SPINE AND NERVE CENTER RIVERVIEW

EMPOWERING MOVEMENT, ENHANCING WELLNESS

13023 Summerfield Square Drive
Riverview, FL 33578

Phone: +1 (813) 741-1071 | Fax: +1 (866) 709-3257

NEW PATIENT PACKET

Page # Description

SPINE AND NERVE CENTER RIVERVIEW
EMPOWERING MOVEMENT, ENHANCING WELLNESS

Patient Information

Patient Name: _____ Date of Birth: _____
Last First M.I.

Mailing Address: _____
Street City State Zip Code

Permanent Address: _____
Street City State Zip Code

Daytime Phone: _____ Ext. _____ Evening Phone: _____

SSN: _____ Marital Status: | SINGLE | MARRIED | DIVORCED | WIDOWED |

Current Employer: _____ Occupation: _____
(If workers' comp, indicate employer where accident occurred)

Employer Address: _____
Street City State Zip Code

Date of Injury/Accident/Illness: _____

Closest friend or relative not living with you: _____

Address: _____
Street City State Zip Code

Daytime Phone: _____ Ext. _____ Evening Phone: _____

Insurance Information

Primary Insurance Company: _____ Insurance ID#: _____
Subscriber's Relationship to Patient: | SELF | SPOUSE | PARENT | OTHER |

Subscriber's Name: _____ Date of Birth: _____
Last First M.I.
Subscriber's Employer: _____ Telephone #: _____

Subscriber's SSN: _____

Secondary Insurance Company: _____ Insurance ID#: _____

Third Insurance, if applicable: _____ Insurance ID#: _____

Referral Information

☐ Referring Physician_____ ☐ Health Plan Provider List _____

☐ Other Source_____ (W/C Adjuster, Case Manager, Website, Friend etc.)

I, the undersigned, do hereby agree and give my consent for ***SPINE AND NERVE CENTER RIVERVIEW, LLC*** to furnish medical care and treatment to, _____ considered necessary and proper in diagnosing or treating my/his/her physical and mental condition.

Patient/Guardian/Responsible Party_____ Date _____

Chief Complaint & Pain History

Main reason for visit: ☐ Follow-Up

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How long have you been experiencing this pain?

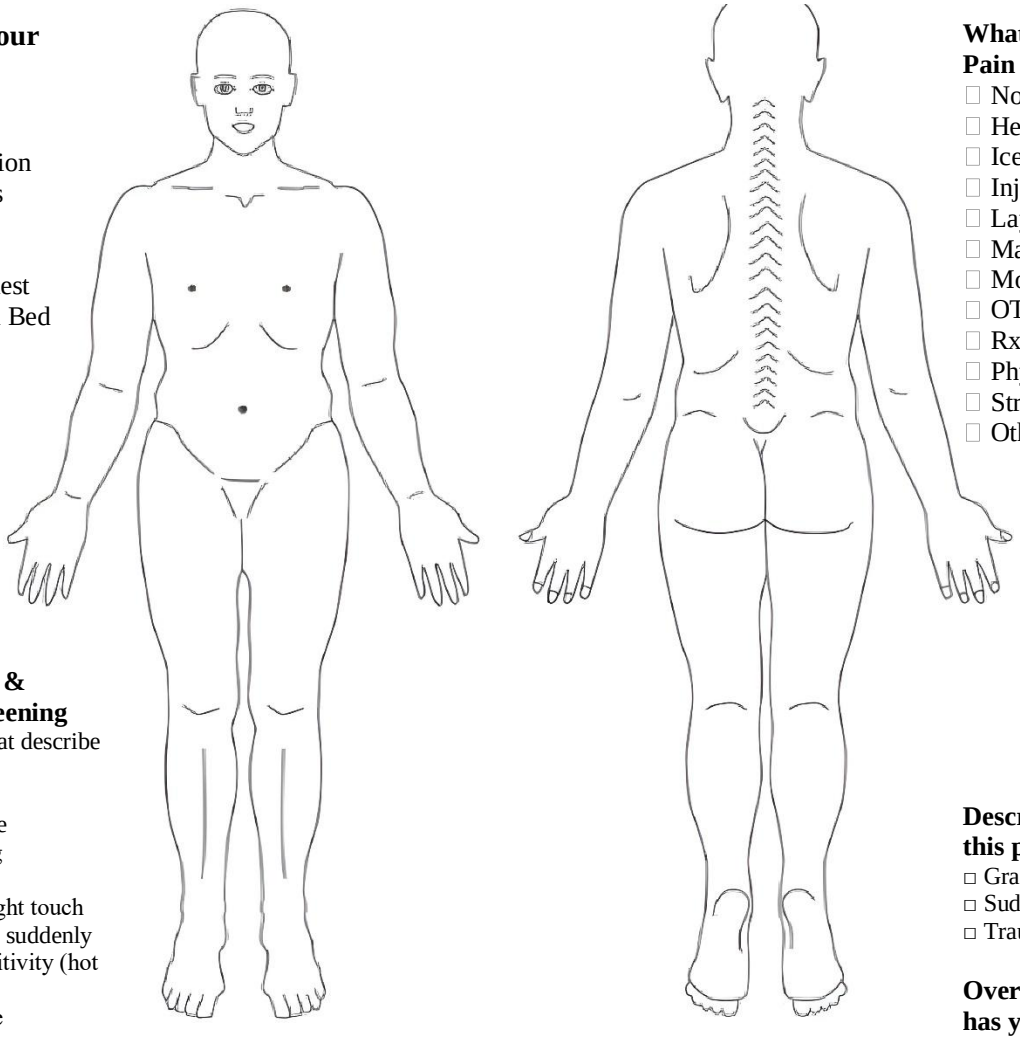
_____ days / months / years | Date of Onset: _____

Pain Location & Pattern

Instructions: Please mark the areas on the body where you feel pain on the diagrams below.

What Makes Your Pain Worse:
- ☐ Nothing
- ☐ Stairs
- ☐ Changing Position
- ☐ Daily Activities
- ☐ Jumping
- ☐ Lifting
- ☐ Laying down/Rest
- ☐ Rolling Over in Bed
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Weather
- ☐ Other:

_____
_____
_____
_____



What Makes Your Pain Better:
- ☐ Nothing
- ☐ Heat
- ☐ Ice
- ☐ Injections
- ☐ Laying Down/Rest
- ☐ Massages
- ☐ Movement
- ☐ OTC Medication
- ☐ Rx Medication
- ☐ Physical Therapy
- ☐ Stretching
- ☐ Other:

_____
_____
_____
_____

Pain Description & Neuropathic Screening
Check any words that describe your pain:
- □ Burning
- □ Electric shock-like
- □ Tingling/prickling
- □ Numbness
- □ Pain evoked by light touch
- □ Pain attacks come suddenly
- □ Temperature sensitivity (hot or cold)
- □ None of the above

- □ Aching
- □ Discomfort
- □ Dull
- □ Gnawing
- □ Piercing
- □ Sharp
- □ Shooting
- □ Stabbing
- □ Throbbing
- □ Tingling
- □ Other: _____

Pain Severity
On a scale from 0–10, where 0 = "no pain" and 10 = "pain as bad as you can imagine":

Average pain in the last week: ____

Worst pain in the last week: ____

Least pain in the last week: ____

Pain right now: ____

Describe the onset of this pain:
- □ Gradual
- □ Sudden
- □ Traumatic

Over the last month, has your pain:
- □ Worsened
- □ Improved
- □ Stayed the same

Is your pain:
- □ Continuous
- □ Fluctuating
- □ Intermittent (comes and goes)

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Diagnostics Tests & Imaging

Mark all of the following tests that you have had related to your current pain complaints:

☐MRI of the: _____ at: _____ Date: _____

☐X-Ray of the: _____ at: _____ Date: _____

☐CT Scan of the: _____ at: _____ Date: _____

☐EMG/NCV study of the: _____ at: _____ Date: _____

☐Other Diagnostic Testing: _____ at: _____ Date: _____

☐ I have not had ANY diagnostic tests for my current pain complaint

Please mark all of the following treatments you have had for pain relief:

	No Change	Worsened Pain	Improved Pain
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
TENS Unit	☐	☐	☐

Interventional Pain Treatment History

☐ None

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar
☐ Joint Injection – Joint(s) _____
☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar
☐ Nerve Blocks – Area/Nerve(s) - _____
☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar
☐ Spinal Cord Stimulator – Trial Only / Permanent Implant _____
☐ Trigger Point Injections – Where? _____
☐ Vertebroplasty/Kyphoplasty – Level(s) _____
☐ Other -

_____
_____

Which of these procedures listed above have helped with your pain? ☐ None

_____
_____

Please list the names of other Pain Physicians you have seen in the past: ☐ None

_____
_____

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist ☐ Neurosurgeon ☐ Psychiatrist/Psychologist ☐ Chiropractor ☐ Orthopedic Surgeon
☐ Rheumatologist ☐ Internist ☐ Physical Therapist ☐ Neurologist ☐ Other _____

Review of Systems

Mark the following symptoms that you currently suffer from:

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Constitutional:
☐Fevers
☐Chills
☐Sweats
☐Weakness
☐Fatigue
☐Decreased Activity
☐Malaise
☐Unexplained weight gain
☐Unexplained weight loss
☐Low sex drive
☐Difficulty sleeping

Eyes:
☐Blurriness
☐Double vision
☐Visual disturbance
☐Pain

Ears/Nose/Throat/Neck:
☐Hearing problems
☐Ear pain
☐Sinus problems
☐Sore throat
☐Nosebleeds

Respiratory:
☐Shortness of breath
☐Cough
☐Sputum production
☐Wheezing

Cardiovascular:
☐Chest pain
☐Palpitations
☐Swelling in feet
☐Shortness of breath
☐Bleeding disorder
☐Blood clots
☐Fainting

Gastrointestinal:
☐Nausea
☐Vomiting
☐Diarrhea
☐Constipation
☐Heartburn
☐Abdominal pain

Genitourinary/Nephrology:
☐Painful urination
☐Blood in urine
☐Change in urine stream
☐Unusual discharge
☐Flank pain
☐Urinary incontinence

Musculoskeletal:
☐Back pain
☐Neck pain
☐Joint pain
☐Muscle pain
☐Muscle cramping
☐Muscle spasms
☐Gait disturbances
☐Joint stiffness
☐Joint swelling
☐Trauma

Integumentary:
☐Rash
☐Itching
☐Lesions
☐Bruising

Neurological:
☐Abnormal balance
☐Confusion
☐Numbness
☐Tingling
☐Dizziness
☐Headaches
☐Loss of coordination
☐Memory loss
☐Seizures
☐Tinnitus
☐Tremors
☐Vertigo

Psychiatric:
☐Feeling anxious
☐Depressed mood
☐Suicidal thoughts
☐Hallucinations
☐Stress problems
☐Suicidal planning
☐Thoughts of harming others

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Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

Cancer/Oncology
☐ Cancer – Type _____

Cardiovascular/Hematologic
☐ Anemia
☐ Heart Attack
☐ Coronary Artery Disease
☐ High Blood Pressure
☐ Peripheral Vascular Disease
☐ Stoke/TIA
☐ Heart Valve Disorders
☐ Presence of stent/pacemaker/defibrillator

Gastrointestinal
☐ GERD (Acid Reflux)
☐ Gastrointestinal Bleeding
☐ Stomach Ulcers
☐ IBS/Crohns Disease

Urological
☐ Chronic Kidney Disease
☐ Kidney Stones
☐ Urinary Incontinence
☐ Dialysis

Neurological
☐ Multiple Sclerosis
☐ Peripheral Neuropathy
☐ Seizures
☐ Balance Disorder
☐ Head Injury
☐ Headaches
☐ Migraines

ENT
☐ Glaucoma
☐ Vertigo
☐ Hearing Problems
☐ Nosebleeds

Respiratory
☐ Asthma
☐ Bronchitis/Pneumonia
☐ Emphysema/COPD

Psychological
☐ Depression
☐ Anxiety
☐ Schizophrenia
☐ Bipolar Disorder
☐ ADD/ADHD
☐ PTSD

Musculoskeletal/Rheumatologic
☐ Bursitis
☐ Carpal Tunnel Syndrome
☐ Fibromyalgia
☐ Osteoarthritis
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Chronic Joint Pains

Endocrinology
☐ Diabetes – Type_____
☐ Hyperthyroidism
☐ Hypothyroidism

Other Diagnosed Conditions

_____

_____

_____

_____

_____

_____

_____

_____

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Surgical History:

Please list any surgical procedures you have had done in the past including date:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

☐ I have **NEVER** had any surgical procedures performed.

Family History:

Mark all appropriate diagnoses as they pertain to your parents and siblings:

☐Arthritis ☐Cancer ☐Diabetes ☐Headaches/Migraines ☐ Stroke

☐High Blood Pressure ☐Kidney Problems ☐Liver Problems ☐Osteoporosis

☐Rheumatoid arthritis ☐Seizures ☐Other Medical Problems: _____

☐ I have no significant family medical history

Social History:

Current/Former Occupation: _____

Who is in your current household? _____

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

Are you currently under worker's compensation? ☐ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

Alcohol Use: ☐ Social drinker ☐ Daily use of alcohol ☐ Never drinker
☐ Drinks per day? _____ ☐ How many years? _____ ☐ Quit Date: _____

Tobacco Use: ☐ Current user ☐ Former user ☐ Never used
☐ Packs per day? _____ ☐ How many years? _____ ☐ Quit Date: _____

Illegal Drug Use: ☐ Denies any illegal drug use ☐ Current user ☐ Former user
Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

Are you currently taking any blood thinners or anti-coagulants? ☐ YES ☐ No

If YES, which ones?

☐ aspirin ☐ heparin ☐ warfarin ☐ dabigatran (Pradaxa) ☐ apixaban (Eliquis)
☐ rivaroxaban (Xarelto) ☐ edoxaban (Savaysa) ☐ dipyridamole (Persantine)
☐ ticlopidine (Ticid) ☐ clopidogrel (Plavix) ☐ prasugrel (Effient)
☐ ticagrelor (Brilinta) ☐ cangrelor (Kenreal) ☐ vorapaxar (Zontivity)
☐ abciximab (ReoPro) ☐ eptifibatide (Integrilin)

Please list all medications you are currently taking <u>including vitamins.</u>
Attach additional sheet if required:

Medication Name	**Dose**	**Frequency**

Please list all past pain medications that you have been on at any point for any reason.

Medication Name	**Dose**	**Frequency**

Do you have any drug/medication allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

Medication Name	**Allergic Reaction**

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

SPINE AND NERVE CENTER RIVERVIEW

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Authorization for Release of Medical Records to Spine and Nerve Center Riverview, LLC

Phone: (813) 741-1071 | Fax: (866) 709-3257

Date: _____

Last name	**First name**	**DOB**
Address		**MRN**

I authorize SPINE AND NERVE CENTER RIVERVIEW, LLC to obtain from any healthcare provider with whom I am currently a patient or have been a patient within the last two years, any information about my health and health care, including the diagnosis, treatment, or examination rendered to me during the period from two (2) years prior to the date of this authorization.

I expressly authorize and consent to the disclosure of my health information related to (check all that apply):

☐ Alcohol and substance use ☐ Mental health ☐ STIs including HIV/AIDS ☐ Genetic testing/counseling

CONFIDENTIALITY POLICY (PLEASE READ BEFORE SIGNING)

Medical records are maintained to serve the patient and the health care team in accordance with all applicable legal and regulatory requirements. The information contained in medical records is considered highly confidential. All patient care information shall be regarded as confidential and available only to authorized users. The phrase "medical records" includes any protected health information (PHI), which includes test results, any medical reports, the medical record itself, claim files, and any correspondence relating to the care of a patient. Any disclosure of my protected health information to a different name, class of person, address, or fax number will require a separate authorization.

I have the right to revoke this authorization in writing, except to the extent that action has already been taken in reliance on this authorization. For the revocation of this authorization to be effective, the above name(s) or class of person(s) must receive the revocation in writing.

This authorization shall expire one year from the date signed. After one year, a new authorization form is needed to continually disclose my PHI. I understand this authorization is voluntary and may refuse to sign it.

I fully understand and accept the terms of this authorization. A copy of this authorization is valid as an original.

Patient or authorized representative signature: _____ **Date:** _____

Patient or authorized representative name: _____

PATIENT FINANCIAL RESPONSIBILITY & AUTHORIZATION FORM

Thank you for choosing Spine and Nerve Center Riverview (SNCR) as your healthcare provider. We value your trust and strive to provide you with the highest quality care. Please read and sign this form to acknowledge your understanding of our financial policies and your rights under Florida law.

1. Patient Financial Responsibilities

1. **Patient Accountability:** The patient (or legal guardian, if the patient is a minor) is ultimately responsible for payment for all services received.
2. **Insurance Information:** SNCR will bill the patient's insurance company for covered services if we are contracted with that insurer. The patient must provide accurate and up-to-date insurance information. The patient bears financial responsibility for charges incurred if insurance details are incomplete, inaccurate, or outdated.
3. **Financial Obligations:** Co-payments, co-insurance amounts, deductibles, and any services or procedures not covered by insurance are due at the time of service. We accept cash, checks, and most major credit cards.
4. **Additional Charges:**
    - **Returned Checks:** The patient is responsible for any fees charged for checks returned by the bank for non-sufficient funds, as permitted by Florida law.
    - **Missed Appointments:** A fee may be charged for missed appointments or cancellations without at least 24 hours' notice.
    - **Extended or After-Hours Phone Services:** Calls requiring diagnosis, treatment, or prescriptions outside normal office hours may incur charges.
    - **Medical Records:** Per Florida Statutes §§ 395.301 and 456.057, patients are entitled to copies of their medical records; however, a reasonable fee as allowed by Florida law may apply.
    - **Extensive Forms Completion:** Fees may apply for completing detailed or multiple forms.
    - **Collection Actions:** Any costs related to collecting outstanding balances, including late fees and other expenses, may be billed to the patient.
5. **Good Faith Estimate (If Applicable):** Under Florida law, you have the right to request a good faith estimate of reasonably anticipated charges for non-emergency healthcare services. If you have questions or wish to receive an estimate, please contact our billing department.

2. Patient Authorizations

1. **Release of Information:** By signing below, you authorize SNCR and its physicians, staff, or associated hospitals to release relevant medical and other information acquired during examination or treatment to insurance companies, third-party payers, or other healthcare providers involved in your care, as permitted by Florida Statutes §§ 456.057 and 395.3025.
2. **Specific Categories of Information:** I understand and authorize the release of the following categories of protected health information **if I place a check mark next to each**:
    - **Alcohol and/or Drug Abuse** (Diagnosis, evaluation, treatment)
    - **HTLV-III or HIV Testing (AIDS)** (Results, diagnosis, treatment)
    - **Psychiatric/Psychological Records** (Evaluation, treatment for mental, physical, or emotional illness, including progress notes, consultations, etc.)
3. **Assignment of Benefits:** I hereby assign financial benefits directly to SNCR for services rendered, in accordance with the terms outlined by my insurance contract. I understand I remain financially responsible for charges not covered by my insurance.
4. **Communication Consent:** By signing below, I authorize SNCR personnel to communicate with me via mail, voicemail, email, or other methods I have provided in my patient registration.

3. Acknowledgment of Florida Patient Rights and Responsibilities

- SNCR is committed to upholding the Florida Patient's Bill of Rights and Responsibilities (Florida Statutes § 381.026). This includes your right to respectful treatment, confidentiality, and access to a good faith estimate of charges.
- If you have questions regarding your rights, you may contact the Florida Agency for Health Care Administration (AHCA).

By signing below, I acknowledge that I have read, understood, and agree to the terms of this Patient Financial Responsibility & Authorization Form. I also confirm that I have been informed of my rights under Florida law.

Patient/Guardian/Responsible Party (Print Name): _____

Signature: _____ **Date:** _____

If you have any questions about this form or your financial responsibility, please contact our office staff or billing department.

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BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to which I am entitled—including Medicare, Medicaid, private insurance, and other third-party payors—to **SPINE AND NERVE CENTER RIVERVIEW, LLC** ("the Practice"). This assignment includes any major medical benefits that apply to treatment received. A photocopy of this assignment is to be considered as valid as the original.

I authorize the Practice to release any information, including my medical records, that may be necessary to secure payment for services rendered, in accordance with the Health Insurance Portability and Accountability Act (HIPAA), **Florida Statutes § 456.057**, and any other applicable federal or state laws.

Information Privacy: The Practice will use and disclose your personal health information for treatment, payment, and regular healthcare operations. Healthcare operations may include activities that improve quality of care. We have prepared a detailed **Notice of Privacy Practices** to help you better understand our policies regarding your personal health information and to comply with both federal and Florida law. The most current version of the Notice will be posted at our facilities, and copies will be available upon request. By signing below, you acknowledge receipt of these privacy practices.

Patient/Guardian/Responsible Party: _____ **Date**: _____

FINANCIAL POLICY STATEMENT

1. **Insurance Billing**: As a courtesy, we will bill your insurance carrier directly for services provided. **Florida law** generally requires insurers to pay or deny claims within certain time limits; however, you are ultimately **responsible for the full balance of your account** at the time services are rendered, subject to any contractual obligations with your insurer.
2. **Estimated Share**: We require that you make arrangements for payment of your estimated share (e.g., copayment, coinsurance, deductible) on the date of service. If your insurance carrier does not remit payment within **60 days**, the remaining balance will be due in full from you.
3. **Insurance Information Accuracy**: Insurance benefits and eligibility are verified as a courtesy to you. We are **not responsible for any incorrect information** provided by your insurance company regarding copays, deductibles, or plan limitations. Your specific policy limitations, exclusions, and effective date(s) of coverage may affect your financial responsibility.
4. **Refunds or Denials**: If your insurance company requests a refund of payments already made (e.g., due to policy termination or retroactive denial of coverage), you will be responsible for the refunded amount. If you receive any payment directly from the insurer for services rendered by the Practice, you agree to promptly forward those funds to the Practice.
5. **Finance Charges**: The Practice reserves the right to assess a finance charge of **18% annually** on any outstanding balance not paid within a reasonable period, in accordance with **Florida Statutes** governing finance charges and usury limits.
6. **Worker's Compensation**: If you are being treated under a Worker's Compensation claim, these policies may not apply. However, should you claim Worker's Compensation benefits that are later denied, you will be responsible for the total amount of charges.
7. **Collection of Past Due Balances**: By signing below, you acknowledge and agree that if you fail to timely pay any amounts owed, you will be responsible for **all costs** associated with collecting outstanding balances, including attorney fees, court costs, and any collection agency fees, in accordance with **Florida law**.

I acknowledge that I have read, understand, and accept these terms. I understand my financial responsibility for the payment of my account:

Patient/Guardian/Responsible Party: _____ **Date**: _____

I have read, understand, and agree to the provisions of this **Patient Financial Responsibility Form**:

Signature of Patient or Guardian: _____ **Date**: _____

WAIVER OF PATIENT AUTHORIZATIONS

If you **do not** wish to have information released to an insurance carrier and prefer to pay in full at the time of service, you may do so. Under this waiver, you assume full responsibility for payment of charges and for submitting any claims to your insurer at your discretion.

Signature of Patient or Guardian: _____ **Date**: _____

ACKNOWLEDGMENT

By signing this Agreement, I confirm that I have read and understand the above policies, notices, and my rights and responsibilities under Florida and federal law.

SPINE AND NERVE CENTER RIVERVIEW
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PHYSICIAN/PATIENT INFORMED CONSENT AND AGREEMENT FOR LONG-TERM OPIOID THERAPY FOR CHRONIC PAIN

Patient Name: _____ **Date:** _____

We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances (e.g., opioids, benzodiazepines, barbiturate sedatives) can be used as part of a comprehensive treatment plan. Because controlled substances carry risks of misuse, diversion, and physical dependence, they are strictly regulated by Florida and federal law. This agreement establishes guidelines for your safety, clarifies our policies, and helps protect your access to treatment.

You have agreed to receive long-term opioid therapy for the treatment of chronic pain. You understand that opioid (narcotic) medications can be highly beneficial but also carry a risk of misuse and are therefore closely regulated under federal and Florida law. The goals of this treatment are:

1. To reduce your pain.
2. To improve your level of function in daily activities.

Florida Law Compliance:

- Your prescribing physician will comply with all relevant Florida laws governing controlled substances, including consultation of Florida's Prescription Drug Monitoring Program (PDMP), known as **E-FORCSE**, prior to prescribing or dispensing opioids.
- Your physician will maintain detailed records consistent with Florida Administrative Code requirements and will ensure that your treatment plan is monitored and re-evaluated on a regular basis.

1. Alternative Therapies

Alternative therapies and medications (including non-opioid treatments) have been explained and offered to you. You have chosen opioid therapy as one component of your overall treatment plan for chronic pain.

Smoking Cessation:

If you are a smoker, you have agreed to participate in a smoking cessation program, as smoking can complicate pain management and medication therapy.

Patient Initials: _____

2. Potential Side Effects

Like all medications, opioids can cause side effects, some of which may persist:

- **Common Side Effects**: Mood changes, drowsiness, dizziness, constipation, nausea, and confusion.
- **Constipation**: Often requires long-term treatment with stool softeners or laxatives.
- **Operating Machinery or Vehicles**: You should not drive or operate machinery if the medication causes sedation or altered mental status.
- **Alcohol and Sedatives**: You must not consume alcohol or take other sedative drugs while on opioids; combining these substances can result in coma, organ damage, or death.
- **Hormonal Effects**: Long-term opioids may decrease sex drive or sexual function due to hormonal suppression (e.g., testosterone). Hormone levels can be monitored during your treatment.

Driving Note: While driving under chronic opioid therapy can be considered acceptable if you have no sedation or altered mental status, law enforcement may still evaluate your ability to drive safely. You could be considered impaired if stopped.

3. Risks

a. Physical Dependence

- Physical dependence is expected with long-term opioid use. If you abruptly stop taking opioids, you may experience a withdrawal syndrome, which can be life-threatening if not managed properly.

b. Tolerance

- Over time, your body may become tolerant to opioids, requiring higher doses for the same pain relief. Changes in therapy, rotation to a different opioid, or tapering/discontinuation might be necessary.

c. Increased Pain (Hyperalgesia)

- Some evidence suggests that prolonged opioid therapy may make you more sensitive to pain. In certain cases, patients who discontinue opioids notice improved pain levels after a few weeks off the medication.

d. Addiction

- **Addiction** is a chronic neurobiological disease influenced by genetic, psychosocial, and environmental factors. Behaviors indicating addiction may include impaired control, compulsive use, continued use despite harm, or craving. Physical dependence or tolerance alone is not addiction.

e. Risk to Unborn Children

- Children born to women who are physically dependent on opioids may also be dependent at birth. Women of childbearing potential should use effective birth control while on opioid therapy and must inform their physician immediately if pregnant.

4. Long-Term Side Effects

- The long-term effects of opioid therapy are not fully understood, but may include hormonal changes, risk of hyperalgesia, and potential dependence. Please raise any concerns or questions with your physician.

Patient Initials: _____

5. Prescriptions and Use of Opioid Medications

1. **Prescribing and Dispensing**: Your opioid prescriptions will be electronically written by the physician managing your pain or that physician's authorized substitute. These prescriptions will not be "called in" to pharmacies except under specific, legally permitted circumstances.
2. **Regular Appointments**: Florida law requires that patients on chronic opioid therapy must be seen regularly—**at least every three months**—for a medical evaluation of treatment effectiveness, side effects, and potential for abuse or misuse.
3. **Dosage Increases**: You agree not to adjust your opioid dose without your physician's supervision. Increasing your dose without authorization could lead to severe consequences including overdose or death.
4. **Medication Adjustments:** Dose changes between appointments are not allowed unless your physician determines it is medically necessary.
5. **Personal Use Only**: Your opioid medication is prescribed solely for you. Never share or sell your medications.
6. **Single Pharmacy**: You agree to use only one pharmacy for filling your opioid prescriptions, unless your physician gives you advance permission to do otherwise.
7. **Medication Security**: You agree to store your medications securely (e.g., locked container). You are responsible for any lost or stolen medication. **Lost, stolen, or destroyed prescriptions or drugs will not be replaced** and may result in discontinuation of therapy.
8. **Compliance with Monitoring**:
    - You agree to submit to random blood or urine tests to monitor medication levels and screen for other substances, per Florida law and your physician's practice policy.
    - You agree to bring your medication bottles to each visit if requested, and to provide a pharmacy printout of all medications you receive.
9. **No Early Refills or "Drop-Ins":** You must follow the dosing schedule prescribed. Refills will be addressed only during regular office hours with at least **48 hours** notice. No refills will be provided on evenings, weekends, or holidays. "Drop-in" requests may be refused.
10. **No Mailing Prescriptions:** Prescriptions cannot be mailed.
11. **Withdrawal Risk**: If you run out of your medication early or lose it, you might experience withdrawal, for which you are solely responsible.
12. **Methadone Note (if applicable)**: If you are prescribed methadone, you must inform all providers of every medication you take. Certain drugs can dangerously increase methadone levels.
13. **Coordination with Other Providers:** You agree to inform us of any new medications or treatments from other providers. Failure to report additional controlled substances may be considered a violation of this agreement.
14. **Legal and Regulatory Exceptions:** If law enforcement, regulatory agencies, or professional boards question your treatment, you agree that we may share relevant medical information per Florida law and professional standards.
15. **Arrest or Incarceration:** If you are arrested or incarcerated for any drug-related offense, your controlled substance prescriptions may be discontinued immediately.

Patient Initials: _____

6. Conditions for Discontinuing Opioid Therapy

Opioid therapy may be reduced, tapered, or discontinued if you:

- Develop unmanageable tolerance or experience unacceptable side effects.
- Fail to achieve adequate pain relief or functional improvement despite proper use.
- Show signs of addictive behavior or obtain controlled substances from unauthorized sources.
- Refuse to stop or continue to smoke against medical advice if that was part of your agreement.
- Abuse any other controlled substances or use illicit drugs.
- Increase medication without the physician's consent.
- Engage in doctor shopping or fill prescriptions at multiple pharmacies without prior explanation.
- Obtain opioids or other controlled substances from multiple physicians without informing us.
- Alter prescriptions, forge prescriptions, or engage in any illegal behavior.
- Lose your medication repeatedly or fail to secure it properly.
- Fail to keep scheduled appointments or follow any part of the treatment plan.
- Refuse or fail to submit to blood/urine tests when requested.
- Violate any other terms of this agreement.

7. Patient Acknowledgment

By signing below, I acknowledge and agree that:

1. I have read and fully understand this **Physician/Patient Informed Consent and Agreement** for long-term opioid therapy for chronic pain.
2. I have been given the opportunity to ask questions about the proposed treatment (including no treatment) and have discussed risks, complications, side effects, and benefits.
3. I willingly accept and assume the risks of the proposed treatment.
4. I agree to abide by all terms of this agreement in compliance with applicable Florida law.

Patient Signature: _____ Date: _____

Print Name: _____

Witness Signature: _____ Date: _____

Print Name: _____

Physician Signature: _____ Date: _____

Print Name: _____

Patient Initials: _____

SPINE AND NERVE CENTER RIVERVIEW

EMPOWERING MOVEMENT, ENHANCING WELLNESS

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received and reviewed the accompanying Privacy Notice, which explains how my protected health information may be used and disclosed under federal HIPAA regulations and applicable Florida law.

Patient or Personal Representative: _____ **Date**: _____

Signature: _____

If the signature above is that of a Personal Representative (not the patient), please describe the Personal Representative's relationship to the patient:

Relationship: _____

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Privacy Notice is being provided to you as required by federal and Florida law, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and Florida Statutes (e.g., § 456.057). It describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes permitted or required by law. It also describes certain rights you have regarding your PHI. "Protected health information" is any written or oral health information about you—including demographic data—that can be used to identify you, is created or received by your health care provider, and relates to your past, present, or future physical or mental health or condition.

We abide by both federal HIPAA regulations and any applicable Florida privacy laws. Where Florida law grants you greater privacy rights or imposes stricter requirements than federal law, we will follow the more protective standards.

I. Uses and Disclosures of Protected Health Information

Spine and Nerve Center Riverview (SNCR) offices may use your PHI for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. PHI may be used or disclosed only for these purposes unless we obtain your authorization or an applicable law permits or requires the use or disclosure without such authorization. Disclosures for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

A. Treatment

We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes coordination or management of your care with a third party. For example, we may disclose your PHI to a pharmacy to fill a prescription or to a laboratory to order a test. We may also disclose your PHI to outside providers who are treating you or consulting about your care.

B. Payment

Your PHI will be used, as needed, to obtain payment for services provided. This may include disclosures to your health insurance company to get prior approval for procedures or to determine whether a service is covered by your health plan. We may also disclose your PHI to another provider involved in your care for their payment activities (e.g., demographic information to anesthesia providers so they can be paid).

C. Operations

We may use or disclose your PHI, as needed, for our own health care operations. These operations include quality assessment, improvement activities, reviewing employee performance, training programs for students or practitioners, accreditation, certification, licensing or credentialing activities, audits, compliance reviews, legal services, and business management.

When appropriate, we may also disclose PHI to another provider or health plan for their health care operations.

D. Other Uses and Disclosures

In connection with treatment, payment, and operations, we may use or disclose your PHI for the following purposes without additional authorization:

- **Appointment reminders** (e.g., to remind you of your surgery date)
- **Information about treatment alternatives or options**
- **Information about health-related benefits or services**
- **Contacting you to raise funds** for the facility or an institutional foundation. You may opt out of fundraising communications by contacting our Privacy Officer.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal and Florida privacy rules allow us to use or disclose your PHI without your permission or authorization for certain reasons, including:

A. When Legally Required
We will disclose your PHI when required to do so by any federal, state, or local law.

B. When There Are Risks to Public Health
We may disclose your PHI for public health activities, such as preventing or controlling disease, reporting adverse events to the FDA, tracking product defects or recalls, and notifying individuals who may have been exposed to a communicable disease.

C. To Report Suspected Abuse, Neglect, or Domestic Violence
We may notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure as required or authorized by law.

D. Health Oversight Activities
We may disclose your PHI to oversight agencies (e.g., Florida Department of Health or other agencies) for audits, investigations, inspections, or disciplinary actions as permitted by law.

E. Judicial and Administrative Proceedings
We may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena if we receive certain assurances required by law.

F. Law Enforcement Purposes
We may disclose PHI for law enforcement purposes, such as to comply with reporting requirements for certain types of wounds, responding to a court-ordered warrant, locating a suspect or missing person, or reporting criminal activity if we believe in good faith that a crime has occurred on our premises.

G. Coroners, Funeral Directors, and Organ Donation
We may disclose PHI to coroners, medical examiners, or funeral directors to identify a deceased individual or determine the cause of death, and to facilitate organ or tissue donation.

H. Research
We may use or disclose your PHI for research approved by an institutional review board or privacy board that has reviewed the research proposal and privacy protocols.

I. Serious Threat to Health or Safety
We may disclose PHI if we believe in good faith that it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

J. Specified Government Functions
In certain circumstances, federal regulations authorize use or disclosure of PHI to facilitate government functions related to military and veterans' activities, national security, intelligence, protective services, and lawful custodial situations.

K. Worker's Compensation
We may release your PHI to comply with worker's compensation laws or similar programs.

III. Uses and Disclosures Permitted Without Authorization But With Opportunity to Object

We may disclose limited PHI to a family member or close personal friend directly involved in your care or payment for your care. We may also disclose limited PHI to help notify a family member about your location, condition, or death. You may object to these disclosures. If you do not object—or we infer from the circumstances that you do not object—we may disclose your PHI as described.

IV. Uses and Disclosures Which You Authorize

Other than as stated above, we will not disclose your PHI without your written authorization. You may revoke your authorization in writing at any time, except to the extent we have already relied on it.

V. Your Rights

You have the following rights regarding your PHI:

1. **Right to Inspect and Copy**
   You may inspect and obtain a copy of your PHI in a "designated record set" (medical and billing records, and other records used in decision-making). Under limited circumstances, we may deny your request, for example if it is likely to endanger someone's safety. If denied, you can request a review of the decision. Submit your written request to our Privacy Officer; fees may apply for copying or mailing.
2. **Right to Request Restrictions**
   You may ask us not to use or disclose certain parts of your PHI for treatment, payment, or health care operations, or to family and friends involved in your care. We are not required to agree to your restriction request, but if we do agree, we must abide by it except in an emergency. Requests must be submitted in writing to our Privacy Officer.
3. **Right to Confidential Communications**
   You may request that we communicate with you in a specific way (e.g., only at work or via mail). We will accommodate reasonable requests. Submit your written request to our Privacy Officer.
4. **Right to Request Amendments**
   You may request an amendment to your PHI if you believe it is inaccurate or incomplete. We may deny your request in certain circumstances (e.g., if we believe the records are correct). If denied, you may file a statement of disagreement. Submit written requests to our Privacy Officer, including the reason for amendment.
5. **Right to an Accounting of Disclosures**
   You may request an accounting of certain disclosures made of your PHI (excluding disclosures for treatment, payment, operations, and some others). Accounting requests must be in writing to our Privacy Officer and may not exceed a six-year period. The first accounting in a 12-month period is free; subsequent requests may incur a fee.
6. **Right to a Paper Copy of this Notice**
   You may request a paper copy of this Notice at any time, even if you receive it electronically.

VI. Our Duties

We are required by law to maintain the privacy of your PHI and to provide you with this Notice. We must abide by its terms as currently in effect. We reserve the right to change this Notice and make any new provisions effective for all PHI we maintain. If we change the Notice, you will receive a copy by mail or in person.

VII. Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with our facility, contact the **Privacy Officer** at the address or phone number listed below. We will not retaliate against you for filing a complaint.

Contact Person

All questions and requests regarding privacy and your rights under HIPAA and Florida law should be directed to our **Privacy Officer**:

Spine and Nerve Center Riverview
ATTN: Privacy Officer
13023 Summerfield Square Drive
Riverview, FL 33578
Phone: (813) 741-1071

IX. Effective Date

This Notice is effective **February 1, 2025** and remains in effect until revised. Any revisions will be promptly shared with you in accordance with applicable law.