

## Gulf Coast Pain Management

3890 Tampa Road Suite 308 \* Palm Harbor, FL 34684 \* (727)789-0891 fax (727)789-1570

Lynne Carr Columbus, D.O.

[www.gulfcoastpain.com](http://www.gulfcoastpain.com)

Dear Sir or Madam:

We are looking forward to seeing you on your upcoming appointment on Your appointment with Dr. Lynne Columbus is at

Enclosed you will find a packet of new patient registration documents. If you would complete these before you arrive for your appointment, it would save you time in the waiting room. If you have any difficulty answering any of the questions, just skip those and we will help you complete the forms when you get here.

Please bring your current (not more than a year old) x-rays, MRI's, CT scans, and myelogram films along with the interpretive reports. It Is Important that you bring a list of the medications you are currently taking, as well as a list of any drug allergies that you may have. Please bring any old medical records that are relevant to your painful disorder. If you are currently receiving pain medications from another physician, such as narcotics, please bring their office notes with you. **No narcotics** will be prescribed without these notes.

We would like you to bring your current insurance cards and driver's license or form of identification. If you have specific insurance questions, it would be helpful to check your insurance company before your appointment. Our staff will also be available to help you with your questions. All necessary referrals must be obtained prior to your appointment, or you will not be able to be seen, this is your insurance company's policy.

It is imperative that you arrive on time for your appointment. If you are more than ten minutes late, there is a possibility your appointment will be rescheduled due to schedule restraints. There is a **\$25.00** fee for appointments cancelled less than **24 hours** prior to the scheduled time.

We accept credit cards, cash or checks for payment, which is due at time of service.

We thank you in advance for your cooperation in doing this work in preparation for your visit. Please do not forget to bring your packet. If you have any questions, please do not hesitate to call us at (727)789-0891 or visit our website at [www.gulfcoastpain.com](http://www.gulfcoastpain.com).

**Please note we are located in the Morton Plant Mease East Lake Outpatient Center on the southwest corner of Tampa Road and McMullen Booth Road.**

Sincerely,

Gulf Coast Pain Management  
Dr. Lynne Carr Columbus



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Dear Patient:

Due to the multiple last minute cancellations we have experienced over the past few months, we are going to strictly enforce our 24-hour cancellation policy. It is imperative that you arrive on time for your appointment. If you are more than ten minutes late, there is a possibility your appointment will be rescheduled due to schedule restraints. Our doctor's time is important. Missed or cancelled appointments at the last minute are an inconvenience to both the doctor and other patients. There is a **\$25.00** fee for appointments cancelled less than **24 hours** prior to the scheduled time.

We accept cash or checks for payment, which is due at time of service. All copays must be paid at the time of service. If a referral is required for your visit, it is your responsibility to obtain the appropriate referral from your primary care physician. If an appropriate referral has not been obtained, payment in full will be due at the time of your visit, this is your insurance policy. If you do not have means to provide a payment at the time of your appointment, your appointment will be scheduled at another time; however, you will still be responsible for payment of the \$25.00 cancelled appointment fee.

All prescriptions and authorizations for renewals should be requested during normal office hours. Check your medication supply frequently. Call us before your medications "run out" so that there is no chance of lapse. We require 24-hour notice for refills!!! Prescription refills will not be written after hours. Remember, check frequently.

**I have read and understand the above stated office policies and will adhere to them.**

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Witness-office staff

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time



## Gulf Coast Pain Management

### **DIRECT PAYMENT AUTHORIZATION WITHOUT ASSIGNMENT OF BENEFITS**

By way of original or a copy hereof, the undersigned patient hereby authorizes the auto insurance personal injury protection or medical payments insurance carrier to make payment directly to Provider for services and supplies necessitated by an accident occurring on or about \_\_\_\_\_.

**If not an auto or work related injury please disregard above paragraph**

This authorization for direct payment does not constitute an assignment of benefits, nor is it intended, by either the undersigned patient or Provider to constitute an assignment of benefits. Further, the sole consideration for this authorization is the mutual convenience of the patient and provider.

Provider has not accepted, nor agreed to accept, an assignment of benefits from the undersigned patient and has not consented or agreed to arbitrate or do anything else that would in any way prevent the undersigned patient from enforcing any provision of the insurance contract with the applicable personal injury protection or medical payments insurance carrier.

The undersigned patient specifically has not granted an assignment of benefits to Provider, as the patient expressly desires to retain all rights to enforce the applicable insurance contract and has not transferred any right, title, or interest in said contract to Provider. The patient intends to merely authorize the applicable insurance company to pay provider directly as a convenience to the patient regarding payment of bills and to avoid the necessity of having to countersign the claim form each time the patient receives treatment. The undersigned patient has not transferred and expressly reserves the right to demand payment from any and all insurance companies obligated to pay medical bills related to treatment rendered by Provider. It is the intention of the undersigned patient and Provider that if the medical bills are not paid, that the patient will have the right and duty to pursue said medical benefits with any, and all applicable insurance companies and that the patient shall remain liable for any outstanding amounts.

Patient hereby authorizes and agrees that all future insurance claim forms submitted will read "signature on file" in box 13 and shall constitute authorization to accept this as a current and valid signature on file for all future claim forms submitted.

\_\_\_\_\_  
Patient Name (PLEASE PRINT)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient SS#

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## Gulf Coast Pain Management

### REFERRAL INFORMATION

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Patient name \_\_\_\_\_

So that we may keep your referring physician informed of your progress under our care, please list the name, address, and phone number of the physician who referred you

Thank you

Name \_\_\_\_\_

Address \_\_\_\_\_

Referral's phone number \_\_\_\_\_

---

Patient signature \_\_\_\_\_

---

Date \_\_\_\_\_

*Dr. Columbus appreciates this information and hopes that following your satisfactory treatment, you will mention her care to this referring physician.*

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## Gulf Coast Pain Management

### HEALTH INSURANCE INFORMATION

#### PRIMARY INSURANCE SOURCE

---

Insurance Company

---

Insurance Company Address

---

Insurance Company Phone

---

Insurance Company Website

---

Policy Number

---

Group Number

---

Subscriber's Name

---

Relationship to Cardholder

#### SECONDARY INSURANCE SOURCE

---

Insurance Company

---

Insurance Company Address

---

Insurance Company Phone

---

Insurance Company Website

---

Policy Number

---

Group Number

---

Subscriber's Name

---

Relationship to Cardholder

---

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I, \_\_\_\_\_

Authorize my physicians, hospitals, and other health care providers to release any medical or other information necessary for the processing of claims related to my treatment and/or other services provided by Gulf Coast Pain Management.

### Authorization to use and Disclose Health Information to others

I authorize Gulf Coast Pain Management to use and disclose a copy of specific health and medical information described below regarding:

\_\_\_\_\_  
(Name of Patient)

consisting of:

(Patient is to list information to be used/disclosed here)

ie, Medical records, labs, imaging studies, billing records, other

Name of Recipient: (example- Primary Care Physician, lawyer, consulting physician, family member etc.)

\_\_\_\_\_  
\_\_\_\_\_

for the purpose of:

(Describe purpose for disclosure here)

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under federal law.

By: \_\_\_\_\_ Date \_\_\_\_\_  
(Patient)

or by: \_\_\_\_\_ Date \_\_\_\_\_  
(Patient's Representative)

Description of Representative's Authority \_\_\_\_\_



Gulf Coast Pain Management  
Lynne Carr Columbus, D.O.  
3890 Tampa Road, Suite 308  
Palm Harbor, Florida 34684

## PRIVACY PRACTICES ACKNOWLEDGEMENT

### ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name \_\_\_\_\_ Birth date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



## Gulf Coast Pain Management

### PRESCRIPTION PAIN MEDICATION AGREEMENT

If pain medication is prescribed for me, **I agree:**

1. To take the medication only as prescribed by my physician, (ie. If prescribed as 1 dose every 6 hours, I will not take 1 dose every 4 hours).
2. To request a refill of medication only during daytime office hours, 8:30am – 5:00pm, Monday – Friday. I understand that prescriptions will not be refilled on an “emergency basis”. (ie. After 5:00pm, during evening hours, or on weekends).
3. To request a refill of medication 1 week before my prescription runs out. I understand that prescriptions will **not** be refilled the day I run out of medication.
4. To provide a copy of the police report, if I allege that my medication has been lost or stolen, otherwise a new prescription will not be written.
5. I understand that failure to adhere to the 5 items of this agreement will result in my physician’s refusal to prescribe medication for me, and may prevent my receiving future treatment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness/Office Staff

*Should you have any questions on this agreement or on any medications you have been prescribed by Dr. Columbus, please do not hesitate to call.*

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## Gulf Coast Pain Management

### **PATIENT/PHYSICIAN CONTRACT FOR OPIOID USE**

I \_\_\_\_\_ agree to the following conditions:

1. I understand that I have a chronic pain problem that requires currently the prescription of opioid pain medications to increase my function. The risks, side effects and benefits of the medication have been discussed with me in *detail*. The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of the risk is not certain. Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.
2. I will obtain prescriptions for opioids and other controlled medicines only from Dr. Lynne Carr Columbus.
3. I will have prescriptions filled at only one pharmacy.
4. I will take the medication only as prescribed and will promptly notify Dr. Columbus if I do not take medication as prescribed. I understand that any extended release medication prescribed for me should be taken whole and are not to be broken, chewed, or crushed. Taking broken, chewed or crushed extended release medications leads to a rapid release of the medication and a potential fatal overdose of the medication.
5. I agree to random urine and blood tests to assess my medication levels. My cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.
6. I understand the eventual goal of tapering the opioid medication.
7. I will meet regularly with Dr. Columbus to assess my progress. Renewals are contingent on keeping scheduled appointments. I understand that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.
8. Lost, misplaced or stolen medications will not be replaced. Refills will not be given early for any reason. I will report any loss or stolen medication promptly to the police and will file a police report. I understand that I will not be able to receive a new prescription without a police report.
9. I will not give or sell my medications to any other person. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, I will keep them out of reach of such people. Likewise, I realize that prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that I will take the highest possible degree of care with my medication and prescription. I will not leave them out where

others might see or otherwise have access to them.

10. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
11. I will inform Dr. Lynne Carr Columbus of any new medical problems or medications, and of any adverse effects I experience from any of the medications that I take.
12. Dr. Lynne Carr Columbus has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for the purpose of maintaining accountability. If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

If I deviate from the above guidelines or the medication loses its effectiveness in increasing my function, I understand that the medication will be promptly tapered and that I may be referred to a psychiatrist, substance abuse program, or a detoxification program.

\_\_\_\_\_  
**Pharmacy Name**

\_\_\_\_\_  
**Telephone Number**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness/Office Staff**

\_\_\_\_\_  
**Dr. Lynne Carr Columbus**

\_\_\_\_\_  
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## Gulf Coast Pain Management

### PATIENT INTAKE INFORMATION

\_\_\_\_\_  
Date Today                      Complete Patient Name

\_\_\_\_\_  
Street

\_\_\_\_\_  
City                                      State                                      Zip code

\_\_\_\_\_  
Home Phone Number                      Work Phone Number

\_\_\_\_\_  
email address                                      SS#                                      date of birth

\_\_\_\_\_  
Employer                                      Position

\_\_\_\_\_  
Employer's Address

\_\_\_\_\_  
Referring Physician                                      Diagnosis

\_\_\_\_\_  
Referring Physician Phone                      Referring Physician City                      State

\_\_\_\_\_  
Primary Physician                                      Since Date

\_\_\_\_\_  
Primary Physician Phone                      Primary Physician City                      State

**IN CASE OF EMERGENCY PLEASE NOTIFY:**  
(Please list someone other than spouse)

\_\_\_\_\_  
Name                                      Relationship (other than spouse)

\_\_\_\_\_  
Telephone                      City                                      State

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## Gulf Coast Pain Management

### PAIN HISTORY

\_\_\_\_\_  
Chart Number                      Patient Name                      Date

\_\_\_\_\_  
Age                      Race                      Referral Source                      Sex

Are you left or right handed? \_\_\_\_\_ When did you first notice pain? \_\_\_\_\_  
Mo                      Day                      Yr

**Where is your pain located?** (Circle all that apply.)

Head	Left Arm	Abdomen	Right Thigh
Face	Right Forearm	L/R Groin	Left Thigh
Neck	Left Forearm	Mid-Back	Right Leg
Right Shoulder	Right Hand	Low Back	Left Leg
Left Shoulder	Left Hand	Right Buttock	Right Foot
Right Arm	Chest	Left Buttock	Left Foot
Other:			

**Under what circumstances did pain begin?**

_____ Accident/Injury at work	_____ At work, but not an accident
_____ Accident/Injury	_____ Secondary to repetitive activity
_____ Motor vehicle accident	_____ Following surgery
_____ Following illness	_____ Pain began unrelated to activity

**If accident or activity, please describe:**

\_\_\_\_\_  
\_\_\_\_\_

**Does your pain travel anywhere?** \_\_\_\_\_ Yes \_\_\_\_\_ No **If yes, where?** \_\_\_\_\_

\_\_\_\_\_

Please indicate which diagnostic tests you have had to evaluate your pain problem

Test	Yes/No	Date
Plain x-ray	_____	____
MRI	_____	____
Bone Scan	_____	____
CT Scan	_____	____
EMG/NGS	_____	____
Other	_____	

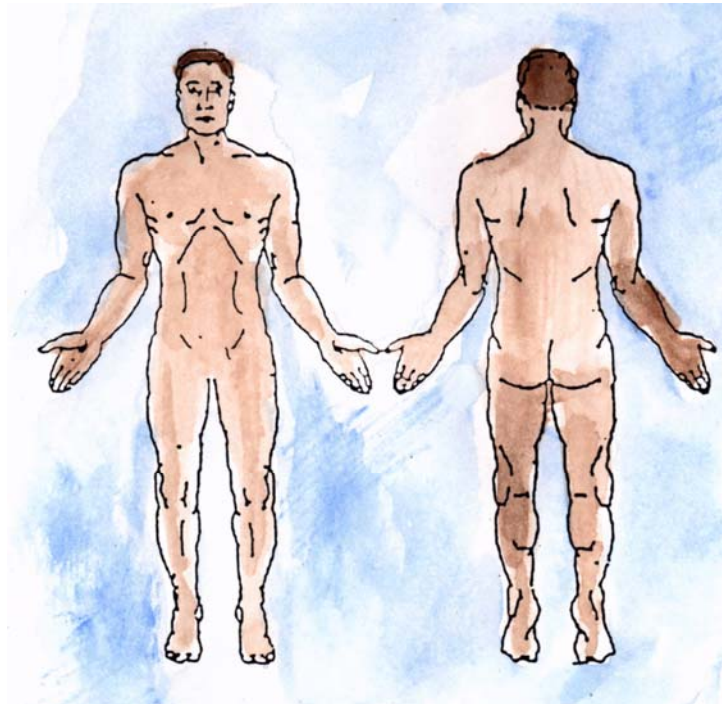
Briefly in your own words, describe your *main* problem:

---



---

Please indicate on the diagram where your pain occurs by X'ing (xxx) out the painful area(s)



Have you had any treatments for your

of the following pain?

	Yes/No	Helpful? Yes/No
PT Exercises	_____	_____
Ultrasound	_____	_____
Hot Packs	_____	_____
Cold Packs	_____	_____
Whirlpool	_____	_____
Massage	_____	_____
TENS	_____	_____
Acupuncture	_____	_____
Manipulation	_____	_____
Spinal Cord Stimulation	_____	_____

**Which statement best describes your pain? (Check)**

- Always present; always the same intensity
- Always present; intensity varies
- Usually present; but have short periods without pain
- Often present, but have pain free periods lasting hours
- Often present, but pain free most of the day
- Occasionally present; have several short pain periods/day
- Occasionally present for brief periods during the day
- Rarely present; have pain every few days or weeks

**Use pain scales to indicate the severity of pain (Circle)**

**Your pain at its worst**

No pain 0 \_\_\_\_\_ - \_\_\_\_\_ 10 Unbearable pain

**Your pain as it usually is**

No pain 0 \_\_\_\_\_ - \_\_\_\_\_ 10 Unbearable pain

**Your pain at the present time**

No pain 0 \_\_\_\_\_ - \_\_\_\_\_ 10 Unbearable pain

**Your pain at its least severe**

No pain 0 \_\_\_\_\_ - \_\_\_\_\_ 10 Unbearable pain

**What time of day is your pain worst? (Check)**

- |  |  |
|--|--|
| <input type="checkbox"/> Morning , on rising     | <input type="checkbox"/> Later in the morning          |
| <input type="checkbox"/> Afternoon               | <input type="checkbox"/> Evening                       |
| <input type="checkbox"/> Bedtime                 | <input type="checkbox"/> Night (during sleep)          |
| <input type="checkbox"/> Pain is always the same | <input type="checkbox"/> Pain varies unrelated to time |

**Do you have any of the following associated symptoms? (Check)**

- |   |   |
|---|---|
| <input type="checkbox"/> Numbness           | <input type="checkbox"/> Tingling, pins and needles |
| <input type="checkbox"/> Weakness           | <input type="checkbox"/> Coldness                   |
| <input type="checkbox"/> Increased sweating | <input type="checkbox"/> Muscle Spasm               |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Bladder or bowel problems  |

**Does pain interrupt your sleep? (Check)**

- Not at all
- Twice per night
- More than three times per night
- Once per night
- Three times per night
- Constantly

List all current pain medications, controlled substances and prescribing physicians.

Medication	Dosage	Times/Day	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all prior ineffective pain medications.

Medication	Dosage	Times/Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How would you describe your pain? Circle all that apply.

- Burning
- Sharp
- Shooting
- Dull ache
- Throbbing

List allergies to medications.

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

List all current non-pain medications and dietary supplements.

Medication/Supplement	Dosage	Times/Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all prior surgeries for your pain problem(s).

Operation	Hospital	Surgeon	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any non-pain surgeries you have had.

Operation	Hospital	Surgeon	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## SOCIAL HISTORY

**Marital Status :** (Circle One) Single Married Separated Divorced Widower Widow

**Education Level Completed:**

Lower School Middle School High School Vocational College Graduate Post Graduate

**Occupation :**

Homemaker Physical Laborer Clerical Worker Manager Professional Other:

**Current Employment Status**

Working Retired Sick Leave Unemployed related/unrelated to pain

**Living Arrangement:**

Alone With Spouse With Children With Relatives With Friends

**Compensation/Disability:** YES NO Pending evaluation

**Litigation:** YES NO Possible in the future

**Tobacco Use:** None Occasional Moderate Heavy

**Alcohol Use:** None Occasional Moderate Heavy

**Medical History** (Please circle all that apply to you)

Heart Disease

Stroke

Liver Disease

Heart Attack

Seizures

Thyroid Disease

Angina

Chronic Bronchitis

Ulcer disease

Pacemaker

Emphysema

Arthritis

Arrhythmia

Asthma

Depression

High Blood Pressure

Diabetes

Cancer/Type\_\_\_\_\_

### Other pertinent information about your past or present environment:

### List all treating physicians within the past year:

Physician

Reason for treatment

# REVIEW OF PATIENT SYSTEMS

Please circle any conditions you have experienced:

<b>Constitutional</b>	Weight gain in last 6 months Weight loss in last 6 months Chills Night Sweats Fever
<b>Skin</b>	Easy bleeding Any rashes Easy Bruising
<b>Eyes, Ear, Nose and Throat</b>	Recent changes in vision Recent changes in smell Recent changes in hearing Recent changes in taste Any dizziness
<b>Respiratory</b>	Short of breath Sputum Wheezing Cough History of Tuberculosis
<b>Cardiovascular</b>	Chest pain Shortness of breath with exercise Feet edema Palpitations Heart Murmur

<b>Gastrointestinal</b>	Nausea Diarrhea Abdominal Pain Vomiting Indigestion Bloody or dark stools
<b>Genito-Urinary</b>	Blood in urine Unable to control bladder Rushing to go Urinary tract infections Unable to control bowel Need to go frequently
<b>Musculoskeletal</b>	Cramps Joint pain/swelling Attack of weakness Morning stiffness
<b>Central Nervous System</b>	Poor appetite Numbness/tingling in feet Crying spells Problem sleeping Numbness/tingling in hands Convulsions

**Please complete if you are a female patient:**

Date of last menstrual period \_\_\_\_\_

Abnormal vaginal bleeding Yes No If yes, approximate date\_\_\_\_\_

History of nipple discharge Yes No If yes, approximate date\_\_\_\_\_

History of breast biopsy Yes No If yes, approximate date\_\_\_\_\_

History of endometriosis Yes No If yes, approximate date\_\_\_\_\_

**Please complete if you are a male patient:**

Date of last prostatic exam \_\_\_\_\_ Date of last rectal test \_\_\_\_\_

Results from these two procedures: \_\_\_\_\_

Date of PSA (Prostate Blood Test) \_\_\_\_\_ Results \_\_\_\_\_

## Immediate Family History

Member	Age	Alive	Deceased	Medical History	Cause of Death
Father					
Mother					
Sibling 1					
Sibling 2					
Sibling 3					
Sibling 4					
Sibling 5					
Sibling 6					
Paternal GFather					
MaternalG Father					
Paternal GMother					
Maternal GMother					

I certify that the preceding patient data has been reviewed and discussed with my patient.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

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# GULF COAST PAIN MANAGEMENT

## TREATMENT ATTESTATION FOR PAIN MANAGEMENT SERVICES

I, \_\_\_\_\_, am seeking healthcare services for the treatment of my painful condition from Gulf Coast Pain Management. I understand that my accuracy, completeness and truthfulness in reporting my history and symptoms will directly contribute to the development of my treatment plan and the improvement in my painful condition. I acknowledge that I intend to provide all necessary releases for healthcare information so Gulf Coast Pain Management may receive my previous healthcare records from other clinicians. I know that if I am not accurate, complete and truthful in providing my history and symptoms, Gulf Coast Pain Management cannot safely treat me for my painful condition.

I intend to disclose the names of all prior treating practitioners and to inform Gulf Coast Pain Management about all current prescribers of controlled substances. I do not intend to seek medications for any purposes other than my personal medical needs. I will not deliberately misrepresent my history, prevent Gulf Coast Pain Management from obtaining my previous medical records, fail to inform Gulf Coast Pain Management about the existence of other sources of prescription medication, or allow anyone other than myself to take medications prescribed to me. I understand that obtaining controlled substances (prescription medication) through false representation is a crime and that I will be reported to law enforcement officials for attempting to fraudulently obtain these medications for non-therapeutic purposes.

I am seeking treatment for the purpose of reducing or relieving my pain. I am not appearing to seek care from Gulf Coast Pain Management as part of an ongoing investigation of Gulf Coast Pain Management. I am a legitimate patient voluntarily seeking healthcare services for a painful condition.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness' signature

\_\_\_\_\_  
Patient's printed name

\_\_\_\_\_  
Witness' printed name

\_\_\_\_\_  
Date

## PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

- |  |   |
|--|---|
| <input type="checkbox"/> Home Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only<br><br><input type="checkbox"/> Work Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication<br><input type="checkbox"/> O.K. to mail to my home address<br><input type="checkbox"/> O.K. to mail to my work/office address<br><input type="checkbox"/> O.K. to fax to this number<br><br><input type="checkbox"/> Other _____<br>_____ |
|--|---|

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Print Name

\_\_\_\_\_

Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

***Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.***

### Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

- (1) Check this box if the disclosure is authorized  
 (2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations  
 (3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other