Advanced
Pain Management Clinic
www.painawayjax.com

PATIENT HISTORY

Patient Name _____ Date _____
Date of Birth _____ Sex _____ Marital Status _____
Telephone Numbers/Home ( )_____Work ( ) _____
Home Address _____
Street _____
City _____ State _____ Zip _____

General Health Review

Medical History (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illnesses, etc.)

_____ _____ _____
_____ _____ _____

Surgical History (**unrelated** to pain; such as appendectomy)

_____ _____ _____
_____ _____ _____

Surgical History (**related** to pain; such as laminectomy)

_____ _____ _____
_____ _____ _____

Allergies (include medication and food allergies)

_____ _____ _____
_____ _____ _____

Intolerances (include side effects from previous medications, such as gastritis, nausea, constipation, etc.)

_____ _____ _____
_____ _____ _____

Current Medications (include vitamins and birth control pills, if applicable)

_____ _____ _____
_____ _____ _____

Advanced
Pain Management Clinic
www.painawayjax.com

Do you have any of the following? (Circle all that apply)

Headaches	Stomach Pain	Chest Pain
Vision Problems	Nausea	Shortness of Breath
Hearing Problems	Vomiting	Urinary Problems
Dizziness	Constipation	Rashes
Difficulty Swallowing	Diarrhea	Swollen Joints
Any Bleeding Problems	Difficulty Sleeping	Chronic Fatigue

Domestic Situation

With whom do you live? _____

Are there any substance abuse issues in the household? Yes_____ No_____

If yes, please explain _____

Are you able to take care of yourself? Yes_____ No_____

If not, please enter name of caregiver _____

Work History

Job Years worked Why did you leave?

_____

_____

Legal Matters

Are you presently involved in a lawsuit? Yes_____ No_____ If yes, please explain.

_____

_____

Substance Use

Which of the following drugs or substances, if any, have you used in the past? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you used it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol _____	Barbiturates _____	Cocaine _____
Heroin _____	Amphetamines_____	Marijuana _____
Other _____ (specify)	Other _____ (specify)	Other _____ (specify)

Are you presently using any of the drugs or substances below? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you use it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol _____	Barbiturates _____	Cocaine _____
Heroin _____	Amphetamines_____	Marijuana _____
Other _____ (specify)	Other _____ (specify)	Other _____ (specify)

Do you presently smoke cigarettes or use tobacco in any form? Yes_____ No_____

If not, did you ever smoke cigarettes or use tobacco in any form? Yes_____ No_____

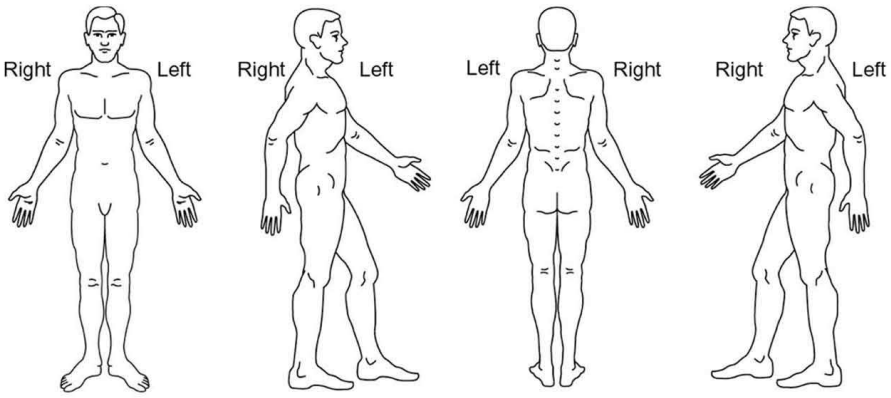
How many packs do (did) you smoke a day? _____ For how many years? _____

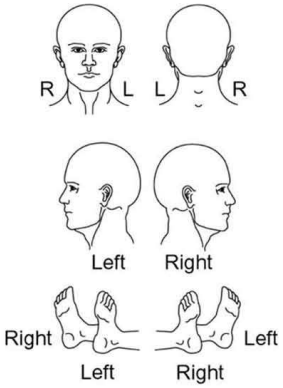
Advanced Pain Management Clinic
www.painawayjax.com

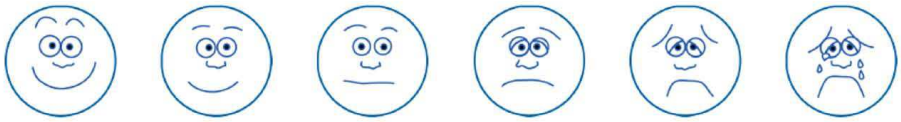
Name_____ Date_____

1. PLEASE MARK AN 'X' ON THE DRAWING WHERE YOU HAVE PAIN.

IF THE PAIN TRAVELS, USE AN 'ARROW ' TO INDICATE THE DIRECTION







2. RATE YOUR PAIN BELOW USING THE ABOVE PAIN SCALE.

Present pain:_____ Worst pain gets:_____ Best pain gets: _____ Acceptable level of pain: _____

3. IS THIS PAIN CONSTANT? ____ YES; ____ NO IF NOT, HOW OFTEN DOES IT OCCUR? _____

4. QUALITY: (For example: ache, deep, sharp, hot, cold, like sensitive skin, sharp, itchy) _____

5. ONSET, DURATION, VARIATIONS, RHYTHMS: _____

_____

6. CURRENT MEDICATIONS:_____

_____

7. WHAT RELIEVES PAIN? _____

_____

8. WHAT CAUSES OR INCREASES THE PAIN? _____

_____

9. **What <u>treatments</u> or <u>medicines</u> are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.**

a) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

b) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

c) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

d) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

10. I (WOULD/WOULD NOT) LIKE TO CHANGE MY TREATMENT. If so, how?_____

_____

Advanced Pain Management Clinic

5757 Booth Road, Building 100
Jacksonville, FL 32207
904-683-2596
www.painawayjax.com

Review of Systems

Please circle if any of the following apply to you:

1. **General** : Weight Changes, Weakness, Fatigue, Fevers, Recent Illness, Recent Hospitalization, Known Cancers, Difficulty Sleeping
2. **Skin**: Rashes, Lumps, Sores, Itching, Dryness, Skin Color Change, Changes in Hair or Nails
3. **Head**: Headache, Head Injury, Other
4. **Eyes**: Changes in Vision, Corrective Lenses, Blurred Vision, Double Vision, Spots, Specks, Glaucoma, Cataracts, Other
5. **Ears**: Changes in Hearing, Ringing, Dizziness, Infection, Discharge, Hearing Aids, Other
6. **Noses**: Frequent Colds, Infection, Nosebleeds, Sinus Problems
7. **Mouth**: Missing Teeth, Gum Problems, Dentures, Dry Mouth, Sore Throat, Difficulty Swallowing, Other
8. **Neck**: Lumps, "Swollen Glands," Goiter, Pain, Stiffness, Other
9. **Breasts**: Lumps, Pain or Discomfort, Nipple Discharge, Other
10. **Lungs**: Cough, Coughing up anything, Coughing Blood, Wheezing, Asthma, Tuberculosis, Emphysema, Bronchitis, Smoker, Other
11. **Heart**: Heart Trouble, Chest Pain or Pressure, Rheumatic Fever, Heart Murmurs, History of Heart Attack or Congestive Heart Failure, Difficulty Breathing, Palpitations, Difficulty Sleeping Flat (Need to Sleep sitting), Swelling in Legs or other places, Past Heart Tests, Other

Initial:_____ Date:_____

Advanced Pain Management Clinic

5757 Booth Road, Building 100
Jacksonville, FL 32207
904-683-2596
www.painawayjax.com

12. **Gastrointestinal**: Heart Burn, Trouble Swallowing, Change in Appetite, Nausea, Vomiting, Change in Bowel Movements, Blood in Stool, Black and/or Tarry Stools, Hemorrhoids, Constipation, Diarrhea, Abdominal Pain, Yellowing of Skin, Liver or Gallbladder Disease, Alternating Constipation and then Diarrhea, Other
13. **Urinary**: Frequent Urination, Getting up at night to Urinate, Burning or Pain on Urination, Bleeding, Difficulty Starting or Stopping, Dribbling, Having Accidents, Urinary Infections, Kidney Stones, Hernias, Other
14. **Vascular**: Poor Circulation, Pain in Legs when walking, Varicose Veins, Leg Cramps, Past Clots in Veins, Bleeding Disorder, Anticoagulant Therapy, Other
15. **Musculoskeletal**: Muscle or Joint Pain, Stiffness, Morning Stiffness, Osteoarthritis, Rheumatoid Arthritis, Gout, Back Pain, Neck Pain, Other
16. **Blood**: Anemia, Easy Bleeding or Bruising, Past Transfusions, any other Blood Disorders
17. **Endocrine**: Thyroid Trouble, Diabetes, Pancreas Problems, Heat or Cold Intolerance, Excessive Sweating, Excessive Thirst, Excessive Hunger, Other
18. **Psychiatric**: Any Psychiatric Disorder, Seeing a Mental Health Professional, Nervousness, Tension, Stress, Depressions, Memory Problems, Alcoholism, Drug Addiction or Abuse, Other
19. **Neurologic**: Tics, Twitches, Convulsions, Seizures, Fainting, Blackouts, Weakness, Paralysis, Numbness, Loss of Sensation, "Pins and Needles," Burning Anywhere, Tremors, Other

Initial:_____ Date:_____

5757 Booth Road, Building 100
Jacksonville, FL. 32207
Telephone: (904) 683-2596
Fax: (904) 683-2597
www.painawayjax.com

Please note the following fees:

No-Show Office Visit	$50.00	If not cancelled **24 hours before appointment**
No-Show Procedure	$200.00	If not cancelled **at least 2 business days prior to scheduled procedure**
Misc. form completion	$100.00	For all forms with more than one (1) page

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Form Updated: 11/12/2012

5757 Booth Road, Building 100
Jacksonville, Florida 32207
Telephone: (904) 683-2596
Facsimile: (904) 683-2597
www.painawayjax.com

PATIENT FINANCIAL RESPONSIBILITY AND AUTHORIZATION FOR LETTER OF PROTECTION

Patient Name: _____

DOB: _____

Patient Account Number: _____

Date of Accident *(if applicable)*: _____

I, _____, hereby agree to make all payments for all professional services to Advanced Pain Management Clinic, LLC (hereinafter "APMC"), with regard to my past, current and future treatment by APMC. I acknowledge responsibility for all payments, in full, whether I have insurance, including HMO, PPO, PIP or Medical Payments coverages or no insurance and whether I am a private pay patient or have a first- or third-party payor.

I further acknowledge that, in the event I am being treated for any accident-related injury or any illness or condition caused by a third party or in the event I have other first- or third-party coverage(s) or benefits, I nonetheless am fully and completely responsible for 100% of my medical bills based upon treatment received at APMC.

I further authorize my attorneys, if I am represented by counsel, to issue a Letter of Protection to APMC and Dr. Michael Willens, as may be necessary to protect the interests of APMC with respect to any first- or third-party recovery I may have as a result of the availability of insurance benefits or proceeds, including, but not limited to, no-fault coverages, medical payments coverages, liability coverages or any other form of compensation or benefits whatsoever.

I have had adequate time to consider and understand this statement of my financial responsibility as a patient and I further understand that in any and all cases, I am the patient and fully responsible for payment of all of my medical treatment and care through this office, APMC. I authorize my attorneys to sign and deliver to APMC all appropriate letters of credit and to make full payment upon receipt of all proceeds, benefits and disbursements, directly towards the outstanding balance, in full, at APMC, on my behalf.

_____ _____
Patient's Name (signature) Dated

_____
Patient's Name (printed)

_____ _____
Witness (signature) Dated

(If the patient is a minor, the parent or legal guardian must sign on behalf of the minor. If the patient is otherwise incompetent and has a guardian, the guardian must sign for the ward.)

www.painawayjax.com

PATIENT REGISTRATION

Name: _____ SS# _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____

Cell Ph: _____ Work Ph: _____

Date of Birth: _____ Gender: _____M _____F

Emergency Contact: _____ Phone #: _____

Employer: _____

Email Address: _____

HEALTH INSURANCE INFORMATION:

Primary Insurance Company: _____

Insurance Address: _____

Telephone #: _____ID #:_____ Group #:_____

Subscriber: _____ Relationship: _____

DOB: _____ SS #: _____

Secondary Insurance Company: _____

Insurance Address: _____

Telephone #: _____ID #:_____ Group #:_____

Subscriber: _____ Relationship: _____

DOB: _____ SS #: _____

ACKNOWLEDGEMENTS AND ASSIGNMENTS

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:

I _____ understand that in the course of providing care to me that Michael Willens, D.O. and or Advanced Pain Management Clinic, LLC., will receive, create, maintain and disclose information about me for the purpose of the practice's and other health provider's provision of treatment, securing payment from me, an insurer, other third-party payer or responsible party, and/or in connection with the health care operations of the Practice(s) and/or the operations other health providers who have treated me and as otherwise required or permitted by State and/or Federal Law. I understand that a further description of these anticipated uses and disclosures of my health information appears in the Notice of Privacy Practices. Except for genetic information, I agree to the sharing, utilization, examination and disclosure of any of my health information, including but not limited to known or suspected HIV/AIDS infection, mental health records, communicable diseases, substance abuse and/or treatment, if applicable, as is reasonably necessary by the practice, its employees and other members of its workforce for the limited purpose of rendering treatment, securing payment for treatment rendered and conducting the practice's operations. I further agree to the disclosure by the practice of such information, as is reasonably necessary, to other health providers involved in my treatment and their employees and other members of their workforce for treatment, payment and health operations, to any private or governmental insurer, including Medicaid and Medicare and its intermediaries and agents, other third-party payers, or other financially responsible party for the purpose of determining benefits and securing payment, and as otherwise permitted by State and/or Federal law. This consent may be revoked at any time but, only to the extent that the practice has not acted in reliance on it. If not previously revoked, this consent will remain valid as long as I am a patient of the practice and for such period of time thereafter as is reasonably necessary to serve the purpose for which it was given; namely, the provision of treatment, securing payment for services rendered and conducting health operation.

BILLING POLICIES:

I further expressly agree and acknowledge that my signature on this document authorized Michael Willens, D.O. or Advanced Pain Management Clinic, LLC., or their employees to submit claims for services rendered without obtaining my signature on each and every claim to be submitted for myself and /or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I am aware that for either practice to bill to my insurance carrier on my behalf is a courtesy being extended to me and it NOT required by law. I further agree and fully understand that I am legally bound to furnish the checks paid to me by my carrier for the services I am receiving from this practice. I also agree and fully understand that as a non-participating physician, Dr. Willens is not bound or legally obligated to accept the payment from my insurance company as payment in full for the services I am receiving, and I will receive a balance bill for the amounts not paid by my carrier. I hereby authorize the above named insurance company/companies to assign directly all benefits payable on my behalf.

I hereby authorize the above named insurance company/companies to assign directly all benefits payable. I make this an irrevocable assignment of benefits. I understand that any insurance checks issued belong to Michael Willens, D. O., or Advanced Pain Management Clinic LLC., for services rendered and I agree to endorse them over should I receive them or otherwise repay any amounts paid to me. Failure to do so would be a crime under Florida Law. I (we) am (are) aware that if payment is not made within a reasonable amount of time by the insurance carrier(s), and the matter is submitted to a collection agency or attorney, I (we) will be responsible for payment of all costs associated with that collection activity, including but not limited to reasonable attorney fees and court costs.

I fully understand that once the account is past due the practice reserves the right to begin adding interest at 1% per month simple interest, and if sent to collection, I (we) will be responsible for costs for collection agents and /or reasonable attorneys fees and /or costs of litigation.

Patient SIGNATURE_____ Date_____

Insured SIGNATURE_____ (if different)

FINANCIAL POLICY

We believe that everyone benefits when our patients understand our financial policies.

Thank you for choosing Advanced Pain Management Clinic, LLC, the office of Dr. Michael Willens as your healthcare provider. We are committed to providing the best medical care possible. We hope that you leave our office with an appreciation for the value of services you have received. Please understand that payment of your bill is considered part of your treatment. Accordingly, we ask all of our patients to pay for their services at the time services are rendered. The following information outlines our Financial Policy which we ask you to read, sign and return to us prior to your treatment. A copy will be provided for you upon request.

All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.

All applicable co-pays, personal balances, both current and prior, are due at time of service. We accept cash and credit cards (VISA or MasterCard).

Regarding Insurance

We are currently participating with Medicare, Aetna, BCBSFL, Cigna, United Health Care, AvMed and TriCare Standard. We do not accept Humana, Medicaid or other insurance companies other than those previously listed. We do accept assignment of benefits but in all cases we require that the guarantor (the person who is financially responsible) is *personally* liable for all balances not covered by insurance. If you are not insured by a plan we do business with, payment in full is expected at the time of each visit or you must make satisfactory payment arrangements with the administrator.

If you do not have an up to date insurance card, it may take some time to verify your coverage. We must obtain a copy of your driver's license and current valid insurance card by the date of your first visit. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You must pay for these services in full at the time of the visit.

The introduction of high deductible policies has made it difficult to estimate all charges at the time of your visit. <u>In the event your insurance company denies payment and/or issues a denial on a non-covered or not medically necessary service for the amount charged by the physician, you agree to be responsible for services rendered at the time of the visit.</u>

Credit Card information is **required** in order to secure payment for the patient responsibility portion of your bill.

While the Credit Card may be checked for validity, **we will not charge your Credit Card without notifying you.**

A credit check may be performed with the information you provide to ensure credit worthiness.

The Credit Card information that you disclose is kept confidential and secure.

VISA MasterCard

Card #_____

Exp. Date: _____

V-Code _____ (three numbers on the back of the card or four numbers on front of AMEX)

Signature (as it appears on card):

X_____

Date: _____

Usual and Customary Rates

We are committed to providing the best treatment for our patients and we charge customary fees for our region and specialty. If your insurance company uses a different fee schedule, you will be responsible for any balance remaining. We update our fee schedules each year – you can request a copy of these fees at any time.

Claims Submission

We will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company and we are not a party to that contract. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

Coverage Changes

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

Missed Appointment/No Show Policy

For office visits, unless canceled at least 24 business hours in advance, our policy is to charge **$50.00 for a missed appointment**. For scheduled procedures, unless canceled at least 48 business hours in advance, our policy is to charge **$200.00 for a missed procedure appointment**. Please help us to serve you better by keeping scheduled appointments. This fee is not covered by insurance so it will be your personal responsibility.

Past Due Accounts

Accounts are considered past due after 90 days. Patients who are sent additional statements will have a statement handling fee of $15.00 charged to each statement unless other satisfactory payment arrangements are made and kept. Overdue accounts will be referred to a collection agency along with the issuance of a 1099 to the IRS for cancellation of debt. Collection fees that we pay to secure past due balances will be added to your account. Once an account had been referred collections, Dr. Willens will terminate the patient relationship and only continue services for thirty (30) days for emergencies on a cash basis. You will be responsible for all collection fees charged to the practice in attempts to collect the past due amount.

Co-Payments and Deductibles

All co-pays and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. If co-pay balances are not paid prior to the next visit date or statement date (whichever comes first), a $10.00 fee will be charged to your account. This fee is not covered by insurance so it will be your personal responsibility.

Returned Checks

We no longer accept personal checks.

Refunds

An office visit is complete when you have received an evaluation and management recommendation. **Refunds are not given because you do not agree with the recommendation**. A refund may be issued if you are not able to see the doctor because of unforeseeable circumstances, overpayment, or other reasons deemed reasonable by management.

Medical Records

All of our patient records are kept confidential. By law, we are required to keep the records in our possession for seven years. Copies may be furnished to you when you request them in writing with exception to state law. Our policy requires 48 hours advance notice for preparation of copies, as well as prepayment for those copies. Our charges are as follows:

For the first 25 pages, the cost is $1.00 per page. For each page in excess of 25 pages, the cost is $0.25 cents each.

5757 Booth Road, Building 100
Jacksonville, Florida 32207
Telephone: (904) 683-2596
Facsimile: (904) 683-2597
www.painawayjax.com

Consent for Medical Treatment

I am the patient or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize care encompassing all diagnostic and therapeutic regimens necessary in the judgment of my provider, for myself, my minor child, or other. I am aware that the practice of medicine is not an exact science. I acknowledge that no guarantees have been made to me as a result of treatments or performed examinations.

I have read this form completely, have had the opportunity to ask questions, and have been fully informed as to the contents of this agreement.

I do hereby authorize the release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to Michael S. Willens, DO., Advanced Pain Management Clinic, LLC.

_____ _____
Signature of patient or responsible party Date

_____ _____
Witness Signature Date

5757 Booth Road, Building 100
Jacksonville, FL. 32207
Telephone: (904) 683-2596
www.painawayjax.com

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Advanced
Pain Management Clinic

5757 Booth Road, Building 100
Jacksonville, FL. 32207
Telephone: (904) 683-2596
www.painawayjax.com

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information**, as follows:

5757 Booth Road, Building 100
Jacksonville, FL. 32207
Telephone: (904) 683-2596
www.painawayjax.com

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to: PRIVACY OFFICER: MICHAEL WILLENS, 5757 BOOTH RD, BLDG 100, JACKSONVILLE, FL 32207.

5757 Booth Road, Building 100
Jacksonville, FL. 32207
Telephone: (904) 683-2596
www.painawayjax.com

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of Advanced Pain Management Clinic's Notice of Privacy Practices (the "Notice"). The Notice contains information regarding potential uses and disclosures of my protected health information - that term is defined under the Health Insurance Portability and Accountability Act of 1996 "HIPAA" that may be made by the Practice, and of my rights and the Practice's legal duties with respect to my protected health information. I have had the opportunity to review the Notice and take a copy with me if I so choose.

_____

Patient's Signature

_____

Patient's name

On behalf of [ ] self; [ ] personal or legal representative

_____

Date

****

IF PATIENT REFUSES TO SIGN ACKNOWLEDGEMENT, COMPLETE THIS SECTION:

_____ ***Patient refuses to sign Acknowledgement. The staff of Advanced Pain Management Clinic made the following attempt to obtain a signature from the patient:***

_____

_____

_____

Signature of Chief Privacy Official

_____

Date

Form Revised: 11/12/2012

Dr. Michael Willens
5757 Booth Rd., Building 100
Jacksonville, Fl 32207
904-683-2596 (o)
904-683-2597 (f)

HIPAA-COMPLIANT RELEASE AND GENERAL AUTHORIZATION
FOR RELEASE OF INFORMATION AND PROTECTED HEALTH INFORMATION

I authorize Advanced Pain Management Clinic, LLC.:

- ☐ To release my medical records to:
- ☐ To request my medical records from:

_____

_____

_____

_____

The undersigned hereby authorizes to disclose, to furnish and to discuss with ADVANCED PAIN MANAGEMENT CLINIC, LLC. 5757 Booth Road, Building 100, Jacksonville, Florida, 32207, (904) 683-2596 (telephone), (904) 683-2597 (facsimile), the entire contents of any and all files and materials in your possession relating to the undersigned, for the records and dates specified below:

Medical records and Protected Health Information (PHI) including the following: hospital admission and discharge forms; dictated reports; physician's orders and progress notes; clinical or diagnostic test results; radiological or imaging studies; medications sheets; operative information; physical or occupational therapy records; nursing information and progress notes; mental health records, emergency room information; itemized billing records, memoranda or correspondence, transfer forms, history and physical, lab results, psychiatric/counseling, neurodiagnostic testing and rhythm strips and tracings, nursing records and **entire medical record or chart.** This shall include all medical, dental, osteopathic, podiatric and chiropractic records, charts and specially all psychological records as well.

Inclusive dates:_____. (If not specified, include **all dates of service).**

I hereby acknowledge or consent to the release of information that may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

I understand that:

- I may refuse to sign this Authorization and that it is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization.
- I understand that I have the right to revoke this authorization, in writing at any time except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that I uses and disclosures already made based upon my original permission cannot be withdrawn. I may revoke this Authorization at any time in writing, but if I do, it will not have any affect and documentation requested for purposes as may be required by them for any lawful use.
- I may see and obtain a copy of the information and documentation described on this form, for a reasonable copy fee, if I ask for it
- I affirm that I have received a copy of this form after I signed it.
- I am signing for myself, or in the event of a minor, as natural guardian of said minor.

A photocopy of this Authorization for Release of Information is binding and has the full force and effect as the original. This Authorization shall remain in effect until canceled by me in writing.

DATE:_____ SIGNATURE:_____

NAME (Printed)_____DOB_____