Patient Information Form

Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Home address: (include city, state, zip code): _____

Email address: _____

DOB: _____ Social Security: _____ Sex: _____

Emergency Contact: _____ Telephone: _____ Relationship: _____

[ ] Married [ ] Divorced [ ] Separated [ ] Widow [ ] Single

Insurance Information

Primary Insurance: _____

Name of Insured: _____ DOB: _____ Relationship: _____

Policy Number: _____ Group: _____

Secondary Insurance: _____

Name of Insured: _____ DOB: _____ Relationship: _____

Policy Number: _____ Group: _____

Please Read and Sign Below

- **Full payment is due at time services are rendered unless payment arrangements are approved in advance.**
- **Returned checks are subject to additional collection fees.**
- **Your insurance is a contract between you, your employer and your insurance company; we are not a party to that contract. We must emphasize that as medical providers, our relationship is with you, not your insurance company. The filing of insurance is a courtesy that we extend; however, all charges are your responsibility.**
- **I hereby authorize direct payment of surgical/medical benefits to Dr Scott Haufe for services rendered in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.**
- **I hereby authorize Dr Haufe to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.**
- **I certify that information given by me in applying for payments is correct. I authorize release of all medical records on request. I request that payment of authorized be made on my behalf.**
- **I hereby authorize any facility/physician to release any records/labs/x-rays/mental health/etc. to Dr Haufe pertaining to my medical treatment.**
- **A photocopy of these assignments shall be valid as the original**
- **A missed appointment fee of $50.00 dollars will be charged if no show or not cancelled within a 72-hour period (we are closed on Friday, Saturday, Sunday, messages left on these days do not count).**
- **A missed appointment fee of $200.00 will be charged for all procedures not cancelled within a 72-hour period (we are closed on Friday, Saturday, Sunday, messages left on these days do not count).**

Patient Signature: _____ **Date:** _____

EMERALD COAST PAIN SERVICES
3997 COMMONS DRIVE W
SUITE M
DESTIN, FLORIDA 32541-8444

Our office is happy to announce that we have implemented a new appointment reminder system. Patients can now be notified by phone, text, and email. To ensure we have your most accurate contact information in our system, please provide the following:

PLEASE PRINT CLEARLY

NAME: _____ DOB: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Thank you!
ECPS Staff

Emerald Coast Pain Services
3997 W Commons Drive Suite M, Destin, Florida 32541
(p) 850-424-3769 (f) 850-460-2491

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT AND RELEASE OF INFORMATION AUTHORIZATION

PRIMARY CARE PHYSICIAN _____ **DATE OF BIRTH** _____

My signature below indicates that I have been provided with a copy of Emerald Coast Pain Services Notice of Privacy Practices.

X _____ X _____
Patient Name (Print) Patient Signature

X _____ X _____
Patient Representative Signature Witness/Date

Medical Information/HIPAA Release Form

[ ] I authorize the release of information including medical or surgical care rendered to me and any financial information related to the care given to:

[ ] _____ Relationship_____ Contact _____
[ ] _____ Relationship_____ Contact _____
[ ] _____ Relationship_____ Contact _____

[ ] Information **is not** to be released to anyone. [ ] Consent Revoked _____

Medical information may be communicated by phone messages to:

[ ] my home [ ] my work [ ] my cell number: _____

If unable to reach me:
[ ] you may leave a detailed message with the person answering the phone
[ ] please leave a message asking me to return your call

Emergency Contact/Phone Number: _____
Email Address: _____
Signed: _____ Date: _____

Witness: _____ Date: _____

Authorization for Retrieval of Prescription History and/or Transmission of Immunization Information

Pharmacy:_____

Emerald Coast Pain Services utilizes an Electronic Medical Record System that can send and retrieve information about your prescription history. This history gives the physician complete information that will assist them in providing the best care and preventing possible prescription interactions.

[ ] I **authorize** Emerald Coast Pain Services to retrieve my prescription history
[ ] I **do not authorize** Emerald Coast Pain Services to retrieve my prescription history

_____ _____ _____
Patient/Parent/ Guardian Signature Patient Name (Please Print) Date
(Parent or Guardian must sign if patient is a minor)

Insurance & Financial Information

Assignment of Insurance Benefits: I hereby assign to and authorize payment directly to Emerald Coast Pain Services of all benefits payable under the terms of any insurance policy or benefits listed above (not applicable when payment is made).

Financial responsibility: I understand that I am financially responsible to Emerald Coast Pain Services for all legal charges incurred by the person(s) named above. In the event that this account is placed in the hands of an attorney for collection, the patient and/or guarantor, jointly and severally, agree to pay all costs of collection which include but are not limited to interest at the highest legal rate, attorney fees, and court costs.

Authorization to Release Medical Information: I hereby authorize the release of any medical information which is necessary to process any insurance claim for the person(s) named above (this includes Social Security Administration, its intermediaries, and insurance carriers for Medicare patients)

_____ _____
Signature of Responsible Party Date

EMERALD COAST PAIN SERVICES
3997 COMMONS DRIVE W SUITE M
DESTIN, FLORIDA 32541-8444
PHONE 850-424-3769 FAX 850-460-2491

PATIENT PORTAL CONSENT FORM

I, _____, agree to the usage of the Patient Portal to enhance the communication process between EMERALD COAST PAIN SERVICES and myself.

Further, I understand the Patient Portal is certified HIPAA Security compliant. _____

PLEASE PRINT

Name: _____

Date of birth: _____/_____/_____

Email: _____

Username: _____

[ ] I decline use of the Patient Portal

PATIENT SIGNATURE: _____

Patient Quality Measure 2020

The federal government requires us to monitor 6 quality measures per year per patient. The following questions were chosen for our specialty. Please assist us by answering the following questions.

Tobacco and Alcohol usage

Do you smoke tobacco? Y / N
Do you want counselling or medication to help you quit? Y / N
Do you drink Alcohol? Y / N
How often? Daily / Weekly / Monthly Quantity: _____

Risk of Falls

Do you have issues with falling? Y / N
Do you have an unsteady or weak gait (walk)? Y / N
Do you utilize an ambulatory aid or furniture to avoid falling? Y / N

Depression and Suicide

0 = Never 1 = Sometimes 2 = Mostly 3 = Always
Do you find pleasure in doing things? 0 / 1 / 2 / 3
Do you feel depressed or hopeless? 0 / 1 / 2 / 3
Do you have suicidal thoughts? 0 / 1 / 2 / 3
Does depression affect your:
Sleep 0 / 1 / 2 / 3
Energy level 0 / 1 / 2 / 3
Appetite 0 / 1 / 2 / 3
Feeling about your self or your relationships? 0 / 1 / 2 / 3
Concentration 0 / 1 / 2 / 3
Movement or speech 0 / 1 / 2 / 3

Social Isolation

Are you currently: Married / Divorced / Separated / Single / Widow(er) / Living w/someone?
How often, during a week, do you speak to another person via phone? Daily / Twice a week / Weekly / Almost never
How often do you get together with friends or relatives? Daily / Twice a week / Weekly / Almost never
How often do you attend religious services? Weekly / Monthly / Annually / Almost never
Do you belong to any clubs or social groups? Y / N

Domestic Abuse – DECLINE TO ANSWER [ ]

During the past year has anyone: (circle all that apply) Threatened you / Abused you / Assaulted you / Raped you Y / N

Insurance Assignment Program

It is our desire to assist our patients whenever possible. The following insurance assignment program allows you, our patient, to receive the care you need without undue financial strain.

1. Waiting for insurance payment is a courtesy provided by Emerald Coast Pain Services. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits during your care period. We must receive your completed coverage verification prior to accepting assignment.
2. All deductible amounts must be paid by you on Evaluation day or prior to first procedure. If contracted with your carrier your balance as determined will be due in full 90 days from date of service. If non-contracted any amount due after payment or adjustment is due within 30 days of notice of claim processing or 90 days whichever comes first.
3. The insurance carriers are billed within 72 hrs of service being rendered. It is your responsibility to supply this office with necessary information required to complete the billing.
4. If you receive payment from your insurance carrier during the period which Emerald Coast Pain Services has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do this may result in collection action.
5. The clinic does not promise that an insurance will pay. In the event that the insurance company disputes or rejects the claim, it will be the patient's responsibility to pay the charges and pursue reimbursement from the insurance company.
6. **We are never guaranteed payment from the insurance company. Our arrangements are with you the patient. Our company will work closely with your insurance company for claim processing however, if payment is not received within a timely manner (60 days), payment of the balance is expected from you the patient no later than 90 days from date of service.**
7. Failure to adhere to this assignment will result in full responsibility of billed charges.

Please read the above Assignment Program *CAREFULLY.*

_____ _____

Patient Signature **Date**

Emerald Coast Pain Services New Patient Form

Please read carefully and answer all questions. Use the back of the paper if necessary.

Name _____ Date of Birth _____

1 Who referred you? _____

2 Where is your worst pain? _____

3 When did you first start having this pain? _____

4 How did this pain occur? _____

5 Have you had this pain before? Yes / No When? _____
Please explain. _____

6 If your pain was caused by an accident, please give the date of the accident. _____
Describe the accident. _____

7 Please describe your pain Sharp / Dull / Knots / Burning / Throbbing / Electric Shocks / Tingling / Aching /

8 Is your pain Constant or Intermittent

9 Do you have any areas of tingling (pins & needles) ? Yes / No Where _____

10 Do you have any areas of numbness (loss of sensation) ? Yes / No Where _____

11 Do you have any weakness in your arms, legs, hands or feet ? Yes / No
Describe _____

12 Do you have any of the following symptoms: Swelling / Stiffness / Bruising / Locking or Catching / Popping / Giving Way / Difficultly Walking / Loss of Control of Bowel / Loss of Control of Bladder /

13. Has your pain become worse recently? Yes / No When did it get worse? _____
Why do you think it became worse? _____

14. Circle what makes your pain worse Standing / Walking / Running / Exercise / Sitting / Lifting / Twisting / Stairs / Lying in bed / Bending / Squatting / Kneeling / Coughing / Sneezing / Rising from a chair / Other: _____

15. Circle what makes your pain better Rest / Elevation / Heat / Cold / Brace / Bandage / Exercise / Therapy / Medication / Other: _____

16 What treatments have you had for your pain Injection / Brace / Therapy / Cane / Crutch /
Other _____

17 Names of prior pain management physicians, locations, dates and treatments

_____

18 For your pain issue do you have any recent MRI's / CT scans / Lab work / Nerve conduction studies / Specialist referrals? Provide dates _____

19 Do you have headaches? Yes / No If yes are they bilateral or one-sided? Describe your headache

_____

20 If you have headaches do you have vision loss / hearing abnormalities / unusual sensations? How often do you get these headaches? _____

21 Have you been **diagnosed** with any of the following Carpal Tunnel Syndrome / Restless Leg Syndrome / Fibromyalgia / Myofascial Pain / Migraines / Menstrual Disorders / Endometriosis / Cluster Headaches Rheumatoid Arthritis / Osteo-Arthritis / Lupus / Chronic Fatigue Syndrome / When were you diagnosed and what treatments have been done? _____

22 Do you get adequate sleep? Yes / No Why not? _____ How many hours? ____

23 Have you ever been **diagnosed** with: Depression / Bipolar / Manic / Psychosis / Addictive Disorder?
Explain _____

24 *PAST MEDICAL HISTORY:* Circle any of the following illnesses you have had: Heart Disease / Hypertension / Stroke / Anemia / Cancer / Leukemia / Diabetes Type 1 / Diabetes Type 2 / Kidney Disease / Thyroid Disease / Lupus / Goiter / Lung Disease / Asthma / Bunion / COPD / Emphysema / Pneumonia / Tuberculosis / Epilepsy / Anxiety / Alcoholism / Colitis / Polio / History of Blood Clots / Bleeding Problems / Problem with Anesthesia / HIV/AIDS / Hepatitis / Stomach Ulcers /
Other _____

25 *SURGICAL HISTORY:* Please list **ALL** previous surgeries and the **DATES** performed
_____
_____
_____

26 *FAMILY HISTORY:* Present Age or Age at Death / Medical Illnesses / Problems
Father _____
Mother _____
Brother/Sister _____
Brother/Sister _____

27 *MEDICAL ALLERGIES:* List **Medicine** and **Type of Reaction** (nausea, itching, rash, hives, wheezing)
_____
_____

28. Are you presently taking **COUMADIN, PLAVIX** or any other **BLOOD THINNER**? Yes / No If yes, why?
_____

29 *CURRENT MEDICATIONS:*

Name of Med / Dosage / Times per Day / Purpose of Med / Prescribing Doctor

_____
_____
_____
_____
_____

SOCIAL HISTORY:

30 **Ethnicity:** Hispanic or Latino Not Hispanic or Latino

31 **Race:** American Indian or Alaska Native Asian Black or African American
Native Hawaiian or Other Pacific Islander White

32 **Education:** Some High School High School Graduate College Student
Some College Associate Degree Bachelor Degree Graduate Student
Masters Degree Doctorate Degree

33 **Marital Status:** Married Single Divorced Widowed

34 Number of Children _____

35 Religion _____

36 Number of People Living in Household: _____

37 What is (or was) your occupation? _____

38 What is your current employment status? ☐ Working Full-Time ☐ Working Part-Time ☐ On Sick Leave
☐ Legally Disabled ☐ Retired ☐ Other _____

39. **Smoking Status:** ☐ Current Smoker _____ Packs/day ☐ Former Smoker ____Years Ago
☐ Never Smoker

40 Do you drink alcohol? Yes / No If yes average number of drinks/day_____ (or) drinks/week_____

41 Have you ever been treated for alcohol or drug abuse? Yes / No If yes explain_____
_____

42 Have you ever been discharged from a pain practice? Yes / No If yes why? _____
_____

43 *ROS:* Please circle any of the following medical problems you have had

HEENT: blurred vision / double vision / vision loss / dryness / wear glasses / wear contacts / trouble swallowing / hoarseness / hearing loss / nosebleeds /
Cardio: chest pain / irregular heartbeat / palpitations / anesthesia problems /
Respiratory: shortness of breath / chronic cough / wheezing /
Abdominal: heartburn / ulcers / nausea & vomiting / blood in stool / jaundice /
Renal: painful urination / blood in urine / difficult urination /
Musculoskeletal: morning stiffness lasting longer than 3 hours / joint pain / joint swelling / back pain / gout /
Skin: frequent rashes / skin ulcers / psoriasis / lumps /
Neurological: headaches / dizziness / seizures /
Psychiatric: depression / anxiety / diagnosed sleep disorder /
Endocrine: heat intolerance / cold intolerance / excessive thirst /
Hematologic/Lymphatic: blood clots / easy bleeding / easy bruising / swollen glands /
Immunologic: hay fever / HIV exposure / persistent infections / skin rash /
Other: Loss of appetite / weight loss /

44 Is your injury Workman's Comp related? Yes / No Automobile Insurance related? Yes / No

45 Is there litigation pending with your injury? Yes / No If so who is your lawyer?_____
Do you want us to share information with your lawyer if he contacts us? Yes / No Your initials, if Yes____

We're glad that you have chosen Emerald Coast Pain Services for your treatment. The practice of pain management includes the usage of medications and some minor procedures or surgeries. There are risks included with any treatment and we want you to be aware of this. Risks from procedures include bleeding, infection, tissue damage, nerve damage and risk of life or limb. These risks are very small, usually less than 1%, but you need to be made aware of them. There are also risks with any medications, which include allergic reactions, psychological changes, worsening of symptoms or even life threatening reactions. Again, these reactions are usually rare. During this visit, we will outline a treatment plan that may include medications, injections, referrals, etc. to help you get better and we expect you to progress along with that plan in a timely manner. **Failure to follow the treatment plan may result in dismissal from the practice.** Nothing in medicine is absolute and not all treatments work in all patients. We want you to be informed and if at any time you desire additional information about your medications or procedures, please ask and make sure your questions are answered.

I _____ have read and understand the above

Name_____ Date____/____/20____