Interventional Pain Physicians
Of South Florida

Nancy Erickson, D.O.

Welcome and thank you for choosing my office for your Pain Management Treatment. Here is the New Patient paperwork that must be filled out prior to your visit (please use blue or black ink and no white out). In order to keep my office running smoothly I do have a late arrival policy, please arrive on time for your appointment or you will be rescheduled. See the list below of the things that you will need to bring with for your visit. Please feel free to call our office at anytime if you have any questions.

**State Issued ID*
**Insurance Cards*
**Any MRI's X Ray's or CT Scan's pertaining to your visit CD's also if you have any*
**List of Medication and bottles of any narcotic medication you are currently taking*
**Any pertinent information that may be useful for the Dr. to review.*
**Primary Care Physician first and last name and phone number (if you have one)*

Our address is:
601 N. Flamingo Rd Ste. 411
Pembroke Pine, Fl. 33028
954-433-8711

Please sign below and bring with you to your appointment

____

Patient Signature

Interventional Pain Physicians Of South Florida

Nancy Erickson, D.O.

PATIENT INFORMATION

Today's Date: ____________________

Patient's Name: ____________________ D.O.B.: __________
Last First Middle

Street Address: ____________________ Apt. #: ________

City/State/Zip Code: ____________________

Home Phone #: ____________________ Work Phone #: ____________________

Social Security #: ______________ Driver's License #: ______________ State: ________

Sex: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ SO

Spouse's Name: ____________________ Spouse's Work #: ____________________

Your Employer: ____________________

Employer's Address: ____________________

City/State/Zip Code: ____________________

Employer's Phone #: ____________________ Position: ____________________

Next of Kin: ____________________ Relationship: ____________________

Home Phone #: ____________________ Work Phone #: ____________________

Person to Notify in Emergency: ____________________ Relationship: ____________________

Home Phone #: ____________________ Work Phone #: ____________________

Responsible Party's Name: ____________________

Relationship to Patient: ____________________ Home Phone #: ____________________

Referred By: ____________________ Phone #: ____________________

Primary Care Physician's Name: ______________ Phone #: ______________ Fax # ______________

Primary Care Physician's Address: ____________________

Reason for Appointment: ____________________
Please check of we may leave a message on your answering machine ☐ Yes ☐ No

601 N. Flamingo Rd. Suite 411, Pembroke Pines, FL 33028
Office: (954) 433-8711 ♦ Fax: (954) 433-3646
www.flpainrelief.com

Interventional Pain Physicians
Of South Florida

Nancy Erickson, D.O.

ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I AUTHORIZE:

The release of any medical information that is needed for submission to my insurance carrier in order to process a claim for utilization review or quality assurance activities.

I ASSIGN:

All medical and/or surgical benefits including major medical benefits to which I am entitled to

__________Dr. Nancy Erickson____
Name of Physician or Group

A photocopy of this authorization shall be considered as effective and valid as the original.

I AGREE:

To accept responsibility for any balance remaining after insurance pays or, if an HMO participant, any appropriate co-payment, deductible, or non-covered. If I do not have insurance coverage, I agree to adhere to payment arrangements made at the time of my appointment, and to be responsible for any legal fees, costs, and expenses incurred by

__________Dr. Nancy Erickson______________________________
Name of Physician or Group

In the pursuit of the collection of fees due to them for services provided.

I understand that this form or a copy thereof is valid for twelve months.

______________________________ ____________________
Patient/Subscriber Signature Date

601 N. Flamingo Rd. Suite 411, Pembroke Pines, FL 33028
Office: (954) 433-8711 ♦ Fax: (954) 433-3646
www.flpainrelief.com

Interventional Pain Physicians Of South Florida

Nancy Erickson, D.O.

Questionnaire filled out by: ____________________

PAIN PATIENT QUESTIONNAIRE DATE: ______________

1. Patient's Full Name: ____
2. Patient's Age: _____ DOB: ___________ Sex (Circle): Male Female
3. Race (Circle one please) Caucasian Black Hispanic Other (specify______________________)
4. Primary Physician: ___________________________ Phone Number: ______________
5. Referring Physician: ___________________________ Phone Number: ______________
6. What is the main complaint for which you are seeking treatment at the Pain Center?

____

____

7. How long have you had the pain problem you are currently experiencing?

____

8. How did your current pain start?

____

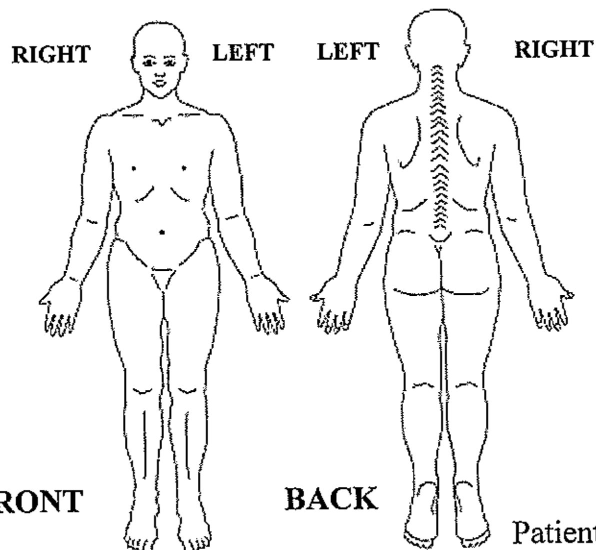
____

9. Have any other Health Care Professionals and/or Specialist been involved in the evaluation and treatment of your current pain? (Please specify)

____

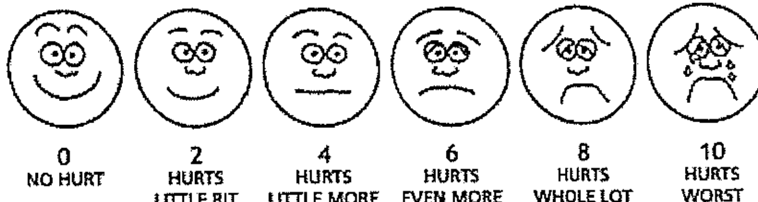
____

PLEASE MARK WHERE YOUR PAIN IS LOCATED



Choose a number from the chart below that best describes:

Your pain now: ________(0-10)
Your pain at its worst: ________(0-10)
Your goal for pain relief: ________(0-10)



Patient's Name____________________

Interventional Pain Physicians Of South Florida

Nancy Erickson, D.O.

1. Please list all of the medications you <u>**have ever tried**</u> for your **current pain problem**.

____

____

2. Please check all of the <u>treatments</u> <u>**you have tried for your pain**</u> from the list below, and complete the appropriate columns at the right.

TREATMENT	**DATES**	**RESULTS**
___ Hospital Bed rest	________	________
___ Traction	________	________
___ Surgery	________	________
___ Acupuncture	________	________
___ TENS (Electrical Stimulator)	________	________
___ Physical Therapy	________	________
___ Chiropractor	________	________
___ Epidural, Nerve Block, Neuroforaminal injections	________	________
___ Exercise – Circle: Structured program, Yoga, Tai Chi, Self gym, Pilates, walking		________
___ Have you had steroid injections of any body part?	________	________
___ Other – Specify or circle: Therapeutic massage, aquatic therapy, etc.		________

3. How often do you have pain?________________________________

4. Check any symptoms and adjectives associated with your pain:

___ Numbness	___ Weakness	___ Urinary Incontinence
___ Redness	___ Swelling	___ Tenderness of affected area
___ Cool, pale skin	___ Burning	___ Pain with only a light touch
___ Mild	___ Shooting	___ Prevents family duties
___ Moderate	___ Stabbing	___ Prevents social duties
___ Strong	___ Tingling	___ Affects appetite
___ Dull	___ Cramping	___ Throbbing
___ Aching	___ Squeezing	___ Sexual Dysfunction

5. Does your pain affect your sleep? (Circle) No Yes Falling asleep? No Yes
   Are there any factors that make your pain:
   Better? (Please list)________________________________
   Worse? (Please list) ________________________________

6. During the past month, is your pain worse in the (circle all that applies):
   ___ Morning ___ Afternoon ___ Evening ___ Night ___ No typical pattern

7. Have you ever had psychiatric or psychological evaluation or treatment for the problems including your current pain? (Circle) No YES

8. Have you had any CT scans or MRI for your current pain problem? (Circle) No Yes
   If Yes, at what facility? ________________________________

Patient's Name________________________

Interventional Pain Physicians
Of South Florida

Nancy Erickson, D.O.

10. Do you have any drug allergies? (Please list)____

____

11. Are you allergic to seafood? (Circle) No Yes

20. Allergic to Latex? (Circle) No Yes

12. Do you have a pacemaker? (Circle) No Yes

22. Allergic to Sunscreen? (Circle) No Yes

13. Have you ever had surgery? (Please list in detail)

Surgery	Date	Doctor or Hospital

14. Do you have any family history of major illness? (Circle) No Yes If yes, please list:

MOTHER'S SIDE	FATHER'S SIDE

15. Are your parents deceased? (Circle) Mother: No Yes Father: No Yes

16. Do you have any siblings? (Circle) No Yes How Many? ____________

Do they have a medical history? (Circle) No Yes If yes, please specify?

Medical History ____

17. Aside from your pain problem, how is your general health? (Please check one)

___ Excellent ___ Minor health problem only ___ Major Health problems

General

___Hearing Loss ___Eye disorders ___Skin Disorders/Type:_________________________
___Cancer -Location:____________________Treatment:_________________________________

Cardiovascular Health

___Chest Pain ___Heart Attack ___Stroke ___Dizziness
___High Blood Pressure___Phlebitis ___High Cholesterol
___Fainting ___Irregular Heartbeat (Type:_______________)

Pulmonary

___Chronic Cough ___Asthma ___Tuberculosis ___COPD ___Pneumonia
___Emphysema ___Oxygen use ___CPAP use ___Snoring ___Bronchitis
___Shortness of Breath ___Wheezing ___ Sleep Apnea

Gastrointestinal

___Ulcers ___Pancreatitis ___Jaundice ___Constipation ___Colostomy
___Diverticulitis ___ GERD ___Hepatitis (Type__) ___Gallbladder Disease

Endocrine

___Diabetes ___Thyroid Disorder

Hematology
___Bleeding disorder ___Anemia

Neurological
___ Numbness in left arm ___ Syncope ___ Numbness ___ Headache ___ Loss of bladder control
___ Memory loss ___ Seizures ___ Stroke or mini stroke (TIA) ___ Tingling/numbness ___ Paralysis
___ Low back pain ___ Numbness in both arms ___ Parkinson's Disease ___ Muscle weakness
___Memory deficit ___Paralysis ___CVA/TIA ___Seizures ___Meningitis
___Headaches ___Depression ___Anxiety ___Numbness/Tingling-arms, legs, face, hands, feet

Genitourinary
___Sexually Transmitted Disease (Specify: ________________________)___Impotence ___Urination difficulty
___Prostate disease ___Kidney disease ___ HIV/AIDS ___Incontinence

Bone/Joint
___ Arthritis or joint disease ____ Bone or Joint surgery in past year ____ Carpal Tunnel
___ Swollen joints ___ Sciatica ___ Painful joints ___ Muscle Aches___ Joint stiffness
___ Weakness ___ Osteoporosis ___ spasms ___ Neck pain ___ Back pain ___ Joint injections in the last year

Other Not Listed:
____

18. Marital Status: ______________________
19. Height: ________________ Weight: __________________ 20. Have you had any of the following health problems? (Please check all that apply)
21. Do you smoke? (Circle) No / Yes -If yes, how many packs per day?______How many Years?____
22. Do you drink alcoholic beverages? (Circle) No / Yes If yes, how often? ____________________ 23. Do you use any recreational drugs? (Circle) No / Yes If yes, what? ________________________
24. Are you actively involved in any recovery, treatment and/or monitoring programs if yes what?
____

25. Currently working? No / Yes If no why?______________________________________
    Is your current work status considered FULL DUTY? No / Yes
    If no, please explain? ____
    What is your occupation? ____
    Please Describe? ____

26. Would you return to work if you had no pain problem? (Circle) No / Yes Full Time Part Time

Patient's Signature_______________________________

Patients Name: ___________________________________ page 4

Interventional Pain Physicians
Of South Florida

Nancy Erickson, D.O.

PAIN MANAGEMENT AGREEMENT

Our goal in the field of Pain Management Medicine is to assist patients with the treatment of their chronic pain. We achieve this goal through various modalities, including injections or nerve blocks, physical therapy, exercise programs, psychological counseling when needed, and referrals to surgeons or other specialists as required. We strive to manage pain through means other than medications to allow patients to live a relatively pain free life. We seek to treat the cause of the pain and not the symptoms. **However, we also understand that strong narcotic analgesic and other prescription medications may be indicated for the treatment of certain chronic pain conditions.**

The purpose of this Agreement is to clarify the conditions under which Dr. Nancy Erickson will prescribe medications for you. This agreement will help you and Dr. Nancy Erickson comply with the laws regarding controlled pharmaceuticals and prevent misunderstandings about the medicines you may take for your pain condition. **Please read each and every item in this agreement very carefully.**

I UNDERSTAND AND AGREE TO THE FOLLOWING TERMS OF ANY AND ALL PRESCRIPTIONS:

1. I WILL USE MY MEDICATION(S) AT A RATE NO GREATER THAN THAT PRESCRIBED BY DR. NANCY ERICKSON. IF I DO OVER-USE MY MEDICATION, THAT MEDICATION WILL NOT BE REFILLED EARLY, AND I MAY BE WITHOUT PAIN MEDICATION FOR SOME PERIOD OF TIME.

2. I WILL NOT SHARE, SELL OR TRADE MY MEDICATION WITH ANYONE. I WILL NOT ATTEMPT TO OBTAIN ANY CONTROLLED MEDICINCES, INCLUDING OPIOID PAIN MEDICINES, CONTROLLED STIMULANTS, OR ANTI-ANXIETY MEDICINES FROM ANY OTHER DOCTOR. I WILL SAFEGUARD MY WRITTEN PRESCRIPTIONS AND PAIN MEDICINE FROM LOSS OR THEFT. I UNDERSTAND THAT LOST OR STOLEN WRITTEN PRESCRIPTIONS OR MEDICINES WILL NOT BE REPLACED.

3. SUDDEN DISCONTINUATION OF A NARCOTIC PAIN MEDICATION MAY LEAD TO UNPLEASANT OR DANGEROUS WITHDRAWL SYMPTOMS.

4. THE POTENTIAL RISKS AND SIDE EFFECTS OF MEDICATIONS TAKEN FOR PAIN, EITHER SHORT TERM OR LONG TERM, CAN INCLUDE: DROWSINESS, NAUSEA, CONSTIPATION, ITCHING, DIFFICULTY WITH URINATION, TOLERANCE, DEPENDANCE, ADDICTION, AND OVERDOSE.

5. IN THE EVENT THAT DR. NANCY ERICKSON FEELS THAT YOUR DOSE OF PAIN MEDICATION IS EXCESSIVE OR MAKES THE DIAGNOSIS OF ADDICTION OR OVERDOSE, DR. NANCY ERICKSON WILL REDUCE THE MEDICINE OVER A PERIOD OF TIME (DAYS, WEEKS, AND MONTHS) AS NECESSARY TO AVOID WITHDRAWL SYMPTOMS. ALSO, A DRUG-DEPENDENCE TREATMENT OR DETOXIFICATION PROGRAM MAY BE RECOMMENDED.

601 N. Flamingo Rd. Suite 411, Pembroke Pines, FL 33028
Office: (954) 433-8711 ♦ Fax: (954) 433-3646
www.flpainrelief.com

6. I UNDERSTAND AND AGREE THAT I AM NOT TO RECEIVE ANY TYPE OF PRESCRIPTION PAIN MEDICATION OR SEDATIVE MEDICATION FROM ANY PHYSICIAN OTHER THAN DR. NANCY ERICKSON UNLESS THERE IS A SPECIFIC MEDICAL NECESSITY. SHOULD YOUR CAREGIVER OR YOU RECEIVE ANY PAIN OR SEDATIVE MEDICATIONS FROM ANY OTHER PHYSICIAN, YOUR CAREGIVER OR YOU MUST INFORM DR. NANCY ERICKSON'S OFFICE EITHER BY TELEPHONE OR IN WRITING WITHIN 72 HOURS OF HAVING FILLED THE PRESCRIPTIONS.

7. REFILLS OF YOUR PRESCRIPTIONS WILL BE ISSUED ONLY AT THE TIME OF AN OFFICE VISIT, DURING REGULAR OFFICE HOURS, OR IMMEDIATELY FOLLOWING A PROCEDURE.

8. REFILLS WILL NOT BE AVAILABLE DURING EVENINGS, ON WEEKENDS OR HOLIDAYS, AND WITHOUT AT LEAST 72 HOURS NOTICE TO DR. NANCY ERICKSON'S OR HER OFFICE STAFF.

9. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KEEP TRACK OF MY SUPPLY OF PAIN MEDICATION AND TO MAKE TIMELY APPOINTMENTS WITH DR. NANCY ERICKSON TO HAVE YOUR PRESCRIPTION(S) REFILLED. **LAST-MINUTE REQUESTS FOR PRESCRIPTION REFILLS ARE NOT WELCOME.**

10. DR. NANCY ERICKSON MAY, AT HER DISCRETION, ISSUE A CHANGE OF YOUR MEDICATION(S) BASED ON A TELEPHONE CONVERSATION THAT SHE HAS HAD REGARDING YOUR PAIN CONDITION AND THE EFFECTS THEY MAY HAVE ON THIS CONDITION.

11. I WILL COMMUNICATE FULLY AND TRUTHFULLY WITH DR. NANCY ERICKSON ABOUT THE CHARACTER AND INTENSITY OF MY PAIN, THE EFFECT OF THE PAIN ON MY DAILY LIFE, AND HOW WELL THE MEDICINE IS HELPING TO RELIEVE THE PAIN. I UNDERSTAND THAT I, OR MY CAREGIVER IS RESPONSIBLE FOR INFORMING DR. NANCY ERICKSON EITHER IN PERSON, AT THE FOLLOW-UP, OR BY TELEPHONE AT DR. NANCY ERICKSON'S OFFICE AT (954-433-8711) DURING REGULAR BUSINESS HOURS (7:00 A.M.- 3:30 P.M., MONDAY THROUGH THURSDAY, FRIDAY 7:00 A.M. – 3:00 P.M.) REGARDING ANY PROBLEMS OR SIDE EFFECTS ENCOUNTERED WITH THE MEDICATION. A MESSAGE MAY ALSO BE LEFT FOR DR. NANCY ERICKSON AT (954-433-8711) REGARDING ANY OF THESE PROBLEMS.

601 N. Flamingo Rd. Suite 411, Pembroke Pines, FL 33028
Office: (954) 433-8711 ♦ Fax: (954) 433-3646
www.flpainrelief.com

12. I HAVE BEEN ADVISED TO ABSTAIN FROM OR SIGNIFICANTLY MODERATE MY USE OF **ALCHOLIC BEVERAGES** WHILE TAKING MEDICATION FOR MY PAIN CONDITION. I WILL NOT USE ANY ILLEGAL CONTROLLED SUBSTANCES, INLUDING MARIJUANA, COCAINE, HEROIN, ECSTASY, GHB, ETC. IF I AM A **CIGARETTE SMOKER**, I UNDERSTAND THAT I WILL BE ASKED TO QUIT. CIGARETTE SMOKERS TYPICALLY HAVE A DECREASED RESPONSE TO PAIN TREATMENT BECAUSE OF THE EFFECTS OF SMOKING ON OXYGEN DELIVERY TO THE PERIPHERAL TISSUES. ADDITIONALLY, **OBESITY** IS ONE OF THE MOST IMPORTANT CAUSES OF FAILED TREATMENT FOR CHRONIC PAIN. EVERY TEN POUNDS OF EXCESS WEIGHT THAT ONE CARRIES ON HIS/HER BODY RESULTS IN ONE HUNDRED POUNDS OF INCRESASED PRESSURE ON THE SPINE, VERTEBRAL DISCS, AND SPINAL NERVES. EXCESSIVE WEIGHT WILL THEREFORE RESULT IN AN INCREASE IN PAIN. IF YOU ARE OVERWEIGHT YOU WILL NEED TO ENROLL IN AN WEIGHT LOSS PROGRAM. PHYSICAL THERAPY WILL ALSO BE DIRECTED IN THIS AREA AS WELL.

13. IF PHYSICAL THERAPY IS PRESCRIBED, I AGREE TO ATTEND AND PARTICIPATE TO THE FULLEST EXTENT POSSIBLE. IF THERE ARE ANY PROBLEMS WITH MY PHYSICAL THERAPY, I AGREE TO COMMUNICATE THIS TO DR. NANCY ERICKSON SO THAT SHE CAN MAKE THE APPROPRIATE CHANGES IN MY THERAPY PROGRAM.

14. I AGREE THAT I WILL SUBMIT TO A BLOOD OR URINE TEST IF REQUESTED BY DR. NANCY ERICKSON TO DETERMINE MY COMPLIANCE WITH MY REGIMEN OF PAIN MEDICATION. FUTHERMORE, AT DR. NANCY ERICKSON'S DISCRETION, THE PRIMARY CAREGIVER WHO'S SIGNATURE APPEARS BELOW SHALL ALSO BE SUBJECT TO PERIODIC URINE AND/OR BLOOD TESTING.

15. IF REQUESTED, I WILL BRING ALL UNUSED PAIN MEDICINE TO AN OFFICE VISIT FOR A "PILL COUNT". DR. NANCY ERICKSON MAY REQUEST ADDITIONAL "PILL COUNTS" AT ANY TIME, AND I AGREE TO COMPLY WITH THESE REQUESTS. I AGREE THAT MY CAREGIVER OR I WILL BRING THE MOST RECENT PRESCRIPTION CONTAINER FOR EACH MEDICATION TO EACH VISIT WITH MY PHYSICIAN. THESE CONTAINERS MUST CORRESPOND TO THEIR LAST PRESCRIPTION RECORDED IN THE MEDICAL RECORD WITH THE PRESCRIPTION LABELS INTACT AND LEGIBLE SO THAT DR. NANCY ERICKSON OR STAFF MEMBER MAY DOCUMENT APPROPRIATE CONTROL INFORMATION. SPECIFICALLY, THE PRESCRIPTION REGISTRATION NUMBER AND PHARMACY TELEPHONE NUMBER WILL BE NOTED AND VERIFIED.

601 N. Flamingo Rd. Suite 411, Pembroke Pines, FL 33028
Office: (954) 433-8711 ♦ Fax: (954) 433-3646
www.flpainrelief.com

16. I WILL USE ONLY ONE PHARMACY TO FILL PRESCRIPTIONS FOR YOUR PAIN MEDICATIONS. **MY PHARMACY IS (NAME)** ______________________**PHONE:** ______________ **PHARMACY LOCATION (STREET/CITY):** ______________________ I AUTHORIZE DR. NANCY ERICKSON AND MY PHARMACY TO COOPERATE FULLY WITH ANY CITY, STATE, OR FEDERAL LAW ENFORCEMENT AGENCY, INCLUDING THIS STATE'S BOARD OF PHARMACY, IN THE INVESTIGATION OF ANY POSSIBLE MISUSE, SALE OR OTHER DIVERSION OF MY PAIN MEDICATION. I AUTHORIZE DR. NANCY ERICKSON TO PROVIDE ME A COPY OF THIS AGREEMENT TO MY PHARMACY. I AGREE TO WAIVE ANY APPLICABLE PRIVILEGE OR RIGHTS OF PRIVACY OR CONFIDENTIALITY WITH RESPECT TO THESE AUTHORIZATIONS. I FURTHER CONCENT TO DR. NANCY ERICKSON CONTACTING OTHER PHYSICIANS TO DISCUSS PRIOR PRESCRIPTIONS THAT I HAVE RECEIVED FROM THOSE PHYSICIANS OR TO OBTAIN THE RESULTS OF DIAGNOSTIC TESTING (PAST OR PRSENT) IN ORDER TO OBTAIN ADEQUATE INFORMATION ABOUT MY CONDITION.

17. I FURTHER UNDERSTAND THAT THIS AGREEMENT IS ESSENTIAL TO THE TRUST AND CONFIDENCE NECESSARY IN A DOCTOR-PATIENT RELATIONSHIP AND THAT DR. NANCY ERICKSON UNDERTAKES TO TREAT YOU BASED ON THIS AGREEMENT. I UNDERSTAND THAT IF I BREAK THIS AGREEMENT OR PROVIDE ANY FALSE INFORMATION, DR. NANCY ERICKSON WILL STOP PRESCRIBING THESE PAIN-CONTOL MEDICINES AND YOU MAY BE IMMEDIATELY REMOVED FROM DR. NANCY ERICKSON'S CARE.

I have reviewed all of the items contained in this four (4) page agreement. I agree to follow all of the guidelines that are described above. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given to me upon request. I voluntarily consent to participation in the pain medication program described in this Agreement.

Patient Signature: ______________________________ Date: ______________

(If applicable) Legal Guardian Name: ______________ Legal Guardian Signature: ______________

Witness Name: ______________________ Witness Signature: ______________________

601 N. Flamingo Rd. Suite 411, Pembroke Pines, FL 33028
Office: (954) 433-8711 ♦ Fax: (954) 433-3646
www.flpainrelief.com

Interventional Pain Physicians
of South Florida

Nancy Erickson, D.O.

DRUG SCREENING

It is the policy of this office to require periodic drug and alcohol checks. This is to protect you. If you are requested to give us a urine/saliva sample it is to be given at the time it is requested. You will not be able to leave and return at a later time to provide the urine sample. If you choose not to give us a urine sample upon request, we will continue to treat your pain with interventional procedures appropriate for your specific problems, however, we will no longer write pain medications for controlled substances. This is for your safety. We are here to help you get better, however, we will continue to do this by helping you to have appropriate medication levels for your safety.

______________________ Patient Name (PRINT	______________________ Witness Name (PRINT)
______________________ Patient Signature	______________________ Witness Signature
______________________ Date	______________________ Date

601 N. Flamingo Rd. Suite 411, Pembroke Pines, FL 33028
Office: (954) 433-8711 ♦ Fax: (954) 433-3646
www.flpainrelief.com

Interventional Pain Physicians Of South Florida

Nancy Erickson, D.O.

Patient Consent for Drug Screening

For the protection of our patients it is our office policy to perform periodic drug and alcohol screenings. If you are requested to give us a urine/saliva sample it is to be given at the time it is requested. You will not be able to leave and return at a later time to provide a sample. If you choose not to give us a urine sample upon request, we will continue to treat your pain with interventional procedures appropriate for your specific problems, however, we will no longer write pain medications for controlled substances. We are here to help you get better and for your safety, we will continue to do this by helping you to have appropriate medication levels

I understand that my physician has requested that I be tested to determine the level of drug or metabolite in my body.

I further understand and agree that the testing will be performed in the physician's office and/or sent to an outside laboratory as needed, on a specimen of my urine that I provide for the purpose of this drug test.

I understand and agree that the outside laboratories used and my physician will maintain the confidentiality of my urine drug test results.

I understand that the test results and interpretation will become part of my medical record. I understand that an insurance company may discover the results of this test by informing them of this test or by obtaining a copy of my medical record from my physician.

I understand that I will be solely responsible for any financial balance to the outside laboratory and/or the physicians office should the drug screening not be covered in part or in full by my insurance company.

All of the above have been discussed with me and I have had an opportunity to have any questions answered that I have regarding the drug testing or my rights to privacy.

______________________ ______________________

Patient Name (print) Witness Name (print)

______________________ ______________________

Patient Signature Witness Signature

______________________ ______________________

Date Date

601 N. Flamingo Rd. Suite 411, Pembroke Pines, FL 33028
Office: (954) 433-8711 ♦ Fax: (954) 433-3646
www.flpainrelief.com

Interventional Pain Physicians
Of South Florida

Nancy Erickson, D.O.

Medication List Update

Including Vitamins, Herbal Remedies and over the counter medications

Date	**Name of Medication** Brand Name/Generic name too if available	**Dose** (mg, units, puffs, drop)	**How Often do you take this medication?**	**Purpose** Why do you take it?	**Physician Name**	**Otc**	**Dr. E**	**D/C Date**

Patient Name: ______________________ Pharmacy #: ______________________

Allergies: ____

601 N. Flamingo Rd. Suite 411, Pembroke Pines, FL 33028
Office: (954) 433-8711 ♦ Fax: (954) 433-3646
www.flpainrelief.com

Interventional Pain Physicians
Of South Florida

Nancy Erickson, D.O.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please select either Option A or Option B

PLEASE PRINT

Option A:

I, ______________________________, authorize Interventional Rehabilitation of South Florida to release or discuss information related to my medical condition (including information related to my treatment plan, test results, medical information and billing information) to the following named persons*:

1. ______________________ ______________________ ______________________
   Name Relationship to patient Date of birth

2. ______________________ ______________________ ______________________
   Name Relationship to patient Date of birth

3. ______________________ ______________________ ______________________
   Name Relationship to patient Date of birth

* Only persons listed above will be able to receive information related to my care, such as treatment and billing information, co-payments, appointment times and test results. This office will not be able to disclose information to any other persons. (NOTE: You do not *have* to list anyone.)

I may change, expand or restrict this list at any time.

OR

Option B:

I, ______________________________, do not authorize Interventional Rehabilitation of South Florida to release or discuss information related to my medical condition (including information related to my treatment plan, test results, medical information and billing information) to anyone but me personally.

Patient Signature: ______________________________ Date: ____________________

601 N Flamingo Rd. Suite 411, Pembroke Pines, FL 33028
Office: 433-8711♦ Fax: (954) 433-3646
www.flpainrelief.com

Interventional Pain Physicians
Of South Florida

Nancy Erickson, D.O.

Authorization for Pharmacy Release of Prescription Information

Patient Name: ______________________________ Date of Birth: __________

Address: ____

Phone #: ________________________ Social Security #: _________________

I authorize (Pharmacy Name, Address, Phone Number):

____

____

____

____

to release any and all medical information relating to my treatment from _________ to __________. This is to include all records, if any, concerning HIV or AIDS, mental behavioral health or psychiatric care, and drug or alcohol abuse.

Purpose of this request: For provision of continuing medical care.

☒ Records of Prescription Medications

Send information via Mail, Fax to: or Hold for pick-up by authorized Representative of:

Dr. Nancy Erickson
601 N Flamingo Road, Suite 411
Pembroke Pines, FL 33028
Phone: 954-433-8711 Fax: 954-433-3646

I understand that this consent can be revoked at any time except to the extent that action has been taken prior to revocation. If not previously revoked, this consent will terminate one year after the date of my signing this consent.

______________________________ ______________________
Signature of Patient or Legal Guardian Date

______________________________ ______________________
Printed Name of Patient or Legal Guardian Relationship to Patient

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices for the company and its subsidiaries and affiliates. I understand that copies of the Notice of Privacy Practices are available on the company's website and paper copies are out and available in the office and that I can take one of these copies with me. The Notice of Privacy Practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including as it has been amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 and any implementing regulations.

Effective Date of Notice: September 23, 2013

Patient: ______________________________ Date: ____________________
(print name)

Patient Signature: ______________________

or

Patient's Representative: __________________ Date: ____________________

Relationship to Patient: __________________

Interventional Pain Physicians of S. Florida
Dr. Nancy Erickson
601 N. Flamingo Road-Pembroke Pines, FL 33028
Phone: 954-433-8711 Fax: 954-433-3646

CANCELLATION / NO- SHOW POLICY FOR MEDICAL APPOINTMENTS

Our goal is to provide quality medical care in a timely fashion. As a result we have found it necessary to implement a cancellation and no-show policy. As with most medical practices, patients referred to this practice may have to wait for days or longer for an appointment. However, every patient is expected to act responsibly and honor an appointment or cancel that appointment. We will make every effort to remind and confirm your appointment at least two days in advance. A patient who cancels at the last minute or who does not show up for an appointment, either for an office visit or a procedure, will deprive other patients of timely access to medical care. This policy enables us to better utilize our available appointments and clinical resources to serve patients in need of medical care.

Cancellation of an Appointment

If you must cancel your scheduled appointment, we require that you call the office by 10 a.m. one (1) working day in advance. Appointments are in high demand and your early cancellation will give another person the opportunity to have access to medical care.

How to Cancel Your Appointment

To cancel appointments, please call 954-433-8711 during normal business hours. If you do not reach the receptionist you may leave a detailed message on the voice mail. Alternately, you may fax your cancellation to 954-433-0638. You **may not** cancel via email or with the after hours service.

Late Cancellations

Late cancellations will be considered as a "no show" unless emergent, extenuating and verifiable circumstances exist. (Socio-economic issues such as lack of a ride do not qualify.)

No Show Policy

A **"No Show"** is someone who misses an appointment without canceling it by 10 a.m. one (1) working day in advance. Failure to present at the time of a scheduled appointment will be recorded in the medical record as a "no show". With the first "no show," a patient will be sent a letter alerting her of the event. With the second "no show," the following fees will apply: Office Visit - $25.00, Procedures -$100.00. Please note that these fees are not billable to your insurance and therefore will be your responsibility. A patient with an outstanding No-Show fee will not be rescheduled until it is paid. Repeated no shows may result in discharge from our practice.

_______________________________ Patient Signature

_______________________________ Date

_______________________________ Patient Name (Please Print)