Right Path
Pain & Spine Centers PLLC

Tom M Porter M.D.
Board Certified in Anesthesiology & Pain Medicine

7350 Sand Lake Commons Blvd. Suite 2205 Orlando FL 32819
141 Webb Drive Suite 300 Davenport FL 33837

407-930-2770 Main | 407-930-2769 Fax
863-422-0020 Main | 863-422-0021 Fax

NEW PATIENT EVALUATION

STAFF USE ONLY DATE OF SERVICE: **STAFF INITIALS**

Date:

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 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 / No **Headache?** Yes / No

What makes pain worse?

What makes pain better?

Severity of Pain? 0 = No Pain----------5=Moderate Pain----------10=Worst

When did the pain start? **Recently?** **Number of years ago?**

When was your last MRI? **X-Ray?** **Bone Scan?** **CT?**

Facility Name:

Current Medications for Pain?

Medication Allergies and Reactions:

Past Treatment for pain: Last Set of Injections: **Last Surgery:**

List all surgeries and dates:

Do you have a chronic illness? Diabetes: Yes / No **Hypertension:** Yes / No **COPD:** Yes / No **CHF:** Yes / No

Other illness:

Patient Name:

DOB:

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NEW PATIENT EVALUATION - CONTINUED

Marital Status: Single / Married / Widowed How many years?

Have you in the past or do you presently use: Tobacco: YES / NO How many years?

Alcohol: YES / NO How many years? Other Drugs**:** YES / NO How many years?

Parents Living or Deceased? Cause of Death?

History of cancer or heart disease in parents or family?

Other symptoms (Please circle the following if present**):** recent weight loss, decreased appetite, chest pain, difficulty breathing with activity, sleep disturbance and how?_____, fever, cough, pain when swallowing, early satiety with eating, night time chills, difficulty walking.

(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: RUE: LUE: RLE: LLE:

ROM: Cervical Spine: Full / Limited / Immobile

Lumbar Spine: Full / Limited / Immobile

Impression:

Plan:

Patient Name:

DOB:

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CURRENT MEDICATION LOG

Patient: _____ DOB: _____

Phone: _____ Pharmacy: _____

Allergies: _____

Date Prescribed	Medication	Dosage	Instructions	Prescribing Physician	Discontinued Date

***Staff Highlight Medications that have been discontinued.**

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GUARANTOR DECLARATION FORM

I _____ on this date _____, check one below:

- ☐ Acknowledge I have health insurance coverage with _____.
  (Insurance Company Name)
- ☐ Deny I have Health insurance (Self Pay / Injury: WC or Auto)

First Name _____ Last Name _____MI _____ DOB _____

Address: _____ City: _____ ST: _____ ZIP:_____

Home Phone _____ Work Phone _____ Cell _____

SSN _____ GENDER: _____

PIP/AUTO, WORKMANS COMP., NEW VISIT

REFERRING PHYSICIAN _____ OFFICE NAME _____

Contact Name_____ Phone _____ EXT _____ Fax _____

LEGAL DATA:

Firm Name_____ Attorney Name _____

Contact Name _____ Phone _____ EXT _____ Fax_____

INSURANCE DATA/INSURANCE CARRIER: _____

Billing address: _____

Name of Insured _____Policy # _____ Gender_____Claim# _____

Adjuster _____ Phone _____ Fax_____

Injured Body Parts _____ Date of Loss/Accident _____ State of Loss/ Accident _____

PATIENT MUST BRING ALL MRI/CD'S/REPORTS TO APPOINTMENT.
CANCELLATION FEES: Office $30, Procedure $50, Hospital $200.

Patient Name _____ **Signature** _____ **Date** _____

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

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, 2011.

Printed Name of Patient _____ Date _____

Signature of Patient _____ Signature of Parent/Guardian of Minor _____

Date of Birth _____

PERSONS THAT ARE ALLOWED TO GIVE/RECEIVED MY PRIVATE HEALTH INFORMATION

METHOD OF ALLOWED RELEASE: _____VERBAL _____WRITTEN

Name	Relationship	Phone #
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 all charges for medical services rendered by Right Path Pain and Spine Center, PLLC, physician regardless of insurance coverage, unless a contractual agreement exists 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-days 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.

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 Visit will be billed to you at $30.00
No Show Office Procedure will be billed to you at $50.00
No Show Hospital Procedure will be billed to you at $200.00 **Initials**_____

AUTHORIZED SIGNATURE

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

Signature of Patient/Authorized Representative _____ Date _____

Relationship (if other than patient) _____

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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.

I look forward to working with you.

Tom M. Porter, MD

PATIENTS KEEP THIS COPY

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INFORMED CONSENT FOR USE OF OPIOID (NARCOTIC) MEDICATIONS FOR PAIN CONTROL

1. The use of medication is not to completely eliminate pain, rather the medication is used to help decrease pain and increase level of activity.
2. Medication will be prescribed by a single physician. This physician will be the one in control of dosage. Obtaining pain medications from another doctor and "doctor shopping" is unacceptable.
3. The individual must report significant side effects to the doctor. For example, over-sedation, nausea, vomiting, or "high" feelings should be reported.
4. It is clearly understood that the use of this medication may result in physical dependence. Physical dependence is not a dangerous problem, as long as the individual avoids abrupt discontinuing of the drug. Medications can be safely discontinued after a period of slow tapering.
5. Addiction can occur, but this is infrequent in patients who have been diagnosed with an organic problem causing chronic pain. Psychological addiction is recognized when the individual abuses the drug to obtain a high (euphoria), when the patient shows drug-craving behavior, or "doctor shopping", when the drug is quickly escalated without correlation with pain relief, and when the patient shows a manipulative attitude toward the physician in order to obtain the drug. If the individual exhibits such behavior, the drug will be tapered and such a patient is not a candidate for continued opioid use.
6. Tolerance is a condition which can occur with the use of opioid medications. It is defined as a need for a higher opioid dose to maintain the same pain control. This condition may be controlled by switching to a different opioid or adding a second different drug to the opioid medication. If tolerance to opioids becomes unmanageable, the opioid will be tapered and discontinued.
7. If the individual develops drowsiness, sedation or dizziness, he or she many not drive a motor vehicles or operate machinery that can jeopardize, his/her or other individuals' lives.
8. Once the maintenance opioid dose has been achieved, the individual will be given a supply according to a schedule as determined by the physician.
9. Withdrawal symptoms can occur if opiate use is stopped. Symptoms usually occur 24 to 48 hours after the last dose. The individual may begin to experience yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot or cold flashes (goose bumps), abdominal cramps or diarrhea. The withdrawal symptoms are usually self-limited, but could be dangerous. Withdrawal may last for several days
10. The individual should not take other drugs such as tranquilizers or sedatives without first consulting the physician. The individual may not use alcohol. A combination of the opioids with these drugs or alcohol may produce profound sedation, respiratory depression, blood pressure drop, and death.
11. Female patients should notify the physician if they are pregnant or at possible risk to become pregnant. It should also be known that children born when the mother is on opioid maintenance therapy, will likely be physically dependent at birth.
12. If there is any evidence of drug hoarding, acquisition of drugs from other physicians, or uncontrolled dose increase, the opioids will be discontinued.
13. By signing this agreement, I authorize Tom M Porter, M.D. and his clinical staff to perform urine drug testing unannounced at their discretion.
14. I also authorize Tom M Porter, M.D. and his clinical staff to contact other providers and/or pharmacies for information about past or current treatment and medications.
15. Will not replace or re-prescribe opiate prescriptions for Lost, stolen, or spilled prescriptions, traveling out of town.

Noncompliance with any of the above may result in discharge from this practice. Lying to a physician to obtain opiate prescriptions or altering opiate prescriptions is a felony offense and prosecutable by law.

I have received, read and understand the consent regarding the use of opioids.

_____	_____	_____
Signature of Patient	Printed name of Patient	Date
_____	_____	_____
Signature of Witness	Printed name of Witness	Date

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Patient Counseling Document on Extended-Release / Long-Acting Opioid Analgesics

Patient Name: _____ DOB: _____ 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
- Bring unused medicine to office for disposal
- Call your healthcare provider for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088

Initials: _____

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

Initials: _____

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

Initials: _____

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

Initials: _____

For additional information on your medicine go to:
dailymed.nlm.nih.gov

Patient Specific Information

Take this card with you 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

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

Initials: _____

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HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: _____
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____
Street Address

_____
City, State and Zip Code

RE: Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- ☐ All medical records, meaning every page in my record, including but not limited to: Office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.
- ☐ All physical, occupational and rehab requests, consultations and progress notes.
- ☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.
- ☐ All employment, personnel or wage records.
- ☐ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.
- ☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- ☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period _____ to _____.
- ☐ Requesting: _____

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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.

This protected health information is disclosed for the following purposes: _____
_____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

_____
Name of Representative

_____
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

I understand the following:

a) 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.
b) The information released in response to this authorization may be re-disclosed to other parties.
c) 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

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____
Name and Relationship of Legally Authorized Representative to Patient

_____ _____
Witness Signature Date