PAIN & WELLNESS INSTITUTE P.A.

Patient Name:_____ **Date:**_____

Address:_____ _____**Apt #:** _____

City: _____ **State:** _____ **Zip code:** _____

Phone #: Cell #: (_____**)**_____**Home #: (**_____**)**_____

Sex: ___ M ___ F Height:_____ **Weight:**_____

Date of Birth: _____

Social Security #:_____-_____-_____

E-Mail address:_____

Preferred pharmacy:_____**Phone # (**_____**)**_____

Address:_____

How were you referred to our office? ☐ **Doctor** ☐ **Friend/Family** ☐ **Internet** ☐ **Other**

Referring Physician:_____**Primary Care Physician:**_____

Health Insurance Name: _____ **Member ID #:** _____

IN CASE OF EMERGENCY, CONTACT:
Name:_____**Relationship:**_____
Phone: (_____**)**_____

Is this a work-related injury? ___ Yes ___ No Date of Accident:_____
Case Manager:_____**Phone #:**_____ _____ **Ext**_____
Claim Number:_____

Is this injury related to a car accident or a slip and fall? ___ Yes ___ No
Date of Accident:_____**Case Manager:**_____
Insurance company: _____
Phone #:_____ _____ **Ext**_____
Claim Number:_____

Do you have legal representation? ___ Yes ___ No
Attorney/ Law office name:_____
Case Manager:_____ _____
Phone #: _____

NEW PATIENT HISTORY / ASSESSMENT FORM

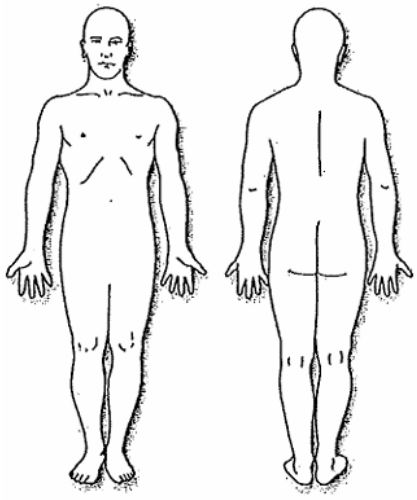
PRESENT ILLNESS

Where is your pain located? _____

How did your pain start? _____

When did your pain start? _____

Please shade the painful areas on the diagram below



NUMERIC PAIN SCALE

Please circle the number that best describes the amount of pain you feel right now.
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

What is the highest number that your pain goes to? _____
What is the lowest number that your pain goes to? _____

Check the words that describe your pain:

_____Aching _____Tender
_____Throbbing _____Burning
_____Shooting _____Sharp
_____Numb _____Radiating

Walking ___ Standing ___ Lifting ___ Twisting ___Bending ___Transfers

___ Medications ___ Chiropractic treatments

Does your pain interfere with your sleep? Yes ___ No

MEDICATIONS

LIST ALL MEDICATIONS THAT YOU ARE TAKING NOW. (INCLUDING PAIN MEDICATION, OVER THE COUNTER, HERBAL, AND VITAMIN)

NAME OF MEDICATION	DOSE (MG)	HOW OFTEN? (# TIMES PER DAY)

Do you take any **blood thinning medication**?_____Which?_____

List all other pain medications that you have tried in the past and why you stopped:_____

_____

ALLERGIES

Please list any known drug, food or environmental allergies and Indicate what the adverse effect/reaction is:

_____

_____

ALLERGIC TO: ☐ Contrast ☐ Steroids: If yes, which?_____

☐ Anesthetics: If yes, which? _____

MEDICAL HISTORY
PLEASE CHECK ALL THAT APPLY

_____Heart Disease	_____Thyroid Disease	_____Seizures	**Cancer**:
_____Hypertension	_____Current Infection	_____Stroke	Site_____
_____Migraine	_____Bleeding Disorder	_____GERD/Ulcer	Diagnosis Date_____
_____Open wound	_____Diabetes, Date:	_____Shingles	Chemotherapy_____
_____Poor blood clotting	_____Liver Disease	_____HIV/AIDS	Radiation_____
_____Lung disease	_____Depression/Anxiety	_____Hepatitis Type___	Other_____
_____Kidney Problems	_____Previous Psychiatric care	_____Other	
		_____Falls in last year. How many:_____	

SURGICAL HISTORY
PLEASE LIST ALL SURGERIES

DATE	SURGERY

SOCIAL HISTORY:

Marital Status: ____Married ____Divorced ____Single
Do your currently work? ____Yes_____ No What is/was occupation?_____
Smoker____Yes ____No If you quit when?_____
How many cigarettes did you/do smoke per day?_____ Number of years_____
Alcohol Use? ____Yes ____No If yes how long?_____
History of street drug use? ____Yes ____No If yes, what type?_____
Do you have a history of alcoholism? ____Yes ____No
Have you received treatment for alcohol or substance (Legal/illegal) abuse? ____ Yes ____ No
Family history of drug or alcohol abuse? ____Yes ____No
Is there a possibility that you are pregnant? ____Yes ____No

FAMILY MEDICAL HISTORY

What diseases run in your family?

___ Heart Disease
___ Cancer
___ Stroke
___ Depression
___ Other:_____

REVIEW OF SYSTEMS

PLEASE CIRCLE ANY OF THE LISTED SYMPTOMS THAT ARE CURRENT PROBLEMS FOR YOU

Constitutional:	fever/chills	Visual change	weight loss or gain	hearing	
Cardiovascular:	palpitations	leg swelling	heart attack	chest pain	high blood pressure
Respiratory:	shortness of breath	asthma	chronic coughs	Sputum production	wheezing
Gastrointestinal:	Heartburn.	nausea	constipation	rectal bleeding	diarrhea
Genitourinary:	change in bowel control	change in bladder control	Blood in urine		
Musculoskeletal:	joint pain or stiffness	swelling in joints	back or neck problems	Redness in Joints	
	Arthritis/joint disease	frequent muscles spasm			
Neurological:	weakness	fainting	numbness	headaches	dizziness	seizures
Psychological:	depression	anxiety	stress		
Endocrine:	frequent urination	change in appetite	heat/cold tolerance	sweating	
Hematologic:	bleeding or bruising				

PATIENT SIGNATURE_____ DATE_____
(OR POWER OF ATTORNEY)

SBIRT DAST-10 Forms

Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Have you used recreational/illegal drugs in the past year?

☐ NONE ☐cocaine

☐cannabis (marijuana, pot) ☐narcotics (heroin, oxycodone, methadone, etc.)

☐ inhalants (paint thinner, aerosol, glue) ☐hallucinogens (LSD, mushrooms)

☐ tranquilizers (valium) ☐ other: _____

☐ methamphetamines (speed, crystal)

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

0	1	3	6
I	II	III	IV

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to Indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

TOTAL SCORE:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

CAGE SCREENING

- Have you ever felt you should **C**ut down on your drinking? ___ Yes ___ No
- Have people **A**nnoyed you by criticizing your drinking? ___ Yes ___ No
- Have you ever felt bad or **G**uilty about your drinking? ___ Yes ___ No
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)? ___ Yes ___ No

PAIN & WELLNESS INSTITUTE P.A.

RELEASE OF MEDICAL RECORDS

PATIENT'S LAST NAME:_____FIRST NAME:_____

DOB:_____/_____/_____ SSN #_____ SEX_____

HOME PHONE(_____)_____ ALT PHONE (____)_____

ADDRESS_____

I hereby authorize_____(office/facility) to release my Personal Health Information. If applicable, I also give permission for the following to be disclosed: Infection with AIDS or HIV, Behavioral Health Services/Psychiatric Care, Treatment for Alcohol/Drug

NAME: PAIN & WELLNESS INSTITUTE		PHONE NUMBER: (813) 873-7777
ADDRESS: 4509 N. ARMENIA AVE.		FAX NUMBER: (813) 873-7776
CITY: TAMPA	STATE: FLORIDA	ZIP CODE: 33603

OFFICE USE ONLY: Please include all:

☐ Consultation Notes	☐ Office Notes	☐ Diagnostic Reports (MRI, CAT... etc.)
☐ Operative Reports	☐ Lab Results	☐ Other

OFFICE USE ONLY: The purpose of this release of information is for:

☐Continuing Medical Care	☐Personal Use
☐Attorney/Legal Case	☐Other:

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal
privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal
Substance Abuse Confidentiality Requirements.
I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.
I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this
authorization.

Finally, I understand that I may revoke this authorization, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization.

PATIENT SIGNATURE_____

(OR POWER OF ATTORNEY SIGNATURE)

PAIN & WELLNESS INSTITUTE, P.A.

New Patient Registration, Consent, Privacy, and Financial Agreement

Consent to Care, Assignment of Benefits, Release of Information, and Financial Agreement

Consent to Care: I am presenting myself to Pain and Wellness Institute, P.A. for care. I hereby voluntarily consent and authorize such care, including diagnostic procedures, surgical and medical treatment by authorized agents and employees of this practice and by its medical staff or their professional judgment be necessary and beneficial. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment of my condition.

Assignment of Benefits: I hereby assign payment directly to Pain and Wellness Institute, P.A. As a courtesy Pain and Wellness Institute, P.A. verifies insurance benefits. However, I understand this is not a guarantee of payment from my insurance carrier. I understand I am financially responsible to Pain and Wellness Institute, P.A., for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.

Release of Information: I hereby authorize Pain and Wellness Institute, P.A. or any physician(s) who have attended to me, to furnish my insurance company (or companies), Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), workers compensation carrier, referring/treating providers, and other payors or entities involved in payment, utilization review, quality review, coordination of care, or claim processing, with medical information and records necessary for treatment, payment, and health care operations, as permitted by law.

Financial Agreement: I agree, whether signing for myself or any dependent, that I will pay Pain and Wellness Institute, P.A., their usual charges for the services rendered within a period of sixty (60) days. I understand that I am assuming the responsibility to pay the bill in full. If for any reason the bill is not paid in sixty (60) days and is turned over to a collection agency, I agree to pay the attorney's fees and collection expense.

A copy of this permit shall be considered as effective and valid as the original.

No-show Policy: We require at least 24 hours' notice to cancel or reschedule an appointment. Failure to provide advance notice will result in a cancellation fee up to $100. This fee is not covered by insurance and must be paid in full prior to your next appointment.

Third party Laboratory Billing: As part of your treatment and controlled substance monitoring, you will be required to provide urine, blood, or oral fluid samples. These samples are frequently sent to outside third-party laboratories for advanced confirmation testing. You will be billed directly by the testing laboratory for these services, and you agree that you are financially responsible for any balances, deductibles, or copays that your insurance carrier declines to pay.

Form Completion: Forms, disability paperwork, attorney letters, narrative reports, and medical-record requests may require advance notice, provider review, appointment, and/or administrative fees where permitted by law.

My signature below constitutes my acknowledgment (1) that I have read and agreed to the foregoing, (2) that the operations or special procedures have been adequately explained to me by my attending physicians or surgeons and that I have all the information that I desire.

Florida Fraud Statute: Section 817.234, Florida Statutes, stipulates that any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, is guilty of a felony of the third degree.

Therefore, I give authorization to: any hospital, pharmacy, physician, health care provider of any nature, and law enforcement agencies as permitted by law and as necessary for treatment, payment, health care operations, compliance, or investigation of possible misuse/diversion of controlled substances.

Communication Consent: Phone, Voicemail, Email, Text Messages, AI and Patient Portal

I authorize Pain & Wellness Institute, P.A. and its staff, providers, billing representatives, and authorized service vendors to contact me using the contact information I provide. Communications may include appointment reminders, scheduling, referrals, test or imaging coordination, prescription/refill reminders, billing/account matters, forms, patient education, and care coordination. I understand appointment reminders are part of treatment and may be sent without a separate HIPAA authorization, but this consent documents my preferences and authorization for use of electronic communications. I agree to receive text/SMS messages and emails to the phone number and email address I have provided.

Text/email risk acknowledgment: I understand that standard text messages and email may not be encrypted and may be viewed by someone with access to my phone, email account, carrier account, or device. Pain & Wellness Institute will attempt to limit sensitive information in routine text/email messages and may direct me to the patient portal for detailed medical information. I may opt out of non-emergency text messages by notifying the office in writing or replying STOP when supported. Opting out may affect the speed of reminders or routine communication but will not affect my right to treatment. The practice will not use standard text/email for emergencies. Patients should call 911 or go to the emergency room for emergencies. Message and data rates may apply.

Telemedicine Consent: I voluntarily consent to telehealth services when needed. I understand these visits have inherent limitations compared to physical exams and that I may opt for an in-person appointment at any time. Telemedicine may not be appropriate for every condition. The provider may require an in-person visit, physical examination, imaging, testing, or referral. Controlled substance prescribing by telemedicine is

Initials: _____

subject to federal and state law and may not be available in all circumstances. I agree to provide my physical location at the time of the visit and understand that emergency care cannot be provided through routine telemedicine.

Ambient artificial intelligence (AI) and audio scribing consent: To ensure highly accurate and efficient medical charting, Pain & Wellness Institute, P.A. utilizes ambient artificial intelligence (AI) scribing software and/or remote personnel during patient visits. By signing this document, you explicitly consent to the secure, private audio processing of your clinical encounters. These recordings are not retained long-term and are used strictly for the purpose of generating your medical record in compliance with HIPAA and Florida law. Refusal will not affect access to care.

I am responsible for notifying the office promptly if my phone number, email address, mailing address, insurance, pharmacy, or authorized contact changes.

Patient Rights and Responsibilities

Patient Rights

- To be treated with dignity, respect, and compassion.
- To participate in decisions about your care and to receive information about your diagnosis, proposed treatment, risks, benefits, and reasonable alternatives.
- To ask questions and to refuse treatment, subject to the medical consequences of refusing treatment.
- To request access to your medical records and request correction of information you believe is inaccurate or incomplete.
- To receive privacy protections described in the Notice of Privacy Practices.
- To receive information about nonopioid alternatives when an opioid medication is being considered or prescribed, as applicable under Florida law.

Patient Responsibilities

- Provide complete and accurate medical, medication, pharmacy, insurance, claim, and contact information.
- Follow the treatment plan, keep appointments, and notify the office as soon as possible if you must cancel or reschedule.
- Bring photo identification, insurance cards, medication bottles when requested, and relevant imaging or reports.
- Use medications only as prescribed and promptly report side effects, hospitalizations, new prescriptions, or significant changes in your condition.
- Treat staff, providers, and other patients respectfully. Threatening, abusive, discriminatory, or disruptive behavior may result in dismissal from the practice consistent with applicable law and continuity-of-care obligations.

Notice of Privacy Practices - Summary and Acknowledgment

This summary describes how medical information about you may be used and disclosed and how you can access this information. A complete copy of the Notice of Privacy Practices is available upon request and posted in the office. The Notice may be revised from time to time, and you may request an updated copy at any time.

Your Rights

- Get a paper or electronic copy of your medical record as permitted by law.
- Ask us to correct your medical record.
- Request confidential communications or ask us to contact you in a specific way.
- Ask us to limit what we use or share, although we may not be required to agree.
- Get a list of certain disclosures of your health information.
- Get a copy of this Notice.
- Choose someone to act for you if that person has legal authority.
- File a complaint if you believe your privacy rights have been violated.

Your Choices

- You may tell us your preferences about sharing information with family, friends, caregivers, or others involved in your care.
- We generally need your written permission for uses or disclosures for marketing, sale of your information, or most sharing of psychotherapy notes.
- You may revoke a written authorization as permitted by law, except to the extent we have already relied on it.
- I understand I am not required to sign this acknowledgment as a condition of treatment, but the practice may document its good-faith effort to obtain acknowledgment

Initials: _____

Our Uses and Disclosures

- Treatment: We may use and share information with physicians, hospitals, pharmacies, laboratories, imaging centers, therapists, and others involved in your care.
- Payment: We may use and share information to bill and obtain payment from health plans, workers compensation carriers, auto/PIP carriers, attorneys, or other responsible payors.
- Health care operations: We may use and share information to run the practice, improve care, conduct quality review, credentialing, compliance, audits, and business operations.
- As required or permitted by law: We may share information for public health, safety, law enforcement, health oversight, workers compensation, medical examiner/funeral director matters, organ/tissue donation, lawsuits, court orders, subpoenas, and other legally required purposes.
- Substance use disorder records: If the practice creates or receives records protected by special federal substance use disorder confidentiality rules, those records will receive any additional protections required by law.
- Electronic exchange: We may exchange information electronically through our EHR, pharmacies, laboratories, imaging providers, health information networks, and other authorized systems used for treatment, payment, and operations.
- Audio or video recording of visits, staff, providers, or other patients is not permitted without prior consent of all parties, except as otherwise permitted by law.

Our Responsibilities

- We are required by law to maintain the privacy and security of protected health information.
- We will notify affected individuals as required by law if a breach compromises the privacy or security of their information.
- We must follow the duties and privacy practices described in the current Notice.
- We will not retaliate against you for filing a privacy complaint.

Privacy Officer / HIPAA Contact: Pain & Wellness Institute, P.A., 4509 N. Armenia Ave., Tampa, FL 33603, Phone: (813) 873-7777. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

Acknowledgment: I acknowledge that I have received or been offered a copy of Pain & Wellness Institute, P.A.'s Notice of Privacy Practices and have had an opportunity to ask questions.

Controlled Substance and Opioid Informed Consent and Treatment Agreement

This agreement applies if Pain & Wellness Institute, P.A. prescribes opioid medication, benzodiazepines, stimulants, muscle relaxants, sedative-hypnotics, or any other controlled substance. Controlled substances may be helpful for selected patients but carry significant risks. The goal of treatment is meaningful improvement in pain, function, and quality of life, not complete elimination of pain.

Informed Consent: Risks, Benefits, and Alternatives

- Potential benefits may include reduced pain and improved function when medication is clinically appropriate and used as prescribed.
- Risks include sleepiness, dizziness, impaired judgment, slowed reaction time, constipation, nausea, itching, hormonal changes including low testosterone, sexual dysfunction, mood changes, depression, falls, motor vehicle accidents, birth defects or neonatal withdrawal if used during pregnancy, medication interactions, physical dependence, tolerance, withdrawal, addiction, overdose, respiratory depression, and death.
- Risk increases when opioids are combined with alcohol, benzodiazepines, sleep medications, muscle relaxants, sedatives, illicit substances, or other medications that impair breathing or alertness.
- I will not drive, operate heavy machinery, work at heights, make important safety-sensitive decisions, or care for vulnerable persons if I feel impaired or until I know how the medication affects me.
- I understand physical dependence can occur even when medication is taken as prescribed, and abrupt stopping can cause withdrawal. Tolerance may occur and dose increases may not improve pain or function.
- I understand that addiction or opioid use disorder can occur and may require tapering, referral, addiction treatment, or medication treatment for opioid use disorder when clinically indicated.
- I understand that my provider may prescribe or recommend naloxone/opioid antagonist rescue medication when clinically appropriate, and I should tell household members where it is stored and how to use it.
- I have been informed that nonopioid alternatives may be available, including nonopioid medications, injections/procedures, physical therapy, home exercise, weight reduction, behavioral health approaches, bracing, complementary therapies, and other nonpharmacologic options. I understand Florida's required educational information about nonopioid alternatives has been offered to me and is available through the Florida Department of Health as well as on the Pain & Wellness Institute website.
- For chronic nonmalignant pain patients receiving controlled substances, the patient must be evaluated at regular intervals as required by Florida law and the treatment plan, generally not to exceed three months, and more often when clinically indicated.
- Continuation of controlled-substance therapy depends on documented benefit, functional improvement, acceptable risk, compliance with the agreement, PDMP review, and absence of evidence of misuse, diversion, or unsafe use
- I understand that combining opioids with benzodiazepines, alcohol, sleep medications, muscle relaxants, sedatives, or illicit drugs can cause respiratory depression, overdose, coma, or death.

Initials: _____

- Signing this agreement does not guarantee that controlled substances will be prescribed or continued.
- Medication will be continued only when benefits, including functional improvement, outweigh risks.
- Unexpected test results may require confirmatory testing and clinical review before final prescribing decisions are made, except where immediate safety concerns require action.
- If controlled substances are reduced or discontinued, the practice may offer tapering, nonopioid alternatives, referrals, or emergency instructions as clinically appropriate. Discontinuation of controlled substances does not necessarily mean discontinuation of all care.

Patient Responsibilities

- I will take medication exactly as prescribed and will not change the dose, frequency, route, or schedule without authorization from Pain & Wellness Institute.
- I will not obtain controlled substances from another prescriber unless authorized by Pain & Wellness Institute or unless treatment occurs in an emergency, hospital, surgery, dental procedure, or other clinically necessary situation. I will notify Pain & Wellness Institute as soon as possible of any controlled substances prescribed elsewhere.
- I will use one pharmacy for controlled substances unless the office approves and documents a change.
- I will tell all treating providers and pharmacies that I am receiving controlled substances from Pain & Wellness Institute.
- I will not share, sell, trade, give away, borrow, or divert medications. I understand this is unsafe and illegal.
- I will not use illegal drugs or non-prescribed controlled substances. I understand marijuana/cannabis, even if legal under certain circumstances, must be disclosed and may affect my treatment plan and prescribing decisions.
- I will store medications securely, preferably locked, away from children, visitors, pets, and others. I will dispose of unused medication through a pharmacy take-back program or other safe disposal method.
- I will submit to urine, oral fluid, blood, serum, or other drug testing when requested. I understand results may affect prescribing decisions.
- I will submit to random pill counts or medication bottle review within the timeframe requested, which may be within 24 hours or the next business day.
- I authorize Pain & Wellness Institute to review E-FORCSE/PDMP data and to communicate with pharmacies, other prescribers, payors, adjusters, and appropriate entities as permitted by law to coordinate care, verify prescriptions, and address safety, compliance, diversion, or payment issues.
- I will keep scheduled appointments. Missed appointments, late cancellations, repeated rescheduling, or failure to follow the treatment plan may result in medication tapering, non-renewal, or discharge from the practice.
- I understand that prescriptions have specific quantity/frequency limits and refills. Early refills are not guaranteed and generally will not be provided.
- I understand that violation of this agreement, unsafe medication use, inconsistent drug testing, concerning PDMP results, diversion, threatening behavior, forged/altered prescriptions, or failure to follow medical advice may result in tapering, discontinuation of controlled substances, referral for evaluation or treatment, and/or discharge from the practice consistent with applicable law and continuity-of-care obligations.
- Dismissal will be handled consistent with applicable law and continuity-of-care obligations.

Provider Responsibilities

- The provider will evaluate whether controlled substance therapy remains medically indicated and will review benefits, risks, function, side effects, and safety at regular intervals.
- The provider may adjust, taper, discontinue, or decline controlled substances if risks outweigh benefits, treatment goals are not met, or safety/compliance concerns arise.
- The provider may recommend nonopioid medications, interventional procedures, therapy, imaging, specialty consultation, behavioral health care, or other alternatives when clinically appropriate.

Acknowledgment: I have read this agreement, had the opportunity to ask questions, and agree to follow it. I understand that controlled substances for chronic nonmalignant pain should generally be prescribed by a single treating registrant unless otherwise authorized and documented.

Opioid Medication/Radiation: Pregnancy, Safety, and Special Populations

- Pregnancy/breastfeeding: I will inform Pain & Wellness Institute immediately if I am pregnant, may become pregnant, planning pregnancy, or breastfeeding. Opioid and controlled substance use as well as procedure radiation may affect a fetus or newborn and require coordination with obstetric care. I understand that by failing to disclose a potential pregnancy, I assume the risks to the unborn child and will not hold Pain & Wellness Institute, P.A., and its providers liable.
- Sleep apnea, lung disease, kidney/liver disease, older age, fall risk, and combining medications that cause sedation may increase the risk of serious side effects, overdose, and death.
- Alcohol and recreational substances can interact dangerously with controlled substances and should not be used in combination with opioid or sedating medications.

Initials: _____

- Naloxone can reverse opioid overdose temporarily and may be prescribed or recommended. Call 911 after naloxone use because symptoms may return.

Good Faith Estimate Notice for Uninsured or Self-Pay Patients

You have the right to receive a Good Faith Estimate explaining how much your health care will cost if you do not have certain types of health care coverage or you choose not to use certain insurance coverage.

- This notice applies to uninsured patients and patients who choose not to use insurance for an item or service.
- You have the right to receive a Good Faith Estimate for the total expected cost of non-emergency health care items or services upon request or when scheduling those services, including related costs that are reasonably expected and known to the practice.
- If you schedule at least 3 business days in advance, you should receive a written Good Faith Estimate within the time required by law. If you ask for one before scheduling, it should be provided within the time required by law.
- If you receive a bill that is at least $400 more than your Good Faith Estimate for a provider or facility, you may have a right to dispute the bill.
- Keep a copy or picture of your Good Faith Estimate. For more information, visit www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

Prescription Refill Policy

- Prescription and refill requests are processed only during regular business hours. No refills are processed after hours, on weekends, or on holidays.
- Please request non-urgent refills at least three (3) business days before you will run out of medication. Same-day refill requests may not be completed.
- Controlled substance prescriptions generally require an office visit or provider evaluation and will not be refilled early. Patients receiving controlled substances must be seen at clinically appropriate intervals and at least as often as required by Florida law and the provider's treatment plan.
- Florida law generally requires prescriptions to be generated and transmitted electronically unless a legal exception applies. Paper prescriptions may be limited by law, pharmacy requirements, or office policy.
- Medication changes, dose increases, replacement prescriptions, and controlled substance issues require provider review and may require an appointment.
- Lost, stolen, destroyed, spilled, confiscated, or misplaced controlled substances generally will not be replaced. A police report does not guarantee replacement.
- Patients are responsible for using one pharmacy for controlled substances unless the office authorizes and documents a change.
- The office may review the Florida Prescription Drug Monitoring Program (E-FORCSE), request urine/oral fluid/blood drug testing, request medication bottle review or pill counts, and communicate with pharmacies and other treating providers as clinically appropriate and legally permitted.
- Prior authorizations, pharmacy communications, and insurance medication appeals are performed as a courtesy and are not a guarantee of approval or payment. Processing time depends on the insurer/pharmacy.
- Electronic prescribing may be unavailable in certain circumstances, including technology failure, pharmacy limitations, legal exceptions, or other exceptions permitted by law.
- Do not stop opioids, benzodiazepines, muscle relaxants, seizure medications, or other medications abruptly without medical advice unless directed due to a serious reaction or emergency.

Final Patient Acknowledgment

By signing below, I acknowledge that I have completed this packet truthfully and to the best of my knowledge. I have read each section including the medical malpractice arbitration agreement, consent to care, financial agreement, opioid informed consent and contract, release of medical records, pregnancy risks, notice of privacy practices and communication consent. I have had the opportunity to ask questions, and agree to the policies and agreements that apply to my care at Pain & Wellness Institute, P.A.

Printed Name of Patient or Representative: _____

Patient or Representative Signature: _____

Date: _____