Resolute. Pain Solutions™

www.resolutepainmd.com

Appointment Details

DATE:_____TIME: _____

DOCTOR:_____LOCATION: _____

WE NO LONGER ACCEPT CHECKS AS FORM OF PAYMENT FOR ANY TREATMENT. WE DO ACCEPT CASH, CREDIT OR DEBIT

WITHOUT YOUR PHOTO ID YOU WILL NOT BE TREATED. IF YOUR ID IS NOT A VALID FLORIDA STATE LICENSE OR IDENTIFICATION CARD YOU WILL ONLY BE ELIGIBLE FOR INJECTIONS.

IF YOU ARE UNABLE TO COMPLETE THIS PAPERWORK YOU MUST BRING SOMEONE WITH YOU TO YOUR APPOINTMENT THAT CAN ASSIST YOU WITH THIS PACKET.

NO SHOW POLICY – To assure that all of our patients have access to care when needed by maximizing the utilization of available appointments, you (the patient) are required to cancel your scheduled appointment with appropriate prior notice (24 hours.) Failure to cancel your appointment without 24-hour notice is considered a "No Show." If you have two "No Show" occurrences, a $50.00 penalty fee will be charged to your account. You will be required to pay this fee prior to being seen for another appointment.

PRINT NAME _____ Date of Birth_____

SIGNATURE _____ Today's Date_____

IF YOU HAVE AN HMO OR AN INSURANCE PLAN THAT REQUIRES AUTHORIZATION FOR PROCEDURES – You will ***NOT*** receive any injections at your first visit. Your insurance requires authorization and in order to obtain that authorization proper documentation of the initial visit must be done.

IF YOU DO NOT HAVE AN HMO – Your initial appointment is a consultation only. If you were referred for an injection there is no guarantee you will receive it at your initial visit. It is possible, but again, there is no guarantee. Getting any injection is a decision that is made between you and the doctor at the time of your visit. Ultimately it is at the physicians' discretion, regardless of any prior treatment or referrals you may have received.

SOME INSURANCES – Will only cover injections if they are performed in a surgery center. If this is the case your injection will be scheduled for a later date during your initial appointment.

HERE IS A GUIDELINE OF MEDICATIONS TO STOP IF YOU ARE ANTICIPATING AN INJECTION AT YOUR INITIAL VISIT

DISCONTINUE FOR 7 DAYS: 325MG Aspirin, Ecotrin, Excedrin, BC/Goody powder and Plavix

DISCONTINUE FOR 5 DAYS: Coumadin, Aggrenox and Warfarin (ONLY WITH A *WRITTEN* CLEARANCE FROM YOUR CARDIOLOGIST)

DISCONTINUE FOR 3 DAYS: 81MG Aspirin, Vitamin E, Fish Oil, Pradaxa, Ibuprofen, Advil, Aleve, Mobic/Melcoxicam, Diclofenac, Naproxen, ETC.

VERY IMPORTANT!

WHEN YOU RECEIVE THIS PACKET IT IS VERY IMPORTANT THAT YOU CALL OUR OFFICE AND LET US KNOW YOU HAVE YOUR PAPERWORK. IF YOUR NEW PT PACKET IS NOT COMPLETED AT THE TIME OF YOUR APPOINTMENT, YOUR APPOINTMENT WILL BE RESCHEDULED.

BOCA RATON	JUPITER	OKEECHOBEE	PORT ST. LUCIE	STUART	TRADITION
950 Glades Road	601 University Blvd.	107 19th Drive	10244 US Highway 1	2100 SE Ocean Blvd.	10050 SW Innovation Way
Suite 5A	Suite 203	Okeechobee, FL 34972	Port St. Lucie, FL 34952	Suite 100	Suite 104
Boca Raton, FL 33431	Jupiter, FL 33458	Tel: 863-357-7246	Tel: 772-337-7676	Stuart, FL 34996	Port St. Lucie, FL 34987
Tel: 561-939-5500	Tel: 561-253-3777	Fax 863-357-7247	Fax 772-337-7876	Tel: 772-223-2115	Tel: 772-345-5588
Fax: 561-939-0555	Fax 561-253-3779			Fax 772-223-9238	Fax: 772-264-3305

POLICY 3.3

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth: _____

Patient Address:_____ Soc. Sec. # _____

_____

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information. Information to be used or disclosed (must be identified in a specific and meaningful fashion); and purpose of use and disclosure: MRI, CT, XRAY, and Lab reports; last H&P, evaluation, and office notes for the purposes of pain management evaluation and treatment; other:

_____

_____

The name or other specific identification of the person(s), or class of persons, *authorized to receive the requested use or disclosure:*

_____

Please *initial* boxes:

☐ (Initial box) I hereby authorize Resolute Pain Solutions to verbally disclose my health information to:

_____

Please print name(s) of authorized individual(s) /Relationship to patient

☐ (Initial box) I hereby authorize Resolute Pain Solutions to verbally disclose my health information on my home answering machine/voicemail on phone/cell phone.

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however, that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

_____ _____

Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am: _____

Authorized Individual /Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Resolute Pain Solutions: "Notice of Privacy Practices" which sets forth Resolute Pain Solutions' privacy practices and my rights regarding privacy of my protected health information.

Patient/Personal Representative Signature _____

Print Name_____ Date _____

INFORMED CONSENT AGREEMENT FOR TREATMENT OF INTRACTABLE PAIN WITH NARCOTICS

Please *initial* all boxes:

☐ (Initial box) I understand I have a pain condition that may require the prescription of a controlled substance.

☐ (Initial box) Any side effects such as constipation, sedation, itching, nausea, and vomiting and the use of substances to counteract these side effects have been explained to me. The issues of tolerance, drug dependence and addiction have also been explained to me to my satisfaction.

☐ (Initial box) I understand that there are alternatives to narcotic drug therapy which include multidisciplinary therapies such as physical therapy, and/or exercise, TENS, cognitive/behavioral therapy, acupuncture, and interventional treatment (i.e. steroidal injections).

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my daily functioning.

☐ (Initial box) I understand that daily narcotic use may increase certain risks, which include, but are not limited to:

- Addiction
- Impaired judgment, sleepiness and confusion
- Breathing Problems
- Development of tolerance
- Cardiac Damage
- Complications to Pregnancy or Breast feeding
- Nausea, vomiting and constipation
- Allergic reactions, overdose and fatal complications
- Dizziness
- Kidney/Liver Damage
- Possible Sexual Dysfunction
- Impaired ability to operate machines or drive motor vehicles

☐ (Initial box) I also understand the following guideline:

As a patient I understand I will not receive more than 5 prescriptions for controlled substances per month. Prescription will not exceed a 30 day supply and may have two refills per MD discretion and DEA regulations. Prior authorizations will not be done and it is the responsibility of each patient to know or bring their insurance formulary.

☐ (Initial box) I also understand that if I do not follow the substance abuse guidelines and any additional testing requirements as necessary (separate contract), my treatment may be terminated.

☐ (Initial box) I have discussed the benefits, risks, and alternatives to narcotic treatment with my provider. I have had an opportunity to ask questions and have received answers to those questions to my satisfaction.

DIVERSION POLICY

WHAT IS DIVERSION? — "The act or an instance of diverting from a course, activity or use."

Diversion is against the law and Resolute Pain Solutions takes this very seriously. If diversion occurs, you will be immediately discharged from our practice without a refund.

Here are some examples of what diversion is when discussing controlled and non-controlled medications.

1. Having a friend, family member, neighbor, or co-worker give you or sell you medication because you missed your appointment with your doctor which is scheduled every 30 days.
2. Going to multiple doctors for the same medication without notifying all physicians.
3. Giving away or selling your medications.
4. Having a positive urine test result for medications when you have not seen a doctor for over 30 days.
5. Having a negative urine test result for medication prescribed within the last 30 days of visit.
6. A positive urine test result for an illicit drug is a mandatory discharge.

I READ THE ABOVE AND UNDERSTAND IT TO THE BEST OF MY KNOWLEDGE

Patient Signature_____ Date _____

Print Patient Name_____ Date of Birth _____

Provider Signature_____ Date _____

Print Name _____ Date of Birth _____ Age _____

Sex _____ Height _____ Weight _____ Home Phone _____ Cell Phone _____

Work Phone _____ Email Address _____

Primary Care Physician: _____ PCP Phone #: _____

Referring Physician: _____ Pharmacy you use: _____

Pharmacy Phone # _____ Pharmacy Address: _____

PAIN QUESTIONNAIRE

Please take a few minutes to complete this Pain questionnaire. Accurate information will help us in evaluating your medical status and taking care of your medical needs. Thank you!

1. How did you hear about us? ☐ Physician _____ ☐ Patient _____ ☐ Phone Book ☐ Newspaper
2. Do you live with anyone? (children in the home, caregiver, assisted living) Yes or No If Yes, Who? _____
3. Tell us, in your own words, where your pain is located? _____
4. How did your pain begin? _____
5. When did your pain first start? _____
6. From a scale of 1-10 (1=no pain at all; 10= the worst pain of your life), what number do you give your pain today? _____
7. How is your appetite? ☐ Normal ☐ Decreased ☐ Increased
8. Are you able to bathe? ☐ Normal ☐ Restricted ☐ Sponge Bath Only
9. Are you able to use the toilet? ☐ Yes ☐ No ☐ Bed Pan or Urinal
10. Can you get up from your bed or chair? ☐ Yes ☐ No ☐ Yes, with great difficulty
11. Can you get yourself dressed for the day? ☐ Yes ☐ No ☐ Yes with assistance from another person
12. Check all of the following activities that make your pain **BETTER**?
    ☐ Sitting ☐ Standing ☐ Walking ☐ Knees flexed
    ☐ Lying Flat ☐ Lying prone (belly down) ☐ Bending/stooping
    ☐ During the morning ☐ During the afternoon
13. Check all of the following activities that make your pain **WORSE**?
    ☐ Sitting ☐ Standing ☐ Walking ☐ Knees flexed
    ☐ Lying Flat ☐ Lying prone (belly down) ☐ Bending/stooping
    ☐ During the morning ☐ During the afternoon
14. Is there any associated weakness or numbness with your pain? ☐Yes ☐ No
    If yes, how many hours of sleep are you getting per night? _____
15. Have you ever had a history of drug or alcohol abuse? ☐ Yes ☐ No
16. Name of Narcotic/Alcohol Treatment Programs _____ or NONE / NOT APPLICABLE
17. Have you ever thought of harming yourself or others? ☐ Yes ☐No
18. Name of Mental Health Facility or Physician _____

MEDICAL HISTORY

1. List all drug and non-drug substances that you are allergic to: _____

2. Check all of the following medical problems yourself, mother, father or siblings are currently or have ever been treated for.

Y= you M=mother F=father S=sibling

Y M F S	Y M F S	Y M F S	Y M F S
☐☐☐☐ Cataract	☐☐☐☐ Diverticulitis	☐☐☐☐ Seizures	☐☐☐☐ Arrthymias
☐☐☐☐ Glaucoma	☐☐☐☐ Hiatus Hernia	☐☐☐☐ Stroke	☐☐☐☐ Heart Disease
☐☐☐☐ Ear/Nasal Problems	☐☐☐☐ Stomach Ulcer	☐☐☐☐ Alzheimer Disease	☐☐☐☐ Mitral Valve Prolapse
☐☐☐☐ Hearing Problems	☐☐☐☐ Prostate Problems	☐☐☐☐ Parkinson Disease	☐☐☐☐ Aneurysm
☐☐☐☐ Headache	☐☐☐☐ Diabetes	☐☐☐☐ Emphysema/COPD	☐☐☐☐ Asthma
☐☐☐☐ High Blood Pressure	☐☐☐☐ Heart Attack/Angina	☐☐☐☐ Liver Disease	☐☐☐☐ Kidney Disease
☐☐☐☐ Bowel Problems	☐☐☐☐ Bladder Problems	☐☐☐☐ CongestiveHeartFailure	☐☐☐☐HIV/AIDS

3. Mother is: ☐Living and well ☐Living, health problems ☐Living, unknown health history ☐Deceased

4. Father is: ☐Living and well ☐Living, health problems ☐Living, unknown health history ☐Deceased

5. List all of your previous major surgeries and dates: a. _____ b. _____

c. _____ . d_____ e. _____ f. _____

6. Please list any hospitalizations and dates: a._____b. _____

c._____d _____e. _____f._____

7. Check all of the symptoms you are currently experiencing?

☐ Weight loss	☐Painful urination	☐ Emotional problems	☐ Fever, night sweats, chills
☐ Visual loss	☐ Urinating frequently	☐ Mouth pain or ulcerations	☐ Change in bowel habits
☐ Yellowing of Eyes	☐Retention of urine	☐ Chest pain	☐ Anemia (low blood count)
☐ Palpitations	☐ Muscle pain	☐ Shortness of breath	☐ Shortness of breath while walking
☐ Epilepsy (seizures)	☐ Muscle weakness	☐ Swelling of ankles	☐ Nausea or vomiting
☐ Peptic Ulcers	☐Tendency to bleed	☐ Blood in urine	☐ Difficulty in swallowing
☐Dizzy spells	☐Blackouts	☐Fainting	

8. Are you working? ☐ Full time ☐ Part time ☐ Not working/limited ☐ Workers' Comp ☐ Litigation involvement ☐ Retired

9. What type of work did you or do you perform? _____

10. Smoking History: Current or Former Smoker? (circle answer) CURRENT FORMER NONSMOKER

If a current smoker, how many cigarettes do you smoke a day? _____ Do you use other tobacco products? ☐ Yes ☐No

11. Have you had a drink containing alcohol in the last year? ☐ Yes ☐No If yes, how often do you have a drink containing alcohol? _____

12. Could you be pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

13. Have you had a flu shot? ☐ Yes ☐ No If yes, date_____

14. Have you had a pneumonia vaccine? ☐ Yes ☐ No If yes, date_____

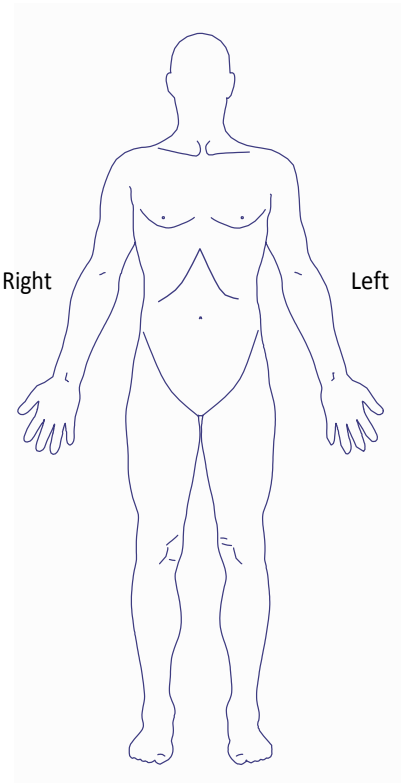
Please list all medications you are currently taking (include aspirin, ibuprofen, vitamin E, herbal remedies)

	Name of Drug	Dose (mg and times per day)	Reason
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

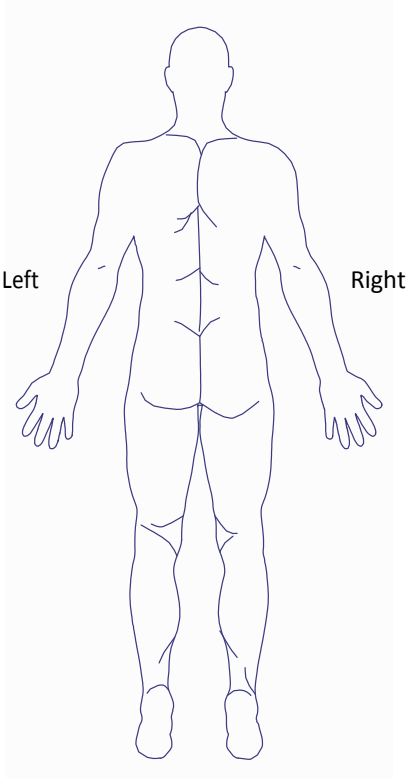
Please check the treatments you are currently or have previously received for your pain. ***(please tell us when and for how long)***

1. Physical Therapy ☐Yes ☐No When: month/year_____ For how long?_____weeks/months % of relief_____%
2. Massage Therapy ☐Yes ☐No When: month/year_____ For how long?_____weeks/months % of relief_____%
3. Chiropractor ☐Yes ☐No When: month/year_____ For how long?_____weeks/months % of relief_____%
4. TENS Unit ☐Yes ☐No When: month/year_____ For how long?_____weeks/months % of relief_____%
5. Epidural Injections ☐Yes ☐No When: month/year_____For how long?_____weeks/months % of relief_____%
6. Facet Injections ☐Yes ☐No When: month/year _____ For how long?_____weeks/months % of relief_____%
7. Spine Surgery ☐Yes ☐No When: month/year _____ For how long?_____weeks/months % of relief_____%
8. Pain Medications ☐Yes ☐No When: month/year_____For how long?_____weeks/months % of relief_____%
9. Hypnosis ☐Yes ☐No When: month/year _____ For how long?_____weeks/months % of relief_____%
10. Biofeedback ☐Yes ☐No When: month/year _____ For how long?_____weeks/months % of relief_____%
11. Home Exercise Program ☐ Yes ☐ No When: month/year_____For how long?_____weeks/months % of relief_____%
11. Hot/Cold Packs ☐ Yes ☐ No
12. Bed Rest ☐ Yes ☐ No
13. Herbal Medicine ☐ Yes ☐ No any relief? _____

Please shade in the areas on the diagrams where your pain is located and circle the words that describe your pain.



ACHING	**SORENESS**
BURNING	**SHARP**
CRAMPING	**RADIATING**
NUMBING	**ANNOYING**
STINGING	**DULL**
STABBING	**TIGHT**
CONSTANT	**HEAVY**
SEVERE	**INSTENSE**
SHOOTING	**BRIEF**
TINGLING	**TRANSIENT**
HOTNESS	**UNBEARABLE**
COLDNESS	**EXCRUCIATING**



FRONT **BACK**

Patient Signature_____Date _____

Print Name_____Date of Birth_____

PAIN MANAGEMENT CONTROLLED SUBSTANCE ACKNOWLEDGEMENT AND AGREEMENT

The purpose of this agreement is to ensure that the patient has given accurate information upon which the doctor can rely in implementing a pain management program. It is also to prevent misunderstandings about certain medications you will be taking for pain management. This is to help both you and your physician comply with the law regarding controlled pharmaceuticals.

PLEASE READ AND INITIAL THE FOLLOWING:

_____ (Initial) I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

_____ (Initial) I understand that if I break this agreement, my doctor will stop prescribing these pain-control medications, I will be discharged from my doctor's care, and I may be criminally prosecuted. In this case, my doctor may taper off the medication over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment program may be recommended.

_____ (Initial) I will communicate fully with my doctor and staff about the character and intensity of my pain, the effects of the pain on my daily life, and how well my medicine is helping to relieve my pain.

_____ (Initial) I will NOT use any illegal controlled substance, including marijuana, cocaine, etc., or any other medication prescribed to anyone other than myself.

_____ (Initial) I will not share, sell or trade my medication with anyone.

_____ (Initial) I will not attempt to obtain any controlled medicines, including opiod pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor, unless coordinated with this office.

_____ (Initial) I will safeguard my medicine from loss or theft. I understand that lost or stolen medication will not be replaced.

_____ (Initial) I agree that refills of my medication will only be available during my regularly scheduled office visits. I understand that it is my responsibility to make and keep timely appointments. Prescriptions will not be phoned in or picked up outside of these visits. Refills will not be available during evening, weekends or holidays.

_____ (Initial) I authorize the doctor, facility and pharmacy to cooperate fully with any city, county, state or federal law enforcement agencies, in the investigation of any possible misuse, sale or other diversion of my medication. I authorize my doctor to provide a copy of this agreement to my pharmacy, primary care provider and referring physician. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ (Initial) I agree that I will submit to blood, urine or saliva tests (at my own expense) if requested by my doctor to determine my compliance with my program of pain control medication.

_____ (Initial) I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time.

_____ (Initial) I will bring all unused pain medication to every office visit.

_____ (Initial) I understand that my pain medications have the potential to impair my judgement and caution should be used when driving or operating heavy machinery.

_____ (Initial) I understand that alcohol may potentate the effects and duration of my medication. I acknowledge that I have been advised to avoid alcohol consumption.

_____ (Initial) I have been fully informed of the psychological dependence (addiction) of a controlled substance. I fully understand the behavioral effects of medications and agree to maintain appropriate behavior at all times with my clinicians and support staff. I will notify clinicians for assistance as needed for concerns regarding side effects. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the same effect of pain control, and I do know that I will become physically dependent on the medication.

_____ (Initial) I understand that it is a criminal offense in the state of Florida to acquire or obtain or attempt to acquire or obtain possession of a controlled substance by misrepresentation, fraud, forgery, deception or subterfuge. I understand that if I make any false statements in this agreement, I will be subject to criminal prosecution.

_____ (Initial) I understand that I may be called into the office for random urine drug screening and/or medication counts. I will be required to present myself to the office by the close of business on that day or I may be discharged from the practice.

Print Name:_____ Date of Birth: _____

Signature:_____ Today's Date: _____

1. Have you seen any other physicians regarding any condition that requires pain management within the last year?
☐ YES ☐ NO

If you have seen other physicians you must list each and every physician name here:

_____

_____

_____

Patient Signature_____

2. Have you obtained a prescription for a controlled substance from another physician within the last year?

☐ YES ☐ NO

If you have received such medication from another physician you must list each and every medication as well as the physician who prescribed it here:

_____

_____

_____

Patient Signature_____

3. I am not presently being treated or attempting to be treated by another physician for any condition that requires pain management.

Patient Signature_____

4. I am not exaggerating any of the symptoms of any condition that requires pain management.

Patient Signature_____

5. I have been completely honest with my doctor regarding any condition that requires pain management.

Patient Signature_____

6. I will not see any other physician regarding any condition that requires pain management unless I notify my doctor prior to visiting the other physicians.

Patient Signature_____

7. If my doctor prescribes pain medications I will only use the following pharmacy to fill any and all prescriptions. If I intend to use any other pharmacy I will notify my doctor immediately.

Pharmacy_____Patient Signature_____

Patient abuse of medication is a serious problem. Please read this form carefully. You will be held to this agreement by your physician and by any law enforcement agency investigation for any possible abuse of the doctor/patient relationship with regard to pain management.

Print Name:_____Date of Birth: _____

Signature:_____Today's Date: _____

I do hereby state that I have read this form completely, and that all of the information is true and accurate. I understand that any false statements given in conjunction with this agreement will subject me to criminal prosecution. I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this documentation has been given to me.

This agreement is entered into on this_____day of_____month _____year

Patient Signature:_____

Provider Signature: _____

Physician Signature: _____

PATIENT INFORMATION

Patient Name (Please Print)_____Date of Birth _____

Address _____

City_____State_____Zip_____

Age_____Sex_____SS#_____Preferred Language _____

Occupation _____

Marital Status: ☐ Married ☐Single ☐ Divorced ☐ Other

Home Phone #_____Cell Phone #_____Work Phone _____

Emergency Contact_____Relationship _____

Phone #_____Alternate # _____

IS YOUR INJURY RELATED TO

☐ Work Injury ☐ Auto Accident If Yes, what is the Date of Injury_____

Claim # Assigned to Injury Case_____Do you have an Attorney? ☐ Yes ☐ No

Attorney or Case Worker Name _____

Attorney or Case Worker Info: Phone #_____Fax # _____

PLEASE *INITIAL* EACH LINE AND SIGN BELOW

____I consent to treatment necessary for the care of the patient indicated on this form. I hereby authorize
(Initial) payment of medical benefits directly to the attending physician for services rendered.

____Authorization is hereby granted to release information as necessary to process and complete my claim.
(Initial) I understand that I am financially responsible for this account.

_____ _____

Patient/Guardian/Guarantor Signature Date

Print Name: _____ **Date of Birth:** _____

Please answer yes or no to the following two questions:

1 Do you have little interest or pleasure in doing things? YES or NO

2 Feeling down, depressed, or hopeless YES or NO

If you answered YES to <u>one or both of the above</u>, please answer the following 9 questions:

1. Little interest or pleasure in doing things
   Not at all **Several days** **More than half the day** **Nearly every day**
2. Feeling down, depressed, or hopeless
   Not at all **Several days** **More than half the days** **Nearly every day**
3. Trouble falling asleep, staying asleep, or sleeping too much
   Not at all **Several days** **More than half the days** **Nearly every day**
4. Feeling tired or having little energy
   Not at all **Several days** **More than half the days** **Nearly every day**
5. Poor appetite or overeating
   Not at all **Several days** **More than half the day** **Nearly every day**
6. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
   Not at all **Several days** **More than half the day** **Nearly every day**
7. Trouble concentrating on things such as reading the newspaper or watching television
   Not at all **Several days** **More than half the day** **Nearly every day**
8. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or that you have been moving around a lot more than usual
   Not at all **Several days** **More than half the days** **Nearly every day**
9. Thinking that you would be better off dead or that you want to hurt yourself in some way
   Not at all **Several days** **More than half the day** **Nearly every day**

Policy 2

NOTICE OF PRIVACY PRACTICES
FOR RESOLUTE PAIN SOLUTIONS

EFFECTIVE DATE: MAY 16, 2014
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

CONTACT - IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR DIRECTOR OF PAIN MANAGEMENT SERVICES, 7100 West Camino Real, Suite 301, Boca Raton, FL 33433.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

To our Patients and their Families:

Resolute Pain Solutions understand that your health information is personal and confidential. This Notice of Privacy Practices ("Notice") describes how Resolute Pain Solutions uses and discloses your protected health information to provide treatment, obtain payment or for other purposes necessary for operations. Your health information includes the reason(s) for your hospitalization/treatment, the type of care and treatment you may receive, and other information, including demographic information (e.g., your home address, age, gender, religious preferences, etc.) that may be either necessary or helpful to identify you, or to assist your Resolute Pain Solutions clinician in providing your necessary medical care. Resolute Pain Solutions must follow the terms of the notice currently in effect.

CHANGES TO THIS NOTICE

We reserve the right to change this notice without written notification to you. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future.

> Your confidential healthcare information may be released to other healthcare professionals within the organization for the purpose of providing you with quality healthcare.

> Your confidential healthcare information may be released to your insurance provider for the purpose of the organization receiving payment for providing you with needed healthcare services.

> Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.

> Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.

> Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).

> Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.

> Disclosure of the following PHI requires your written authorization: use of psychotherapy notes, disclosure of PHI for marketing, and disclosures that constitute a sale of PHI. You may revoke your permission to release confidential healthcare information at any time.

> You may be contacted by the organization to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

- You may be contacted by the organization for the purposes of raising funds to support the organization's operations. You may opt out of receiving such communications by calling the following number 561-465-2598 or by following the directions provided on the fundraising materials.
- You have the right to restrict the use of your confidential healthcare information. However, the organization may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to restrict disclosure to your health plan of any PHI created from a service that you have paid for out of pocket.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- The organization is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.
- The organization will notify patient(s) when a reportable breach is discovered. Notification will be made to the patient(s) as soon as possible and no later than 60 days from when the breach is discovered. Notification will include a brief description of the how breach occurred, a description of the PHI involved, and steps patient(s) should take to protect themselves from harm. The notification will also include contact information for the individual to ask questions.
- Resolute Anesthesia and Pain Solutions shall abide by the terms of this notice. The organization reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.
- Health plans are prohibited from using or disclosing genetic information of an individual for underwriting purposes.
- You have the right to complain to the organization if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the organization:
- ATTN: DPO Resolute Anesthesia and Pain Solutions 7100 West Camino Real Suite 301 Boca Raton, FL, 33433

  All complaints will be investigated. No personal issue will be raised for filing a complaint with the organization.

  For further information about this Privacy Notice, please contact: Sherry Piasecki Privacy Officer

SUMMARY OF THE FLORIDA PATIENTS BILL OF RIGHTS AND RESPONSIBILITIES

- A patient has a right to be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
- A patient has the right to refuse treatment, except as otherwise provided by law.

- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, up front and in advance of treatment, whether the healthcare provider or health facility accepts Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, including over-the-counter products and dietary supplements and allergies and sensitivities, and other matters relating to his or her health.
- The patient is responsible for keeping appointments, and when he or she is unable to do so for any reason, for notifying the Surgery Center and/or the physician.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions, or he or she does not follow the physician's orders.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient has the right to change primary or specialty physician if other qualified physician is available.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following the health care and facility rules and regulations affecting patient care and conduct.
- A patient is responsible for being considerate of the rights of other patients and facility personnel.
- A patient is responsible for being respectful of his or her personal property and that of other persons in the Surgery Center.
- A patient is responsible to provide a responsible adult to transport him or her home from the facility and remain with him or her for 24 hours, if required by his or her provider.
- This is to inform you that certain physicians that perform procedures at this Surgery Center (Jensen Beach Surgery Center and Laser & Surgery of the Palm Beaches) may have a partnership in the facility. If you have questions regarding your physician, please do not hesitate to ask.
- Also, this is to inform youthat we have on site laboratory diagnostic testing.
- Regarding Advanced Directives - Due to the elective nature of the surgery and/or procedures performed in this facility, Advanced Directives are suspended for the duration of the stay.
- If you have a complaint against a hospital or ambulatory surgical center, call the Consumer Assistance Unit at 1-888-419-3456 or write to the address listed below.

AGENCY FOR HEALTH CARE ADMINISTRATION
CONSUMER ASSISTANCE, UNIT 2727, MAHAN DRIVE, BUILDING I
P.O. BOX 14000 TALLAHASSEE. FL 32308

This notice is effective as of May 16, 2014

Averting a Serious Threat to Health or Safety - We may use and disclose health information about you when necessary to prevent a serious threat to your health or safety, or the health and safety of another person or the public. These disclosures would be made only to someone able to help prevent the threat.

Public Health Activities - We may disclose health information about you for public health activities.

These generally include the following:

- To prevent or control disease, injury or disability.
- To report births and deaths.
- To report child abuse or neglect.
- To report reactions to medications, problems with products or other adverse events.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse (including elder abuse), neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities - We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes - If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute. We would only disclose this information if efforts have been made to tell you about the request to allow you to obtain an order protecting the requested information.

Law Enforcement - We may disclose health information if asked to do so by law enforcement officials for the following reasons:

- In response to a court order, subpoena, warrant, summons or similar process.
- To identify or locate a suspect, fugitive, material witness or missing person.
- About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement.
- About a death we believe may be the result of a criminal conduct.
- About criminal conduct at our facility.
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Home Directors - We may disclose health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death of a person. We may also release health information about patients at our facility to funeral home directors as necessary to carry out their duties.

National Security and Intelligence Activities - We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Inmates - If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose health information about you to the correctional institution or the law enforcement official. This is necessary for the correctional institution to provide you with health care, to protect your health and safety and the health and safety of others, or for the safety and security of the correctional institution.

Health Care Operations - We may use and disclose health information about you for health care operations, including, for example: quality assurance, peer review, and risk management activities; administrative activities, including Resolute Pain Solutions financial and business planning and development; and customer service activities, including investigation of complaints. These uses and disclosures are necessary to operate Resolute Pain Solutions and make sure all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of the Resolute Pain Solutions clinicians who care for you.

Business Associates - There are some services provided in our organization through contracts with business associates. Examples of business associates include billing companies, management consultants, quality assurance reviewers, etc. We may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, we require our business associates to sign a contract that states they will appropriately safeguard your information.

Appointment Reminders - We may use and disclose health information to contact you as a reminder that you have an appointment for treatment or medical care from a Resolute Pain Solutions clinician. We may call you and leave information on your answering machine regarding food and liquid restrictions prior to a surgery and procedures, unless you tell us not to.

Individuals Involved in your care or payment for your care - We may disclose health information about you to a friend or family member who is involved in your medical care, unless you tell us in advance not to do so. We may leave preoperative or postoperative instructions for you on an answering machine or voice mail at the phone number you have provided to Resolute Pain Solutions or the facility where you will be receiving care, unless you tell us not to do so.

WITH YOUR SPECIFIC WRITTEN "AUTHORIZATION"

If there are reasons we need to use your information that has not been described in the sentences above, we will obtain your written permission (called "authorization"). If you authorize us to use or disclose health information about you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosure we have already made with your permission, and that we are required to retain our records of the care that we provided to you. Some typical disclosures that require your written authorization, or the written authorization of your representative are for disclosure of Drug and Alcohol Abuse Treatment, HIV and AIDS Test Results, and Mental Health Treatment.

SPECIAL SITUATIONS THAT DO NOT REQUIRE YOUR INFORMATION CONSENT OR AUTHORIZATION

We will disclose health information about you without your permission when required to do so by federal, state or local law. The following disclosures are permitted by law without any oral or written permission from you, although this list is not intended to be all-inclusive:

Organ and Tissue Donation - If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans - If you are a member of the armed forces, we may release health information about you as required by military command authorities.

Worker's Compensation - We may release health information about you for worker's compensation or similar programs if you have a work related injury. These programs provide benefits for work related injuries.

Acknowledgement of receipt of Resolute Anesthesia and Pain Solutions Patient Privacy Notice (HITECH compliant) and ACHA bill of rights.

Print Patient Name:_____Date of Birth: _____

Patient/Guardian/Parent Signature: _____

Date:_____ Relationship: _____