authorize the release of any medical information necessary to process for private insurance and request payment of insurance benefits to Advanced Pain Care, Inc.

I understand that my insurance will be filed as a courtesy to me. I agree to be responsible for payment of charges for services rendered to me by Stanley R. Dennison, Jr., MD, MBA. The fact that I may have insurance does not release me of my personal responsibility of payment. I understand that if my insurance has not made payment within 60 days I will be billed and responsible for the balance of the account.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature

**FOR MEDICARE PATIENTS ONLY**

Medicare part B Signature Authorization

I authorize any holder of medical or other information about me to be released to the social security administration and health care financing administration or its intermediaries or carriers, or to the billing agent or the physician or supplier, any information needed for this or related Medicare claims. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment.

Medicare will only pay for services that determine to be reasonable and necessary under section 1862(a) of the Medicare law. Although it would otherwise be covered, if Medicare determines that a particular service is not reasonable and necessary, Medicare will deny payment for that service. We believe that, in your case, Medicare may be likely to deny payment for one of the following reasons: Diagnosis and/or frequency of exam. The staff of Dr. Dennison does not have prior knowledge of said services being performed within the past 6 months.

I have been notified by Advanced Pain Care, Inc. that in my case, Medicare may be likely to deny payment for the services identified above, for the reason stated. If Medicare does deny payment, I agree responsible for payment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature