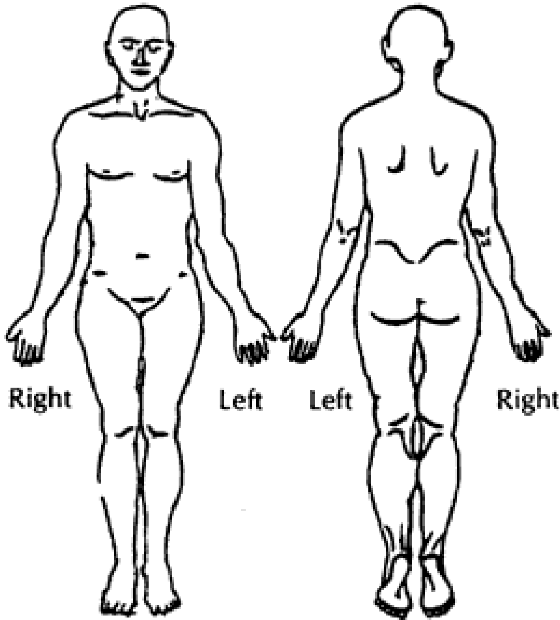
NEW PATIENT EVALUATION

Date:	**Patients Name**:	**DOB**:
Name of Referring Physician:		
Age:	**Place of Employment**:	**Current Position**:
City of Residency:	**How long**?	
Pain Location:		
Is pain local or does it extend to the other locations:		
Consistency of Pain (Consistent / Daily / Intermittent / How often?):		
Character of Pain (Aching / Burning / Sharp):		
Is there numbness, tingling or weakness associated with the pain?		
Is there loss of bowel or bladder control? Yes/No	**Blood in urine or stool?** Yes or No	**Headaches?** Yes/No
What makes pain worse?		
What makes pain better?		
Severity of Pain? 0 = No Pain--------------5=Moderate Pain----------------10=Worst Pain		
When did the pain start?	**Recently?**	**Number of years ago?**
When was your last MRI? **Facility:**	**X-Ray?**	**Facility:**
Bone scan? **Facility:**	**CT?**	**Facility:**
Past treatment for pain: Last set of injections:	**Last Surgery:**	
List all surgeries and date:		
Do you have a chronic illness? Diabetes: Yes/No **Hypertension:** Yes/No **COPD:** Yes/No **CHF:** Yes/No		
Other illness:		
Marital Status: Single / Married / Widowed / Divorced	**How many years?**	
Have you in the past or do you presently use: Tobacco: Yes/No	**How many years?**	**How often?**
Alcohol: Yes/No How many years? **How often?**	**Other Drugs:** Yes/No	**How often?**
Parents Living or Deceased?	**Cause of Death?**	
History of cancer or heart disease in parents or family?		
ADL Functions: In a typical day how many hours can you manage these activities:		
SIT 0-1 1 2 3 4 5 6 7 8	**STAND** 0-1 1 2 3 4 5 6 7 8	**WALK** 0-1 1 2 3 4 5 6 7 8
Have the ease of performing these activities improved?		
Walk Unassisted? Yes/No **Drive a Car?** Yes/No	**Mop/Sweep?** Yes/No	**Shower Unassisted?** Yes/No
Brush Teeth/Hair? Yes/No **Climb Stairs?** Yes/No	**Do Dishes?** Yes/No	**Use Bathroom Unassisted?** Yes/No

RIGHTPATH™
PAIN & SPINE CENTERS

Date: Patients Name: DOB:



WHERE IS YOUR WORST PAIN?

*****If injury case please fill out below**

DATE ACCIDENT:__________________

WHERE WAS THE ACCIDENT? CIRCLE THE SELECTION
CITY, INTERSECTION, PARKING LOT
WERE YOU THE DRIVER? YES/NO **PASSENGER** YES/NO
WERE YOU RESTRAINED? YES/NO
POINT OF CONTACT? REAR ENDED, T-BONED
DID YOU LOSE CONSCIOUSNESS? YES/NO
WERE YOU HOSPITALIZED? YES/NO
DID AIR BAGS DEPLOY? YES/NO
TREATMENT SO FAR: YES/NO CHIROPRACTIC, PT, INJECTIONS, SURGERY

(BELOW IS FOR STAFF TO COMPLETE)

Physical Exam: General: Height: Weight: BMI:
BP: / HR: R: HEART: Lungs: ABD:
Musculoskeletal:
Ambulation: Stable / Antalgic Limp: Yes/No **Which Leg?**
Strength: RUE: 1 2 3 4 5 **LUE:** 1 2 3 4 5 **RLE:** 1 2 3 4 5 **LLE:** 1 2 3 4 5
Extremity ROM: Strength: RUE: 1 2 3 4 5 **LUE:** 1 2 3 4 5 **RLE:** 1 2 3 4 5 **LLE:** 1 2 3 4 5
ROM: Cervical Spine: Full / Limited / Immobile
Lumbar Spine: Full / Limited / Immobile
Impression:
Plan:

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PAIN & SPINE CENTERS

MEDICATION LOG Please list ALL current medications including over the counter and supplements					
Name:			**DOB:**	**Phone:**	
Pharmacy:					
Allergies/Reactions:					
Date Prescribed	**Medication**	**Dosage**	**Instructions**	**Prescribing Physician**	**Discontinued Date**

The Dos and DON'Ts of Extended-Release / Long-Acting Opioid Analgesics

DO:

- Read the Medication Guide
- Take your medicine exactly as prescribed
- Store your medicine away from children and in a safe place
- Call your healthcare provider for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088

Call 911 or your local emergency service right away if:

- You take too much medicine
- You have trouble breathing, or shortness of breath
- A child has taken this medicine

Talk to your healthcare provider:

- If the dose you are taking does not control your pain
- About any side effects you may be having
- About all the medicines you take, including over-the-counter medicines, vitamins, and dietary supplements

Take your Opioid pain medicine exactly as prescribed by your healthcare provider

DON'T:

- Do not give your medicine to others
- Do not take medicine unless it was prescribed for you
- Do not stop taking your medicine without talking to your healthcare provider
- Do not break, chew, crush, dissolve, or inject your medicine. If you cannot swallow your medicine whole, talk to your healthcare provider
- Do not drink alcohol while taking this medicine

Every time you see your healthcare provider and tell him/her:

- Your complete medical and family history, including any history of substance abuse or mental illness
- The cause, severity, and nature of your pain
- Your treatment goals
- All the medicines you take, including over-the-counter (non-prescription) medicines, vitamins, and dietary supplements
- Any side effects you may be having

RIGHTPATH™
PAIN & SPINE CENTERS

INFORMED CONSENT FOR THE USE OF OPIOID (NARCOTIC) MEDICATION FOR PAIN CONTROL

1. The use of opiates is not to completely eliminate pain, rather the medication is used to help decrease pain and increase level of function.
2. Opiates will be prescribed by a single physician and filled by one pharmacy, which must be documented. The physician(s) at this practice will be the one in control of dosing. Obtaining opiates from another provider and "doctor shopping" is unacceptable.
3. At each visit, the patient must provide a self-report of pain relief, side effect, adverse effect of treatment, and function. Side effect includes, but not limited to: over-sedation, nausea, vomiting or euphoria "high" feeling.
4. Opiate therapy may result in physical dependence, tolerance and/or addiction.
5. Physical dependence involves withdraws if opiates are stopped abruptly. Withdrawal is not a dangerous problem, but may cause significant physical discomfort.
6. Tolerance is a condition in which the patient develops a need for a higher opiate dose to maintain the same pain control. This condition can be managed by switching to a different opiate. If tolerance becomes unmanageable, the opiate will be tapered and discontinued.
7. Addiction is infrequent in patients who have been diagnosed with an organic problem causing chronic pain. Psychological addiction is when an individual abuse the medication to obtain a "high". This is recognized when a person exhibit drug-craving behavior, seeking medication from other doctors "doctor shopping", the medication is quickly escalated without correlation with pain relief, and/or when the patient shows a manipulative attitude towards the physician/provider in order to obtain the drug. This will result in immediate discharge from the practice.
8. The use of opiates can result in drowsiness, sedation, or dizziness and he/she should not drive a motor vehicle, or operate heave machinery. This can jeopardize his/her or other individuals' lives.
9. Withdrawal symptoms can occur if opiate use is abruptly stopped. Symptoms can occur 24 to 48 hours after the last dose and include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot or cold flashes (goose bumps), abdominal pain, nausea/vomiting, and /or diarrhea.
10. Patients who are prescribed opiates will consent to a random urine drug screen and pill count at the discretion of the prescribing physician. Among other considerations, the absence of prescribed medications in a urine drug-screen may result in discharge from the practice.
11. The patient will not engage in aberrant behavior which includes: selling or lending of medication, altering prescription, obtaining unauthorized prescription, using illegal street drugs including marijuana, and self escalating dosages. ***Marijuana is considered a DEA Schedule 1 drug and is illegal on the federal level!***
12. The patient should not take other drugs including tranquilizers, stimulants, benzodiazepines or sedatives without first consulting the physician/provider. The patient should not use alcohol when taking prescribed/controlled medication(s). A combination of these drugs or/and alcohol may produce profound sedation, respiratory depression, and death.
13. Alternative pain treatment was discussed with the patient and he/she would like to proceed with opiate therapy. Once the maintenance dose is achieved, the patient will be given a supply according to a schedule determined by the physician. Opiates will only be prescribed during normal business hours.
14. It is the patient's responsibility to safeguard medications. Medications or prescriptions will not be replaced if lost, stolen, spilled, damaged, destroyed, left on an airplane, etc. Keep medication(s) out of the reach of children and pets.
15. There will be no early refills. Opiate prescription is written for a 30 days period, unless otherwise specified.
16. **Females:** Should notify the physician/provider if they become pregnant or at risk of becoming pregnant. Children born when the mother is on opiate maintenance therapy can result in birth defects or physical dependence of the child.
17. **Males:** Chronic use of opiate has been associated with low testosterone levels. This may affect mood, stamina, sexual desire, and sexual performance.
18. Patient will agree to waive privacy so that his/her provider may contact other providers or pharmacies to discuss treatment and/or medication.
19. It is the patient's responsibility to disclose visits to the emergency department and receipt of controlled substances. Patients receiving emergency prescription written for an opiate or controlled medication MUST obtain clearance by Dr. Tom Porter before filling and using.
20. A breach of any of the above conditions will result in termination of opiate prescribing and possible discharge from practice.

I understand and will adhere to the above guidelines.

____________________	____________________	__________
Print name of Patient	**Signature of Patient**	**Date**
Print name of Witness	**Signature of Witness**	**Date**

PATIENT KEEPS THIS COPY

OFFICE POLICIES REGARDING OPIOID PRESCRIPTIONS

As a Pain Management Specialist, I am well aware of the rules and regulations governing the use of opioid (narcotic) medications. I am also aware of the potential abuse of this type of treatment. For this reason, many physicians avoid prescribing opioid medications for the treatment of pain. However, due to the benefits I have seen in patients who are treated with opioids for their chronic pain, I may utilize this class of medication as part of your overall treatment plan. Not all patients will receive opiate medication prescriptions. This will be determined on a patient by patient basis.

You are here so that I can help you get your pain under control. It is unrealistic to think that I can "cure" your pain or make you pain free. My goal is to provide you with the highest quality of medical care and help you return to a more productive lifestyle. This is why this specialized treatment is referred to as "Pain Management".

There has been much media attention lately regarding the use of opioid medications and the state of Florida has passed regulations and Laws regulating opiate prescribing. While most patients are sincere and have legitimate findings that cause their acute or chronic pain, there are those people that exaggerate their symptoms in order to obtain medications for non-medical use. I can assure you that in our practice we are extremely careful about documenting and keeping track of all of our prescriptions. If we feel there is a problem developing, it will be discussed with you immediately.

Our patients depend on us for their chronic pain management. Our Policies are procedures regarding opioid medication abuse are fair and also strict.

- Early releases of medication for vacations may be given at our discretion. A visual pill count may be performed to verify that you have been using your medications on schedule.
- Please be advised that we do not accept police reports for stolen medications. Your medications are your responsibility and they should be kept in a secured location.
- Failure to provide a urine specimen when asked will result in the discontinuation of opioid medications and possible discharge from the practice.
- There is a 48 hour minimum turnaround time on medication changes or routine refills. These requests need to be addressed during office hours when we have access to your chart. You are encouraged to leave a voicemail message with detailed refill request information. Messages are checked frequently daily.

I am hopeful that you will understand the reasons for our concern. If you need a medication change or a dosage increase, we will be happy to discuss this with you during office hours, but you absolutely cannot increase or change the dosage on your own without our approval. Right Path Pain and Spine Center is committed to providing comprehensive, compassionate care to all patients.

We look forward to working with you.

Right Path Pain & Spine Center, PLLC

PATIENT KEEPS THIS COPY

GUARANTOR DECLARATION FORM

First Name _________________________Last Name ______________________MI____ DOB_________

Address__________________________________ City ______________________ST ____ ZIP__________

Home Phone ______________________ Work _______________________ Cell____________________

Email ____________________________________ SSN ________________________ Gender __________

REFERRING PHYSICIAN _________________________ OFFICE NAME ___________________________

Phone _____________________ EXT ______ Fax ________________

I _________________________ on this date ____________________, check one below:

☐ Acknowledge I have health insurance coverage ☐ Deny ☐ Self Pay (please see disclaimer)

Primary

INSURANCE DATA/INSURANCE CARRIER____

Billing address: ____

Name of Insured ____________________________Policy # ___________________Gender___________

Secondary

INSURANCE DATA/INSURANCE CARRIER____

Billing address: ____

Name of Insured ____________________________Policy # ___________________Gender___________

☐ Acknowledge I have an injury case: Circle one (PIP/Auto, Workers Comp) ☐ Deny

INSURANCE DATA/INSURANCE CARRIER ____

Billing address: ____

Name of Insured ____________________________Policy # ___________________Gender___________

Claim# ____________________________________Adjuster ____________________________________

Phone _________________________ Extension___________ Fax________________________________

Injured Body Parts ____

Date of Loss/Accident __________ State of Loss/ Accident _________

☐ Acknowledge I have legal reposition ☐ Deny

LEGAL DATA

Firm Name_______________________________ Attorney Name _________________________________

Contact Name ___________________ Phone ___________________ EXT _______ Fax_______________

ACKNOWLEDGMENT OF RECEIPT OF RIGHT PATH PAIN AND SPINE CENTER, PLLC'S
NOTICE OF PRIVACY PRACTICES FOR PROTECTED INFORMATION

PERSONS THAT ARE ALLOWED TO GIVE/RECEIVE MY PROVATE HEALTH INFORMATION

METHOD OF ALLOWED RELEASE ___VERBAL ___WRITTEN

________________________________ ________________________________ ______________________________

Name Relationship Phone #

METHOD OF ALLOWED RELEASE ___VERBAL ___WRITTEN

________________________________ ________________________________ ______________________________

Name Relationship Phone #

AUTHORIZATION TO CONTACT YOU REGARDING APPOINTMENTS AND SERVICES

May we contact you regarding appointments and test results? Yes or No
May we leave information on voice mail? Yes or No
May we leave a message with the person that answers the phone? Yes or No

Initials __________

BILLING POLICY

All outpatient visits are to be paid on the day of the visit. I understand that I am responsible for full payment of charges for medical services rendered by Right Path Pain and Spine Center, PLLC, physician regardless of insurance coverage, unless a contractual agreement exist and all medical services are paid in full by my insurance carrier.

Initials __________

SIGNATURE ON FILE

I hereby authorize the Right Path Pain and Spine Center, PLLC, to submit to my insurance plan all covered services rendered by the physician and to furnish complete information (including Medical Records, if necessary) to my plan regarding services rendered. I understand that in signing this form, the Center will not release to anyone, including those processing my Clinic claim, any information that the law specifically protects and for which a special consent is required. For those records to be released, I will need to sign a separate consent. I authorize and direct my insurance carrier to issue payment check(s) directly to the physician rendering covered services unless otherwise notified.

Initials __________

2- DAY CANCELLATION POLICY

If a patient needs to cancel an appointment, the patient must give 2-day prior notice to the scheduled appointment. For example if the scheduled appointment is on a Thursday, the appointment would need to be cancelled no later than Tuesday.

<u>IF YOU ARE MORE THAN 15 MINUTES LATE TO YOUR APPOINTMENT, YOU WILL BE ASKED TO RESCHEDULE**</u>**

Initials __________

NO SHOW POLICY

For any appointment that is missed and not cancelled per the above 2-day Cancellation Policy, the following fees will be billed to you for payment upon receipt.

No Show office will be billed to you at $30.00
No Show Procedure will be billed to you at $50.00
No Show Hospital Procedure will be billed to you at $200.00

Initials __________

I acknowledge that I have read and received a copy of Right Path Pain and Spine Center, PLLC's Notice of Privacy Practices, dated January 1, 2019.

AUTHORIZED SIGNATURE

I have read this form or had it read to me. I understand it.

______________________________________ ____________________________________ ________________

Print name of Patient **Signature of Patient** **Date**

______________________________________ ____________________________________ ________________

Print name of Parent/Guardian of Minor **Signature of Parent/Guardian of Minor** **Date**

OFFICE, PRESCRIPTION AND APPOINTMENT POLICIES

APPOINTMENTS, QUESTIONS AND CONCERNS

All phone calls will be returned within 24-48 hours of receipt during normal office hours of 9am-4:30pm M-F. Please be available during this time period to return your call. Please **DO NOT** make multiple phone calls to the office, we will return your call promptly.

If you believe that your concern is a medical emergency, **CALL 911**.

YOU WILL BE ASKED TO MAKE AN APPOINTMENT FOR ISSUES OF GENERAL CONSULTATION.
****IF YOU ARE MORE THAN 15 MINUTES LATE TO YOUR APPOINTMENT, YOU WILL BE ASKED TO RESCHEDULE****

PROCEDURE APPOINTMENTS

If you are scheduled to have a procedure in our clinic, your wait time on the day of your procedure at times may vary from ***ONE TO THREE*** hours, as with most procedures they are patient specific and can take longer than expected. We will try our best to keep you as close as possible to your appointment time, **BUT** please allow time and be prepared for a visit of this length on the day of your procedure.

ABSOLUTELY NO PRESCRIPTION REFILLS GIVEN ON DAY OF PROCEDURES

GOING FORWARD, ANY PRECRIPTION REFILLS OR CHANGE REQUESTS REQUIRE A FACE TO FACE OFFICE VISIT.

MEDICATION REFILLS

You should take the medications for your condition **EXACTLY** according to the instructions. If you take the medication other than the manner it was prescribed or discontinue taking a medication due to side effects, you are instructed to notify our office **immediately**.

THE POLICY OF THIS OFFICE AND **PER STATE REGULATIONS** IS THAT PAIN MEDICATIONS ARE DISPENSED IN A **30 DAY** SUPPLY.
PRESCRIPTION PAIN MEDICATIONS CANNOT BE TELEPHONED OR “CALLED IN” TO PHARMACIES.
YOU MUST PICK UP PAIN MEDICATIONS DURING A SCHEDULED CLINIC APPOINTMENT.
****EARLY REFILLS ARE NOT ALLOWED FOR PAIN MEDICATIONS****

You must call the office NO LATER THAN 72 hours prior to running out of other medications. Please provide medication, name, strength, and dispensing directions. Please allow 24-48 hours before medication is called into your pharmacy or available for pick-up. Please include pharmacy name, area code, and phone number.

If you have missed your appointment for any reason and are in need of a refill, you **MUST** be seen in the clinic before refills are called in.

Please remember, PAIN MEDICATIONS CANNOT be called in so it is imperative to keep scheduled appointments.

CO-PAY’S AND BALANCES

INSURANCE CO-PAYS ARE DUE AT THE TIME OF VISIT. YOU WILL ALSO BE ASKED TO PAY OR SCHEDULE A PAYMENT PLAN ON ANY REMAINING BALANCE DUE ON YOUR ACCOUNT PRIOR TO BEING SEEN FOR A SCHEDULED APPOINTMENT.

CANCELLATIONS

PLEASE NOTIFY THIS OFFICE **NO LATER THAN 2 DAYS PRIOR** TO YOUR SCHEDULED APPOINTMENT IF YOU CANNOT BE PRESENT FOR YOUR APPOINTMENT. YOU MAY BE CHARGED A FEE FOR A MISSED APPOINTMENT IF YOUR FAIL TO CALL ATLEAST 48 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT.

__________________________________ _________________________________ _______________

Print name of Patient **Signature of Patient** **Date**

Notice: Affiliated Business Disclosure

To: Right Path Pain & Spine Center Patients
From: Tom M Porter M.D.

STATEMENT:
This is to give you notice that Right Path Pain & Spine Centers, whose management offices are located in Davenport FL, have a business relationship with Davenport Surgery Center. The CEO and owner of Right Path, Tom M Porter M.D. is a founding member and co-owner of the Davenport Surgery Center. Because of this relationship, this referral may provide Tom M Porter M.D. a possible financial benefit.

ACKNOWLEDGEMENT:
I/we have read this disclosure form, and understand that an employee of Right Path Pain & Spine Centers is referring me/us to the Davenport Surgery Center and that this referral may result in Tom M Porter M.D. receiving a possible financial benefit as the result of this referral.

______________________________	______________________________	____________
Print name of Patient	**Signature of Patient**	**Date**

Request for Access to/Authorization for Use and Disclosure of Protected Health Information

Patient Name:____
Last First MI Maiden or Other Name

Date of Birth: _____-_____-_____ Former Name: ___________________ Medical Record # ___________________
MO DAY YR

Address: _______________________________City: _____________________________State:_____ Zip: ________

Home Phone:____ Cell: ____________________________________

Authorizes:
Right Path Pain and Spine Center
___141 Webb Drive Suite 300, Davenport, FL 33837
P: 863-422-0020 F: 863-422-0021

To Obtain/Release protected health information from:
____
____
____
____
P: F:

(Please provide name, address, phone, & fax to the above)

Information to be obtained: I hereby authorize you to obtain/release my medical records for my treatment as marked below

☐History & Physical ___________________________
☐Progress Notes ___________________________
☐Lab Reports ___________________________
☐X-Ray Reports ___________________________
☐MRI ___________________________
☐CT ___________________________
☐Bone Scan ___________________________
☐EMG ___________________________
☐ Psychiatric Evaluation ___________________________
☐Other (specify content and dates):____

Purpose of disclosure:

☐Changing physicians ☐Consultation ☐Insurance / Workers' Compensation ☐ Legal ☐Personal access
☐Other (specify): ____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZAITON:

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

I understand the following:

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- The information released in response to this authorization may be re-disclosed to other parties.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

I acknowledge and understand the terms of the **Request for Access to/Authorization for Use and Disclosure of Protected Health Information**.

____ Patient/Legal Representative Signature Date

____ Parent/ Legal Guardian Signature Date

____ Patient / Legal Representative Printed Name

____ Parent / Legal Guardian Printed Name

____ Relationship

____ Relationship

SOAPP-R

	ANSWER THE FOLLOWING QUESTIONS BELOW BY CHECKING 1 BOX PER QUESTION. BE AS HONEST AS POSSIBLE. THERE ARE NO WRONG ANSWERS.	NEVER	SELDOM	SOMETIMES	OFTEN	VERY OFTEN
1.	How often do you have mood swings?					
2.	How often have you felt a need for higher doses of medication to treat your pain?					
3.	How often have you felt impatient with your doctor(s)?					
4.	How often have you felt that things are just too overwhelming that you can't handle them?					
5.	How often is there tension in the home?					
6.	How often have you counted pain pills to see how many are remaining?					
7.	How often have you been concerned that people will judge you for taking pain medication?					
8.	How often do you feel bored?					
9.	How often have you taken more pain medication than you were supposed to?					
10.	How often have you worried about being left alone?					
11.	How often have you felt a craving for medication?					
12.	How often have others expressed concern over your use of medication?					
13.	How often have any of your close friends had a problem with alcohol or drugs?					
14.	How often have others told you that you had a bad temper?					
15.	How often have you felt consumed by the need to get pain medication?					
16.	How often have you run out of pain medication early?					
17.	How often have others kept you from getting what you deserve?					
18.	How often, in your lifetime, have you had legal problems or been arrested?					
19.	How often have you attended an AA or NA meeting?					
20.	How often have you been in an argument that was so out of control that someone got hurt?					
21.	How often have you been sexually abused?					
22.	How often have others suggested that you have a drug or alcohol problem?					
23.	How often have you had to borrow pain medication from family or friends?					
24.	How often have you been treated for an alcohol or drug problem?					

For Staff use Only

Total: _______________

Patient Name (Please Print):

____

DOB: ______________________ Date: ______________________