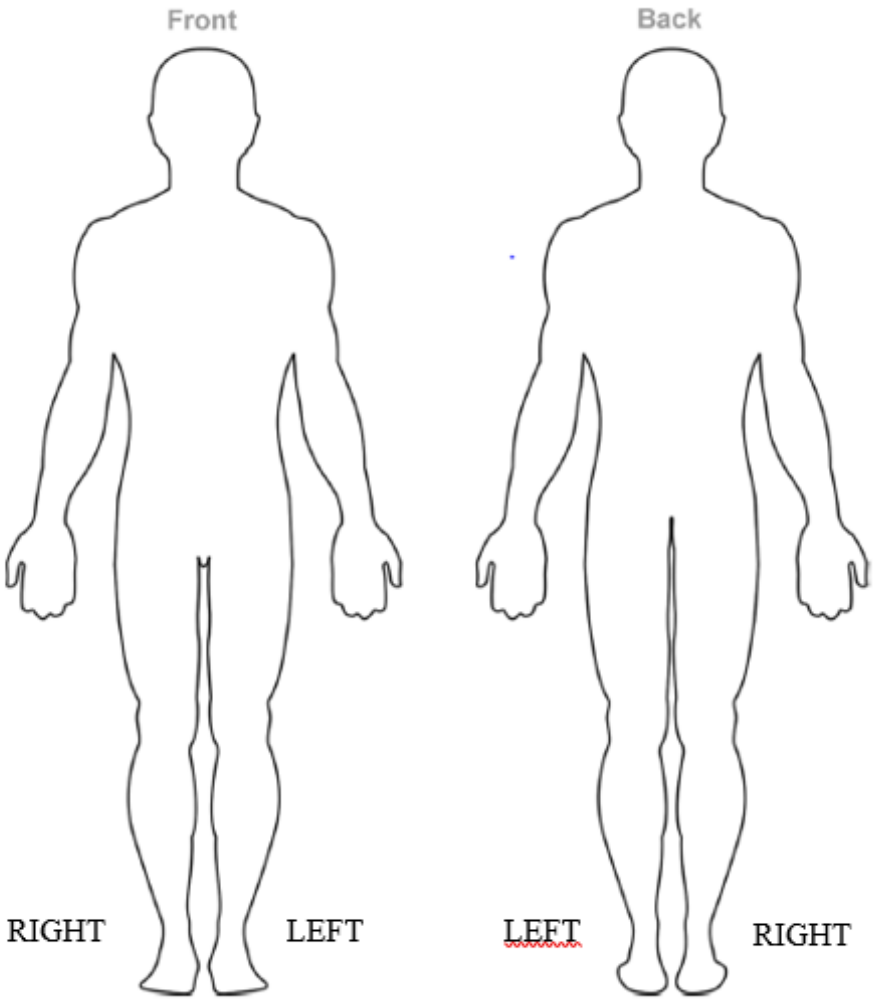
Physical Medicine and Rehab of Brevard, P.A.
Antonio Rivera, M.D. 840 Executive Lane, Suite 120 Phone: 321-449-1112
F.A.A.P.M.R. Rockledge, FL. 32955 Fax: 321-449-1172

PATIENT NAME: _____ **DATE: _____**

Please Mark Where You Are Experiencing Pain:



CIRCLE YOUR PAIN LEVEL:

No Pain Moderate Pain Intolerable Pain

0 1 2 3 4 5 6 7 8 9 10

TYPE OF PAIN: Aching Stabbing Burning Throbbing Consistent

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PATIENT NAME: _____ DATE: _____

PATIENT INFORMATION

FIRST NAME_____ MIDDLE INITIAL _____ LAST NAME_____

ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

SSN_____

DATE OF BIRTH _____/_____/_____ SEX _____

EMAIL _____

CELL PHONE_____

HOME PHONE_____

ETHNICITY: ☐ DID NOT SPECIFY ☐HISPANIC/LATINO
☐ NOT HISPANIC/LATINO

RACE: ☐ DID NOT SPECIFY ☐ ASIAN
☐WHITE ☐ BLACK / AFRICAN AMERICAN
☐AMERICAN INDIAN / ALASKA NATIVE
☐NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER

MARTIAL STATUS: ☐ SINGLE ☐ MARRIED
☐ DIVORCED ☐ WIDOWED

OCCUPATION_____

EMPLOYER_____

PLACE OF BIRTH_____

NEXT OF KIN_____

RELATIONSHIP_____

CONTACT NUMBER_____

EMERGENCY CONTACT: _____

PHONE NUMBER: _____

RELATIONSHIP: _____

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? ☐ YES ☐ NO
IF NO PLEASE COMPLETE THIS SECTION

RELATIONSHIP_____ SEX_____

FIRST NAME_____MIDDLE_____

LAST NAME_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

CONTACT NUMBER_____

EMAIL_____

EMPLOYER_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

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PATIENT NAME: _____ DATE: _____

INSURANCE INFORMATION **PLEASE PROVIDE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST**

INSURANCE COMPANY_____ INSURED'S DOB_____

INSURANCE/CARD HOLDER'S NAME_____RELATIONSHIP_____

ID#_____ GROUP #_____EFFECTIVE DATE_____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY_____ INSURED'S DOB_____

INSURANCE/CARD HOLDER'S NAME_____RELATIONSHIP_____

ID#_____ GROUP #_____EFFECTIVE DATE_____

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT OR GUARDIAN_____DATE_____

PRINTED NAME_____

Visit Summary

What medical problems (injury) brought you to the doctor today? _____
_____

When did the injury occur? _____
How did the injury occur? _____

Did the injury occur on the job? ☐Yes ☐No

What is your job description? _____

Date of Employment _____ How long in present position? _____ Date last worked.? _____

☐ **Check if this is a Worker's Comp Related Injury**

Have you received treatment for this injury? _____ If yes, When? _____
Who has treated you? _____
Have you ever had an injury like this before? ☐ Yes ☐ No If yes, when? _____

Who referred you to us? ☐ Yellow Pages ☐ Insurance Co. ☐ Referring Physician ☐ Friend.

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Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am always financially responsible to Physical Medicine and Rehab (hereinafter "PMR") and and/or its affiliated entities, for any charges not covered by my healthcare benefits. It is my responsibility to notify PMR of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill and/or balance of the bill as determined by PMR and/or my healthcare insurer, if the submitted claims or any part of the claim are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above, for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare if I am a Medicare beneficiary, to PMR for all covered medical services and supplies provided to me during all courses of treatment. This includes care provided by PMR and/or its affiliated entities or otherwise at its discretion. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with PMR, which will authorize and allow for direct payment to PMR of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by PMR.

_____ _____
Printed Name of Patient **Name of Guardian/Personal Representative**

_____ _____
Signature of Patient **Signature of Guardian/Personal Representative**

Date: / / **Witness:** _____

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PATIENT NAME: _____ **DATE: _____**

HEALTH HISTORY & INFORMATION

YES	NO	MEDICAL HISTORY	YES	NO	MEDICAL HISTORY
☐	☐	Stroke	☐	☐	Mental illness
☐	☐	Heart Trouble	☐	☐	Kidney trouble
☐	☐	High Blood Pressure	☐	☐	Cancer, what kind?
☐	☐	Diabètes			_____
☐	☐	Arthritis	☐	☐	Bleeding Disorder
☐	☐	Gout	☐	☐	Alcoholism
☐	☐	Hemorrhoids	☐	☐	Tuberculosis
☐	☐	Seizures	☐	☐	Lung Disease
☐	☐	Anemia	☐	☐	Phlebitis
☐	☐	Ulcers	☐	☐	Liver Trouble
			☐	☐	Thyroid Trouble

OTHER, PLEASE SPECIFY:

Family Health History
(Please state any if applicable to the right)

Disease	Who	When Diagnosed

ALCOHOL USE

Did you have a drink containing alcohol in the past year?

☐ Yes
☐ No

If "Yes," how often?

☐ Never
☐ Monthly or less
☐ 2 to 4 times a month
☐ 2 to 3 times a week
☐ 4 or more times a week

SOCIAL HISTORY

CAFFEINE INTAKE
(Coffee, Tea, Soda, Etc.)

☐ None
☐ 1-2 cups per day
☐ 2-3 cups per day
☐ 3-4 cups per day
☐ More than 4 cups per day

EXERCISE / ACTIVITY LEVEL

☐ None
☐ Daily
☐ 1-2 x per week
☐ 2-3 x per week
☐ Occasionally

SURGICAL HISTORY: (MONTH & YEAR IF KNOWN)

Smoke (Cigarettes):
☐ Yes
☐ No

____ Packs per day
____ Years smoked.

Tobacco Use:
☐ None
☐ Presently
☐ Past Problems

What kind?
_____

Drug Abuse:
☐ None
☐ Presently
☐ Past Problems

If so, when? _____

Marijuana Use:
☐ Yes
☐ No
☐ Has Medical Card

Issue Date:
_____

Expire Date:
_____

Primary Care Physician:

Name:

Phone Number:

City & State:

Height:

Weight:

Allergies (if any):

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Medication List

NAME	***DOSAGE***	***FREQUENCY***

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PATIENT NAME: _____ **DATE: _____**

Additional Medical History:

Yes	NO		Yes	NO		Yes	No	
		Glasses			Nausea or vomiting			Seizures
		Change in Vision			Stomach Pain			Frequent rash
		Loss of Hearing			Ulcers			Hot or Cold Spells
		Ear pain			Frequent Belching			Recent Weight Change
		Hoarseness			Dentures			Nervous Exhaustion
		Nosebleeds			Blood Transfusion			Trouble Sleeping
		Difficulty Swallowing			Loose Bowels			Depression
		Morning Cough			Constipation			Nervous Tension
		Shortness of Breath			Blood in Bowel Movements			WOMAN ONLY
		Chills or fever			Hemorrhoids			Irregular Periods
		Heart or Chest Pain			Frequent Urination			Vaginal Discharge
		Abnormal Heartbeat			Burning on Urination			Frequent Spotting
		Badly Swollen Ankles			Difficulty Starting Urination			Taking Birth Control
		Calf Cramps When Walking			Difficulty Stopping Urination			Could You Be Pregnant
		Poor Appetite			Get Up Frequently at Night to Urinate			Are you Breastfeeding
		Tooth Ache			Frequent Headaches			**Date of Last Period**
		Gum Trouble			Blackouts			_____

Immunizations:

Covid _____ Brand_____ year_____

Tetanus (TD) _____ year_____

Pneumovax (Pneumonia) _____ year_____

Influenza (flu shot) _____ year_____

Alternative to Opioids: *Please initial below that you understand.*

_____ **Non-opioid alternatives for pain treatment, which may include non-opioid medicinal drugs or drug products are available.**

_____ **Non-opioid interventional procedures or treatments which may include acupuncture, chiropractic treatments, massage, physical or occupational therapy, or other appropriate therapy are available.**

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PATIENT RESPONSIBILITIES & AUTHORIZATIONS

PLEASE READ AND INITIAL EACH LINE.
IF YOU HAVE ANY QUESTIONS, PLEASE ASK THE RECEPTIONIST FOR ASSISTANCE.

____ I understand that my co-payment is due at each visit. Cash, check, Mastercard, and Discover cards are acceptable methods of payment.

____ I understand that I could be discharged from the practice at Dr. Rivera's discretion.

____ I understand that I will be charged $25 for any returned check.

____ I understand that I am financially responsible for the charges not covered by my insurance, such as: deductibles, coinsurance.

____ I authorize the release of any medical or other information necessary to process the insurance claim(s).

____ I authorize payment directly to the billing office of this physician/clinic for the medical and/or surgical benefits, if any, otherwise payable to me for services.

____ I understand that I will be charged $50 for any/all missed appointments without 24-hour notice of cancellation prior to the appointment.

____ I understand that I may be responsible for charges related to the completion of certain forms and letters. The cost for such forms or letters is $25.

____ I understand that regardless of my insurance status, I am responsible for the balance of my account.

____ I understand that I am responsible for any collection and/or attorney fees should my account be turned over to a collection agency.

____ I authorize payment of insurance benefits to the physician or supplier for all services rendered.

____ I understand that I may not be seen if more than 15 minutes late for my scheduled appointment.

I UNDERSTAND AND ACCEPT THE ABOVE RESPONSIBILITES AND AUTHORIZATIONS.

SIGNATURE OF PATIENT OR GUARDIAN_____DATE_____

PRINTED NAME_____

Health Care Advance Directives

These are legal documents that communicate a person's wish about health care decisions in the event the person becomes incapable of making health care decisions. These are two basic kinds of advance directives: living wills and health care powers of attorney.

A living will express, in advance, a person's instructions or preferences about future medical treatments, particularly end-of-life care, in the event the person loses capacity to make health care decisions.

Do you have a living will? _____(Y)_____(N)

A health care power of attorney appoints a person to make decisions for the person in the event of incapacity to make health care decisions.

Also, do you have a Power of Attorney? _____(Y)_____(N)

If so, who is you POA? _____ Phone Number_____

Date: _____

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PATIENT NAME: _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of this document is available upon request.

I understand that as part of my healthcare, Physical Medicine and Rehab of Brevard and its affiliates originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans or future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), we request that you acknowledge the following information with your signature. The HIPAA Privacy Rule permits health care providers to communicate with patients regarding their health care. This includes communicating with patients at their homes, whether through the mail or by phone. In addition, the Rule does not prohibit covered entities from leaving messages for patients on their answering machines. The HIPAA Privacy rule also permits health care providers to leave a message with a family member or other person who answers the phone when the patient is not home. The Privacy Rule permits covered entities to disclose limited information to family members, friends, or other persons regarding an individual's care, even when the individual is not present. However, covered entities should use professional judgement to assure that such disclosures are in the best interest of the individual and limit the information disclosed.

Please check all that may apply:

- ☐ Office may leave messages on answering machine.
- ☐ Office may call cell phone _____.
- ☐ Office may call patient at work: _____.
- ☐ Office may leave message with spouse and/or significant other. Name: _____Phone: _____.
- ☐ Office should speak with patient ONLY.
- ☐ Medical information can be given to family members or friends, such as:

  Name: _____ Phone: _____
  Name: _____ Phone: _____
  Name: _____ Phone: _____
  Name: _____ Phone: _____

_____

Patient's Signature **Date**

_____

Patient's Representative (if applicable) **Relationship to Patient**

For Office Use Only: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgment could not be obtained because:
[__] Individual refused to accept Notice [__] Individual was unable to sign [__] An emergency prevented us from obtaining acknowledgment.
[__] Individual refused to sign Acknowledgment [__] Other: _____.

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CONTRACT FOR MEDICATIONS/CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (narcotics, tranquilizers, and barbiturates) are particularly useful, but have a high potential for misuse and abuse, and are therefore carefully controlled by the local, state, and federal government. They are intended to assist in pain tolerance and improve function and/or ability to work. If Dr. Rivera is prescribing such medication for me to help manage my pain, I agree to the following conditions:

Please review the following statements closely and initial where indicated:

1. I AM RESPONSIBLE FOR MY MEDICATIONS/CONTROLLED SUBSTANCE PRESCRIPTIONS. If the prescription for medication is lost, misplaced, or stolen, or if I use it sooner than prescribed it **will not be replaced during that prescription period**. **_____**

2. (a.) I agree that **I WILL NOT REQUEST OR ACCEPT** controlled medications from any other physician or individual while I am receiving such medication from Dr. Antonio Rivera. I fully understand that besides being illegal to do so, it may endanger my health, and failure to comply will result in immediate discharge from Physical Medicine and Rehab. _____
   (b.) I will inform Dr. Rivera and medical assistant of all prescriptions I am receiving from any other physicians, including medical marijuana or over-the-counter THC products. _____
   (c.) I agree to comply with the plan of the physician in its entirety. I will seek non-medication related methods to control pain when instructed to do so. (For example, physical therapy, home exercise program, etc.) _____
3. Refills of medications/controlled substances will:
   a. **BE MADE ONLY DURING REGULAR OFFICE HOURS**: The normal operating hours of Physical Medicine and Rehab P.A. are Monday through Thursday 9AM to 5PM. Friday from 9AM to 12PM. In addition, no refills will be made as "an emergency," such as on holidays or weekends because "you suddenly remember you will run out tomorrow." **I AM RESPONSIBLE TO KEEP TRACK OF MY MEDICATION AND PLAN AHEAD**. _____
   b. I am responsible for taking the medication ONLY in the dose prescribed by Dr. Rivera will not under any circumstances adjust the prescribed dose of my medication without first consulting Dr. Rivera. _____
   c. I understand that it is my responsibility to call Physical Medicine and Rehab, 48 hours in advance for refills to ensure that I do not run out of medication. _____
4. I understand that if at any time I violate any of the above conditions, my controlled substance prescriptions, and my treatment at Physical Medicine and Rehab, P.A. may end immediately. If the violation involves obtaining controlled substances from another individual other than a physician, I may be reported to my primary physician, local medical facilities, as well as other authorities. _____
5. I understand that to continue receiving any refills of prescribed medications, I must schedule and keep routine follow-up appointments as determined by my physician. _____
6. **I agree to choose one pharmacy where I can obtain all controlled prescriptions. The pharmacy I have chosen is _____.**
7. I understand that by accepting controlled substance medications from this office, **I agree to undergo urine toxicology screens (laboratory testing to determine what drugs, if any, I have been taking) as deemed necessary by Dr. Rivera**. I also understand that the presence of unauthorized substances will result in the cessation of treatment with controlled substances and formal discharge from the practice. _____
8. **I understand that at any point during the month, I could be called in for a random pill count**. _____
9. **I understand that I will need to bring in any medications that Dr. Rivera prescribes to my appointments.** _____

Your signature on this contract affirms that you have the full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all its terms as outlined above.

*Patient Signature*_____ *Witness*_____ *Date*_____

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PATIENT NAME: _____ DATE: _____

SOAPP® Version 1.0-14Q

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1.	**How often do you have mood swings?**	**0 1 2 3 4**
2.	**How often do you smoke a cigarette within an hour after you wake up?**	**0 1 2 3 4**
3.	**How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?**	**0 1 2 3 4**
4.	**How often have any of your close friends had a problem with alcohol or drugs?**	**0 1 2 3 4**
5.	**How often have others suggested that you have a drug or alcohol problem?**	**0 1 2 3 4**
6.	**How often have you attended an AA or NA meeting?**	**0 1 2 3 4**
7.	**How often have you taken medication other than the way that it was prescribed.**	**0 1 2 3 4**
8.	**How often have you been treated for an alcohol or drug problem?**	**0 1 2 3 4**
9.	**How often have your medications been lost or stolen?**	**0 1 2 3 4**
10.	**How often have others expressed concern over your use of medication?**	**0 1 2 3 4**

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

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11. How often have you felt a need for higher doses of medication? to treat your pain?	**0 1 2 3 4**
12. How often have you been asked to give a urine screen? for substance abuse?	**0 1 2 3 4**
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	**0 1 2 3 4**
14. How often, in your lifetime, have you had legal problems or been arrested?	**0 1 2 3 4**
15. How often have you felt impatient with your doctors?	**0 1 2 3 4**
16. How often do you feel bored?	**0 1 2 3 4**
17. How often have you run out of pain medication early?	**0 1 2 3 4**
18. How often have you counted pain pills to see how many were? remaining?	**0 1 2 3 4**
19. How often have others suggested that you have a drug or alcohol problem?	**0 1 2 3 4**
20. How often have others told you that you have a bad temper?	**0 1 2 3 4**

Please include any additional information you wish about the above answers. Thank you.

Patient Initials: _____

Staff: _____

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PATIENT NAME: _____ **DATE: _____**

Patient Health Questionnaire – 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle 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/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 let yourself or family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the Newspaper or watch T.V.	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

FOR OFFICE CODING **0** **+ ____ + ____ +_____**
= Total Score: _____

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or have a good relationship with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
❒	❒	❒	❒