New Patient Packet

Thanks so much for your interest in becoming an established patient at Summerfield Pain Management!

Attached is our new patient packet to be filled out and returned to us at your earliest convenience. New patient packets can be returned via email, fax, or dropped off in-office.

Please note that PRIOR to being scheduled for an appointment, we must have received:

- A completed new patient packet – Including any medical records from previous pain management treatment, if applicable, and/or your primary care provider. ***If you have one or more doctors' offices that we need to request records from, please provide multiples of page 3 of the packet, one for each doctor's office/hospital/imaging center.***
- A valid FL state identification (Please provide any ID and Insurance cards so we can make a copy)
- A recent MRI dated within the last 2 years – ***We do not need the disk of your imaging, just the report. We will obtain imaging reports via page 3 of the packet, so please include any imaging centers that have those records. If you have not had an MRI within the past 2 years (2022-2024), please request from your referring/primary care provider to order an updated MRI prior to chart review/scheduling.***
- A complete list of medication for the last 6 months (we will obtain record of any controlled prescriptions, but may also need a list if there are any additional medications)
- An arrest record within the last year (we will obtain)

Once the new patient packet has been filled out completely and *returned to our office*, we will request your records and imaging reports needed for Chart Review. ****We are unable to schedule an appointment or review your chart if we have not received your medical records and recent imaging reports.**** Once we have received those records from your previous doctor(s), Dr. Watson will review your chart, MRI(s) and medical history to evaluate your case/candidacy for pain management. Once your chart has been reviewed and approved, our staff will reach out to you to schedule an appointment.

Should you have any additional questions or concerns, feel free to contact our office and we will gladly assist you with the matter.

Sincerely,

Karina M.
Front Office Manager
Summerfield Pain Management
13055 Summerfield Square Drive
Riverview, FL 33578
Tel: 813-741-2473 | Fax: 833-806-1660
SummerfieldMedical1@yahoo.com
SummerfieldPainManagement.com

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Patient Information		
Last Name:	First Name:	Primary Language Spoken:
Date of birth:	Age:	SS#:
Mailing Address:	City, State & Zip code:	Sex:
Phone:	Work:	Email:

Occupation:	Marital Status:
Primary Care Physician:	Phone number:
Preferred pharmacy:	Phone number:
Insurance Company:	
Insurance ID #:	Insurance Group #:
Policy holder Name:	Relation to patient:
Policy holder DOB:	Policy Holder SS #:

Do you give our office permission to discuss your medical information with family members? ____ Y ____ N

If yes, please provide their names and phone numbers below.

Name:	Phone number:
Name:	Phone number:

May we leave personal medical information on your answering machine or cell phone:	Y/N	If yes, what number do you prefer we use:

Emergency Contact Information		
Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

Sign	Date

Please sign so we may have your insurance authorization on file.

I authorize any holder of medical or other information about me to release to the above insurance company (s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

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Chief Complaint? _____

_____

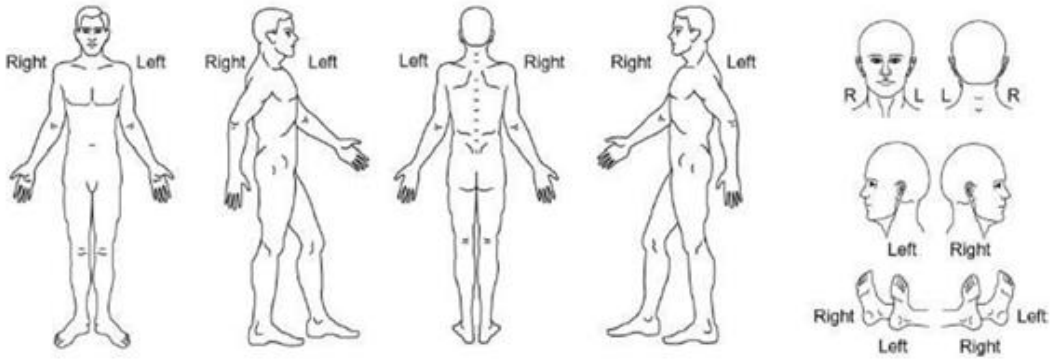
Does this pain radiate? If so, where? _____

_____

Please list any additional areas of pain: _____

_____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Onset of Symptoms

Approximately, when did this pain begin? _____

_____

What caused your current pain episode? _____

_____

How did your current pain episode begin? ☐ **Gradually** ☐ **Suddenly**

Since your pain began, how has it changed? ☐ **Improved** ☐ **Worsened** ☐ **Stayed the same**

Mark all of the following tests that you have had related to your current pain complaints:

☐ **MRI of the:** _____ **Date:** _____
☐ **X-Ray of the:** _____ **Date:** _____
☐ **CT Scan of the:** _____ **Date:** _____
☐ **EMG/NCV study of the:** _____ **Date:** _____
☐ **Other Diagnostic Testing:** _____ **Date:** _____
☐ **I have not had ANY diagnostic tests for my current pain complaint**

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Please mark all of the following treatments you have had for pain relief:

	No Change	Worsened Pain	Helped Pain
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
TENS Unit	☐	☐	☐

Interventional Pain Treatment History

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar

☐ Joint Injection – Joint(s) _____
☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar

☐ Nerve Blocks – Area/Nerve(s) - _____
☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar

☐ Spinal Cord Stimulator – Trial Only/Permanent Implant _____
☐ Trigger Point Injections – Where? _____
☐ Vertebroplasty/Kyphoplasty – Level(s) _____
☐ Other - _____

Which of these procedures listed above have helped with your pain? _____
_____

Please list the names of other Pain Physicians you have seen in the past: _____
_____

Mark the following physicians or specialists you have consulted for your current pain problem(s): ☐ Acupuncturist ☐ Chiropractor ☐ Internist ☐ Neurosurgeon ☐ Orthopedic Surgeon ☐ Physical Therapist ☐ Psychiatrist/Psychologist ☐ Rheumatologist ☐ Neurologist ☐ Other _____

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** ATTENTION **

It is a FELONY to provide medical information that is FALSE or intentionally MISLEADING for the purpose of acquiring CONTROLLED prescription medications and this clinic will notify the authorities if any such wrongdoing is discovered during your course of treatment here.

It is our mission to provide quality medical management of MEDICALLY SIGNIFICANT issues of Pain, Mood, or Sleep as determined by Dr. Watson and staff.

WE WILL NOT TOLERATE OR CONDONE MISUSE, ABUSE, OR DIVERSION OF ANY CONTROLLED SUBSTANCES and will notify the authorities whenever such behavior is discovered or suspected.

By signing this statement, I, _____, understand and accept that Dr. Watson may share information with legal authorities as deemed legally necessary and appropriate in order to insure no patient of this clinic will be permitted to abuse Dr. Watson's compassion or violate his trust for the purposes of committing any illegal activity related to prescription drugs.

_____	_____	_____
Signature	Witnessed by	Date

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By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient's name _____ Date of birth _____

The information you may release subject to this signed release form as follows:

	Complete Medical Records		**History & Physical**		**Progress Notes**
	Care Plan		**Lab Reports**		**Radiology Reports**
	Pathology Reports		**Treatment Record**		**Operative Reports**
	Hospital Reports		**Medication Record**		**Other**

Release my protected health information from the following physician/person/facility/entity and/or those directly associated in my medical care:

Provider Name: _____
Address: _____
City, State, Zip Code: _____
Phone: _____
Fax: _____

The purpose/reason for this release of information is as follows:

_____

Patient signature: _____ Date: _____

Patient SSN: _____

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Date: _____

To whom it may concern:

I, _____ am requesting to be discharged from your clinic / practice due to the fact that I am now under the care of Summerfield Pain Management.

I, _____ am requesting to be dual enrolled at your facility for injections, in conjunction with Summerfield Pan Management for opioid treatment. I am not to receive any further opioid medication from your facility, as it will immediately discharge me from Summerfield Pain Management.

I am requesting that you send a discharge letter to 833-806-1660, as soon as possible.

Thank you for your assistance,

Patient Signature_____

DOB_____

Discharging Facility / Doctor

_____

_____

_____

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Consent To Be Photographed and Published

I, _____, Consent to be photographed on _____ by Summerfield Pain Management for their electronic health records and paper chart. I further authorize that the photographs may be published for any medical purpose.

_____ _____

Signature of Patient Date

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Pain Treatment Program Statement

We here at **Summerfield Pain Management** are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

- We will help you schedule regular appointments for medication refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.
- We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.
- We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.
- We will work with your medical insurance providers to make sure you do not go without medication because of paperwork or other things they may ask for.
- We will help connect you with other forms of treatment to help you with your condition.
- If you become addicted to these medications, we will help you get treatment.

_____	_____	_____
Patient signature	Patient name printed	Date

_____	_____
Staff Signature	Date

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Patient Financial Responsibility Form

Medical Consent: I, the undersigned, consent to the treatment and procedures which may be performed during this. I have the right to refuse any treatment and to be informed of the possible medical consequences of refusal. My signature on this document indicates my general consent to be treated. My physician may request that I sign a more specific form relative to any procedure that may be performed.

Release of Information: Summerfield Pain Management may disclose any or all parts of these medical records to my insurance carrier(s) and any organization(s) contractually responsible for purposes of satisfying all charges billed by the physician(s). This includes but is not limited to all claim filings, appeals, and correspondence regarding the charges billed.

Financial Policy Statement

Benefits and eligibility are verified prior to your visit as a courtesy and as a result, we are not responsible for incorrect information provided by your insurance company as it relates to copay or benefit plan limitations. Your policy must be in effect at the time of service.
In order for us to file with your insurance company we MUST have a copy of your insurance card. At the time of service, you will be responsible for any and all copay, deductibles, and co-insurance amounts.
All insurance changes must be given to us at the time of service. If your insurance changes and we are not notified in writing, you will be responsible for all charges, and we will be unable to bill your insurance for any services before the change in notification.

- **IN Network Insurance Office Policy**: If we are contracted with your insurance company, you will only be responsible for your co-pays and co-insurance as outlined on your EOB (Explanation of Benefits)
- **OUT of Network Insurance Office Policy**: If we are not in contract with your insurance company, we will file the insurance on your behalf and accept assignment of the payments. Any balance will be patient responsibility. We are not obligated to write off amounts your insurance company recommends to us.
- **Self-Pay Policy:** Payment is mandatory at time of visit. You will not be permitted to carry a balance and if a balance remains you will not be able to come back for another visit until satisfactory arrangements have been made.
- As a courtesy, we will file your secondary insurance provided that all insurance information is given at the time of service. If no payment is received from the secondary carrier within 45 days of filing, the unpaid balance becomes patient responsibility.
- All patient balances become due and payable immediately upon your benefits determination or our receipt of the payment or denial notice from your insurance carrier.
- For those patients who are members of an insurance plan that requires a referral, please verify with our front desk staff that current authorization has been received prior to your visit. If we do not have your completed authorization, you will be responsible for your visit.
- The patient, not your office or the insurance company, is responsible for all charges incurred regarding all medical care. We advise you to know your insurance plan and your covered benefits. You will be billed directly for all non-covered services.

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You agree to the following:

Medicaid: I am aware that Summerfield Pain Management does not accept Medicaid Insurance. If I have Medicaid Insurance, I am responsible for the full cash payments at SPM. If I choose to use my Medicaid Insurance, I will find a doctor/facility that accepts Medicaid and I will sign a medical release to transfer my records.

Financial Responsibility: I understand and acknowledge the policy of this office that payments are made at each visit and I am responsible for payment of all services rendered on my behalf.

Financial Balance Policy: I understand that if I have established a balance that is 45 days or older and have not made arrangements to pay it, I will be discharged 30 days from the date the practice notifies me in writing. I must pay any balance owed before I am a patient of the practice again. If the balance is not paid within 30 days, the account will be turned over to collections and reported to the credit bureaus.

Scheduling and No-Show Policy: If I am more than fifteen minutes late for my scheduled appointment time, I will be rescheduled to the next available slot. (This includes time for filling out the necessary paperwork for your appointment.)

If you do not cancel or reschedule your appointment 24 hours before your appointment time, this will be considered a no-show and you will be charged a $50.00 cancellation fee. If you do not pay this charge, you will be subject to our Financial Balance Policy described above.

Medical Records: Charge for the copying and distribution of patient medical records is $1.00/page for the first 25 pages and $0.25 for each additional page after.

I have read and understood the patient financial responsibility form and agree to the responsibility for the payment of my account:

_____ _____

Signature of Patient Date

_____ _____

Signature of Staff Date

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PHYSICIAN/PATIENT INFORMED CONSENT & AGREEMENT NOTICE OF MATERIAL RISKS OF TREATMENT FOR LONG-TERM OPIOID/NAROCTIC THEARAPY CHRONIC PAIN FORM

Patient Name: _____ Date: _____

You have agreed to receive opioid/narcotic therapy for the treatment of chronic intractable pain. The goal of this treatment is to treat your condition with controlled substances to: (a) provide pain control; (b) functional improvement; (c), and restoration of quality of life. These medications are intended to decrease the symptoms of your painful condition but are not expected to cure your underlying disease process.

- We have discussed alternatives, including physical therapy, pain injections, and/or surgical referral. You have chosen opioid/narcotic therapy as one component of treatment.

The use of cigarettes demonstrates a dependence of nicotine. This complicates opioid therapy. If you are a smoker, you have agreed to a smoking cessation program.

SIDE EFFECTS

You must be aware of the potential side effects and risks of these medications - they are explained below. If you have any questions or concerns during the course of your treatment, feel free to contact your physician.
Side effects are normal physical reactions to medications. We have discussed potential side effects and the risks of controlled substances, common side effects of opioid/narcotics including:

- Sleepiness, confusion, difficulty thinking
- Nausea, vomiting, constipation often persists and may require additional medication
- Difficulty breathing, shortness of breath, wheezing
- Potential for allergic reaction. EX: Rash, itching, hives, swelling
- Potential for interaction with other medications (increasing effects or side-effects of medications taken together)
- Potential for dose escalation/tolerance (need for higher doses for the same effect may occur with long-term use
- Potential for dependence/addiction to medication(s) (higher risk of addiction for family history to drug or alcohol problems)
- Potential for withdrawal (stopping medications abruptly may cause nausea, vomiting, abdominal pain, sweating, aching, abnormal heartbeat or other symptoms that can be life-threatening)
- Potential for addiction if medications are not taken appropriately (compulsive drug use not related to pain relief)
- Potential for death if medications are not taken appropriately or are combined with alcohol or illegal drugs
- Potential for impaired judgment and/or motor skills (driving or operating machinery may be hazardous due to effects on the brain and nerves)
- In men: Lowered testosterone levels
- In pregnant women: Newborn drug dependency and potential for birth defects

You should NOT:

a) Operate a vehicle or machinery if the medication makes you drowsy;
b) Consume ANY alcohol while taking opioids / narcotics; or
c) Take any other non-prescribed sedative mediation while taking opioids / narcotics.

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The effects of alcohol and sedatives are additive with those of opioids / narcotics. If you take these substances in combination with opioids / narcotics, a dangerous situation could result, such as coma, organ damage or even death.

Long-Term Side Effects

The long-term effect of opioid/narcotic therapy is not fully known. Most long-term effects have been listed above. If you have any additional questions regarding the potential long-term effects of opioid/ narcotic therapy, please speak to your physician.

Prescriptions and use of opioid/narcotics medication(s)

Your medication(s) will be prescribed by your physician for control of pain, based on your individual needs, you will be provided with enough medication on a 28-day monthly basis. New injuries or pain problems will require reevaluation. Prescriptions will NOT be "called in" to the pharmacy.

I agree to the following:

- ✓ I am responsible for all my medications. I will not share, sell, or trade my medications. I will not take anyone else's medications.
- ✓ I will not increase my medication(s) until authorized by my physician to do so.
- ✓ My medication(s) may not be replaced if it is lost, stolen, or used up sooner than prescribed (grounds of discharge for violation from facility)
- ✓ I agree to give a blood and/or urine sample, if asked, to monitor for drug use or medication compliance. I also agree that other doctors and law enforcement may be notified of the results.
- ✓ The facility does not give refills at any given time; as such I will keep all appointments set up by my doctor or staff every 28 days to get evaluations and medication(s).
- ✓ I agree to only use one pharmacy to get my medication. My doctor may talk with pharmacist about my medication(s).

This confirms that I asked you if you wanted a more detailed explanation of the proposed treatment, the alternatives, and the material risks, and you (check one):

- ☐ Are satisfied with the explanation and desire no further information.
- ☐ Requested and received, in substantial detail, further explanation of the treatment, alternatives, and risks.

If this form accurately represents our discussion, and if you are satisfied with the explanation given, sign this document indicating your consent to the use of controlled substances in treating your chronic pain:

Signed: _____ Date: _____
Patient

Explained by me & signed in my presence: _____ Date: _____
Physician

Witness: _____ Date: _____

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PAIN MEDICATION CONTRACT

You are coming to this clinic for the evaluation and management of a significant chronic pain condition, the documentation of which you have or have had provided to us. This is a good faith agreement between you and your consultant-treating physician. The purpose of this agreement is to prevent misunderstandings about certain medications that you will be taking for pain management. This is to help both you and your doctor maintain compliance with the law regarding controlled substances and to promote medication safety.

I, _____, understand and voluntarily agree that
(Initial each statement after reviewing):

_____ • I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the staff.

_____ • I will safeguard my prescriptions and/or pain medicines from loss or theft. *Lost, stolen, damaged prescriptions or medicines will not be replaced, and there will be NO EXCEPTIONS*. Furthermore, I will safeguard my prescriptions and/or pain medicines from access by others, especially by children.

_____ • I agree that I will use my medicine as prescribed, at a rate no greater than the prescribed rate, and I understand that use of my medicine at a greater rate than prescribed increases the likelihood of dangerous side-effects and may also result in my being without medication for a period of time.

_____ • I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. *No refills will be available after clinic hours or on weekends. We do not call in controlled medications.*

_____ • I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the staff immediately.

_____ • I will respect the office of SPM and its employees, by not engaging in any disorderly conduct (i.e., bad language or being abusive to the staff or other patients), or I will be asked to leave the premises.

_____ • I will not share, sell, or trade my medication with anyone. I understand if I do, my treatment will be stopped.

_____ • I will sign a release form to let the doctor speak to all other doctors or providers that I see.

_____ • I will not attempt to obtain any controlled medicines, including opioid pain medications, from any other individual or doctor. I understand that the only exception to this is if I need pain medicine in the event of an emergency, and I will notify Summerfield Pain Management immediately.

_____ • I will only use one pharmacy to get all my medications: _____

_____ • Furthermore, I will not attempt to obtain any controlled anti-anxiety medicines from any other doctor or individual, unless prescribed by my primary care doctor, psychiatrist, or an emergency room doctor who is aware of my current medication list, in which case I will immediately inform my pain doctor of any new medications that have been prescribed by these other doctors.

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_____ • I will **NOT** use any illegal substances, including <u>marijuana, cocaine, etc</u>.

_____ • I agree that I will submit to blood or urine tests if requested by my doctor to determine my compliance with my program of pain control medicine or to evaluate for any adverse health effects of the medicines. I will come in for the counting of my pills if called to do so within 24-48 hours. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs. *If you refuse or test positive for illegal drugs, you will be discharged.*

_____ • I will keep up to date with any bills from the office and tell the doctor or member of the staff if I lose my insurance or can't pay for treatment anymore.

_____ • I understand that I may lose my right to treatment in this office if I break any part of this agreement. *In certain cases, the doctor will taper off the medicine over a period of days as necessary, to alleviate withdrawal symptoms. Also, a drug-dependence or treatment program may be recommended.*

_____ • I understand that if I am arrested for any criminal charges pertaining to drugs, I will be discharged.

_____ • For women: I agree to notify my pain physician and my obstetrician immediately if I am pregnant or intend to become pregnant.

I agree to follow the above agreement that has been fully explained to me by a member of Summerfield Pain Management. All of my questions and concerns regarding treatment have been adequately answered.

Patient signature_____ **Date**_____

Physician signature_____ **Date**_____

Witness signature_____ **Date**_____

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Prescription from other doctors:

If I see another who gives me a controlled substance medicine (for example, a dentist, a doctor from the emergency room or surgeon, etc.) I must bring this medicine to our office in its original bottle, even if there are no pills left.

Privacy

While I am taking this medicine, my doctor may need to contact other doctors to get information about my care and/or use of this medicine. I will be asked to sign a medical release at that time.

Termination of Agreement:

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way.

I have talked about this agreement with my doctor and I understand the above rules.

Provider responsibilities:

As your doctor, I agree to perform regular checks to see how well the medicine is working.

_____ _____

Patient's Signature Date

_____ _____

Physician Signature Date

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