RESTORE
MEDICAL PARTNERS

WELCOME TO THE OFFICES OF RESTORE MEDICAL PARTNERS

We thank you for choosing Restore Medical Partners for your healthcare needs. We are honored to be your physicians and we're committed to providing you with the best healthcare possible. By working closely with our providers, our hope is that we form a partnership to reduce your pain and keep you as healthy and functional as possible.

Our physician assistants and nurse practitioners are an extremely important part of your care team and you will often meet with them in addition to our physicians. They come from diverse backgrounds and help us to design unique treatment plans you resolve you pain. To read more about our providers, please visit our website at www.RestoreMedicalPartners.com.

At Restore Medical Partners, you'll find a unique experience. We take a comprehensive approach to treating your pain, including a thorough review of your history to ensure accurate diagnosis, making sure you have a complete understanding of your problem, and taking the time to explain all results and expectations.

We will use a multi-modal approach to develop your treatment plan. This may include physical therapy, acupuncture, chiropractic medicine, regenerative medicine, interventional treatment, and medication management. Throughout this process, we will guide you and ensure the best possible outcome for treatment of your pain.

We strive to offer a very welcoming environment and ensure our staff is committed to making your experience as pleasant as possible. Our goal is to provide excellent customer service, prompt phone call return within 24 hours, prompt scheduling within 24 hours, and consistently show the highest level of compassion for our patients.

We value your feedback and welcome you to leave comments on patient feedback surveys throughout your experience with us. Finally, we look forward to your upcoming office visit and to helping you relieve you pain and get back to living a wholesome and active lifestyle.

Sincerely,

Lindsey Job MD
Peter Fernandez MD
Lindsay Shroyer MD
Kathryn Flavin MD
Drew Fritschle PA-C
Joshua Beasley PA-C
Krista Gorman PA-C
Marie Zambelli APRN

333 S Tamiami Trail, Suite #171
Venice, FL 34285
Phone: (941) 375-3006
Fax: (941) 218-4825
www.restoremedicalpartners.com

RESTORE
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RMP BACK PAIN PROGRAM

In today's medical environment, we are striving more than ever before to achieve optimal and industry-best outcomes for our patients, and we accomplish this by integrating a wide modality of high-quality treatments and therapies. At Restore Medical Partners, we have developed a structured and specialized back pain program that has been proven effective in reducing and/or resolving back pain in over 50% of patients. This program entails a multidisciplinary approach including varied treatment options.

Interventional Therapies

All patients will receive evaluations for interventional therapies in our state-of-the-art facilities. These therapies are comprised of image-guided, targeted injections and other advanced minimally-invasive procedures designed to alleviate pain and restore quality of life. Our double-board-certified physicians regularly providing cutting-edge therapies to our community, achieving superior patient outcomes.

Physical Therapy

The importance of physical therapy to the patient with back pain cannot be overstated. All patients receiving care with Restore's pain team will be evaluated for physical therapy. This therapy will include specialized spine-care regimens designed to improve core strength and protect against future injury or reinjury.

Bracing

The world of medical bracing has grown rapidly, as has the technology of such braces. All appropriate back pain patients will undergo a complimentary evaluation with our DME specialist to determine if one of our specialized braces would be beneficial. This evaluation typically occurs on the day of your first appointment but may be scheduled at your convenience as needed. Please select below if you a have a preference on the day/time of your consultation.

SAME-DAY (INITIAL APPOINMENT)	**FOLLOW UP** (SECOND APPOINTMENT	**ALTERNATE DAY/TIME** (Write-in below)

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COMPREHENSIVE PATIENT AGREEMENT FORM

As your providers, we are committed to providing you, the patient, with the best possible medical care. In order to achieve this goal, we need your assistance and understanding of our practice policy and procedures that effect all providers and patients.

OFFICE HOURS:
8:00am-5:00pm Monday through Friday.

Please notify our office at least 24 hours in advance if you are unable to keep your scheduled appointment by phone or the online patient portal. **Missed appointments and/or last-minute cancellations may incur a $50 charge for office visits, and $100.00 for procedures.** You may call our office at (941) 375-3006 for any appointment change notifications.

PRESCRIPTIONS AND REFILLS:

You are responsible for your medication and their refills. Please call the pharmacy for all refill requests. The office has a 24 hour and a 48-hour turnaround policy regarding digital and written prescriptions accordingly. The pharmacy will notify our office of your request. ***This process is much faster as we will have all the information that the pharmacy needs to process your refill.*** In order to comply with the Drug Enforcement Agency there will be NO prescriptions called in after hours or on weekends by any on-call Provider. Controlled medications will not be "called in" under any circumstances.

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION & AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We strongly feel that all patients deserve from us the best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy. *Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.* Please read the following:

- I authorize Restore Medical Partners to release or receive any information necessary to expedite insurance claims.
- I hereby authorize Restore Medical Partners to bill my insurance company directly for their services.
- I authorize payment directly to my Physician of any insurance benefits otherwise payable to me.
- In the event I receive payment from my insurance carrier, I agree and endorse any payment I receive over to my Physician for which these fees are payable.

I understand that I am directly and fully financially responsible to my Physician for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgement or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay by balance in full, or there is no payment made within 60 days, it is my responsibility to pay my bill directly. I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee. I have read and understand what is expected of me, the patient, in relation to any care, my insurance carriers and my financial responsibilities.

PAYMENT AT THE TIME OF SERVICE

It is our office policy that payments are due at the time of service. If we have a contract with your insurance company, we will file with your insurance on your behalf. However, YOU are responsible for all co-pays, co-insurances, deductibles, and or non-covered services at the time of service. It is also your responsibility to make sure you have

a valid referral and or authorization on file with your insurance company for dates of service billed on your behalf. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I certify that the information provided to the office is the most recent insurance information and it is true and correct to the best of my knowledge. I will notify the office of any changes in this information. A photo copy or other reproduction of this will be as valid as original. I hereby authorize Restore Medical Partners to furnish my insurance companies, hospitals, referring or consulting physicians and billing agents, all information with regard to my medical care. I also consent to receive medical care from Restore Medical Partners.

ONLINE COMMUNICATION & HIPAA

Upon signing the HIPAA consent form, you agree to be solely responsible for your username and password. It is not to be shared. If you choose to share this information you are allowing that person to see your PHI (Private Health Information). By signing this form you acknowledge and accept all of the following:

- I have been explained the details of the online patient portal. I understand them, and my questions have been answered.
- Alternative methods are available to me via (in person, mail, telephone).
- I am aware that my private health information (PHI) carries a risk to my privacy should it be compromised.
- I agree to take precautions to keep my online communication safe, including but not limited to:
    - Keeping passwords confidential.
    - Closing my computer or screen when not in use.
    - Refraining from storing PHI on employer-owned computers or phones, etc.

I agree to indemnify and hold harmless, Restore Medical Partners, of and from any claims, losses, causes of action, damage, lawsuits, judgements, including attorney's fee and cost.

HIPAA Notice of Privacy Practices

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.

RESTORE MEDICAL PARTNERS adheres strictly to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at all times. The following method of operations will be used to insure privacy of a patient's Protected Health Information (PHI).

- Based on HIPAA guidelines your medical records may be transferred to another care provider upon your signed authorization. Records will not be transferred without you or your legal designee's signed authorization.
- You may review your records by scheduling a time with the office.
- After review of your records if you disagree with any of the documentation in the records you have the option of writing your own documentation to be placed in the chart.
- If an appointment with another medical provider is required, only the necessary information to schedule an appointment will be provided.
- If you elect to not allow any other member of your family access to your records you have the right to notify our office. That notice must be in writing. If you wish to provide access to your records to a designated individual you may also provide that notice in writing.
- Our office will not provide any information about you or your medical condition to any other party other than other medical providers to whom you have been referred for treatment without your specific authorization.
- If you are chosen to be part of any research program you will be required to sign additional authorizations and releases so that your PHI may be used in the program.

- Under the HIPAA rules, we may use the necessary PHI from your medical records to file insurance claims on your behalf. Your authorization and insurance assignment allows the practice to file insurance on your behalf.
- There will be certain circumstances where public health authorities and health oversight agencies may require a copy of your records. They are authorized under law to collect that information and we are required to furnish a copy of your PHI.
- We are required by law to protect and privacy of all of our patients, preventing any and all disclosure of PHI to unauthorized parties.
- We are required by law to maintain the privacy of, and to provide individuals with, this notice of our legal duties and privacy practices with regard to PHI.
- If you are on active duty military or are called to active duty military, under federal law we are required to supply a copy of your record.

Patient Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Late cancellation/ “No Call, No Show” Policy

Restore Medical Partners is committed to providing high quality, efficient, and timely care to all of our patients. If an appointment is canceled or rescheduled within 24 hours of your scheduled time, a $50 fee may be applied. There will also be a $50 charge for all “No call, No Show” appointments. Please make note of the person’s name that you spoke with when cancelling or rescheduling your appointment. We understand that there may be extenuating circumstances that cannot be controlled, so we will do our best to accommodate.

I hereby acknowledge receipt, understanding, and agreement with all information listed within this Comprehensive Patient Agreement. I also acknowledge that these policies have been put in place for the benefit of patients, including myself, and that I commit to abiding by these guidelines whilst I am a patient of Restore Medical Partners.

PATIENT SIGNATURE		DATE	

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CONSENT FOR COMMUNICATION AND/OR DISCLOSURE

I request the following alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Restore Medical Partners. I understand that this HIPAA consent applies to ALL providers of Restore Medical Partners. It is my responsibility to notify Restore Medical Partners of any changes.

Please Print (Last Name) **(First Name)** **(Middle Initial)** **(Date of Birth)**

I give permission to share the following information with the person(s) listed below. Please mark yes (Y) or no (N) in the columns to the right.

Name:_____ **Relationship:**_____ **Appointment:**_____
Billing:_____
Medical: _____

Name:_____ **Relationship:**_____ **Appointment:**_____
Billing:_____
Medical: _____

Name:_____ **Relationship:**_____ **Appointment:**_____
Billing:_____
Medical: _____

Please note that if a person is not listed on this form, Restore Medical Partners will not share information with him/her. Signature below will also constitute your unrestricted agreement that medically relevant information may be left on a voicemail or other answering device that you provide to us.

PATIENT SIGNATURE		DATE	
WITNESS SIGNATURE		DATE	

CONTROLLED MEDICATION TREATMENT AGREEMENT

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work effort. A record of all prescriptions and treatments will be maintained by the office as well as your updated treatment plan.

SHOULD I BE PRESCRIBED AND AGREE TO BE TREATED WITH CONTROLLED MEDICATIONS; I the patient understand I will need to remain compliant to remain a patient of Restore Medical Partners and that I have the following responsibilities: **A**. I will take medications only at the dose and frequency prescribed. **B**. I will not increase or change medications without the approval of this doctor. **C**. I will actively participate in RTW efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities). **D**. I will not request opioids or any other pain medicine from physicians outside of Restore Medical Partners. My doctor will approve or prescribe all other mind and mood-altering drugs. **E**. I will inform this doctor of all other medications that I am taking. **F.** I will obtain all medications from one pharmacy, when possible known to this doctor with full consent to talk with the pharmacist given by signing this agreement. **G.** I will protect my prescriptions and medications. Lost prescription or medication will not be replaced. I will keep all medications from children. **H**. I agree to participate in psychiatric or psychological assessments, if necessary. **I**. If I have an addiction problem I will be forthright with the doctor, **J**. I will not use illegal drugs or alcohol. **K.** If a new condition develops, such as trauma or surgery, then the physician treating that problem may prescribe narcotics; however; I agree to notify Restore Medical Partners within 48 hours of such a prescription.

1. This doctor may ask me to follow through with a program to address actual or suspected addiction issue. Such programs may include the following:12-step program and securing a sponsor, Individual counseling, Inpatient or outpatient treatment or other treatment.

2. I understand that in the event of an emergency, this doctor should be contacted and the problem will be discussed with the emergency room or other treating physician. I am responsible for signing a consent to request record transfer to this doctor. No more than 3 days of medications may be prescribed by the emergency room or other physician without this doctor's approval.

3. I understand that I will consent to random drug screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking. I also consent to random pill counts, and agree to report within 24 hours when requested.

4. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.

5. I understand that this doctor may stop prescribing opioids or change the treatment plan if: **A**. I do not show any improvement in pain from opioids or my physical activity has not improved. **B**. My behavior is inconsistent with the responsibilities outlined in #1 above. **C**. I give, sell or misuse the opioid medications. **D**. I develop rapid tolerance or loss of improvement from the treatment. **E.** I obtain opioids from other than this doctor. **F**. I refuse to cooperate immediately when asked to get a drug screen. **G.** If an addiction problem is identified as a result of prescribed treatment or any other addictive substance. **H**. If I am unable to keep follow-up appointments.

YOUR SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOIDS/ ANELGESICS/ BENZODIAZEPINES: You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or driving. SIDE EFFECTS OF OPIOIDS: • Confusion or other change in thinking abilities • Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles • Breathing too slowly – overdose can stop your breathing and lead to death • Nausea • Sleepiness or drowsiness • Vomiting • Constipation • Aggravation of depression • Dry mouth THESE SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX OPIOIDS WITH OTHER DRUGS, INCLUDING ALCOHOL. RISKS: • Physical dependence. This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following: Runny nose Difficulty sleeping for several days Diarrhea Abdominal cramping Sweating 'Goose bumps' Rapid heart rate Nervousness • Psychological dependence. This means it is possible that stopping the drug will cause you to miss or crave it. • Tolerance. This means you may need more and more drug to get the same effect. • Addiction. A small percentage of patients may develop addiction problems based on genetic or other factors. • Problems with pregnancy. If you are pregnant or contemplating pregnancy, discuss with your physician. PAYMENT OF MEDICATIONS: State law forbids L&I from paying for opioids once the patient reaches maximum medical improvement. You and your doctor should discuss other sources of payment for opioids when L&I can no longer pay.

I have read this document, understand, and have had all my questions answered satisfactorily. I consent to the use of opioids to help control my pain and I understand that my treatment with opioids will be carried out as described above.

PATIENT SIGNATURE		DATE	
WITNESS SIGNATURE		DATE	

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MEDICATION NAME	DOSE (mg, mcg, etc)	REGIMEN (twice daily, etc)	DATE (MONTH) STARTED

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NEW PATIENT INTAKE FORM

Completed intake paperwork helps our physicians and other providers get to know you and your medical history better. We depend on its accuracy and completeness to provide you with the best possible care. Please contact our front desk at (941) 375-3006 if you need assistance with any of the sections on this form.

Patient Information

NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: ___/___/_____ REFERRING PHYSICIAN: _____

AGE: _____ PRIMARY CARE PHYSICIAN: _____

HEIGHT: _____ PREFERRED PHARMACY: _____

WEIGHT: _____ PREFERRED IMAGING FACILITY: _____

HOW DID YOU HEAR ABOUT US:

☐ Physician ☐ Friend/Family ☐ Google/Internet ☐ Social Media ☐ Billboard ☐ TV Commercial

Other: _____

ALLERGIES

Do you have any drug/medication allergies? ☐ YES ☐ NO

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

	Medication Name	Allergic Reaction
1)		
2)		
3)		
4)		
5)		

FAMILY HISTORY

Mark all appropriate diagnoses as they pertain to your first degree relatives:

☐ Arthritis
☐ Asthma
☐ Back Problem
☐ Blood Coagulation Disorder
☐ Cerebrovascular Accident
☐ Chronic Obstructive Lung Disease
☐ Coronary Arteriosclerosis
☐ Depression
☐ Diabetes
☐ Disorder of Thyroid Gland
☐ Heart Disease
☐ Hypercholesterolemia

☐ Other Medical Problems: _____

☐ I have no significant family medical history

PAST SURGICAL HISTORY

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

☐ Appendectomy
☐ Back Surgery
☐ Caesarean Section
☐ Carpal Tunnel Surgery
☐ Cholecystecomy
☐ General Surgery
☐ Hernia Repair
☐ Hysterectomy
☐ Joint Replacement
☐ Knee Surgery
☐ Neck Surgery
☐ Orthopaedic Surgery
☐ Plastic Surgery
☐ Shoulder Surgery
☐ Sinus Surgery
☐ Tonsillectomy/ Adenoids
☐ Other: _____

Date of Procedure: _____

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NEW PATIENT INTAKE FORM
CONTINUED

SOCIAL HISTORY

Tobacco Use:

☐ Never Used ☐ Former user ☐ Current Every Day Smoker ☐ Current Some Day Smoker

Packs per day _____ How many years? _____ Quit Date: _____

Alcohol Use: ☐ Social Use ☐ Daily Use ☐ History of alcoholism ☐ None

Caffeine Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Illegal Drug Use:

☐ Denies any use ☐ Currently user ☐ Former User ☐ Abuse of narcotic or prescription medication

Occupation: _____ When was the last time you worked? _____

Who is in your current household? _____

Are there any stairs in your current home? ☐ Yes ☐ No If Yes, How many? _____

Disability:

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

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

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

PAST MEDICAL HISTORY

Do you have ANY history of Cancer? ☐ Yes ☐ No

Have you ever had an appendectomy? ☐ Yes ☐ No **Date:** _____

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

	YES	NO
Acid Reflux (GERD)	☐	☐
Anemia	☐	☐
Anxiety	☐	☐
Asthma	☐	☐
Bipolar Disorder	☐	☐
Bronchitis/Pneumonia	☐	☐
Bursitis	☐	☐
Cancer	☐	☐
Carpal Tunnel	☐	☐
Chronic Joint Pains	☐	☐
Chronic Kidney Disease	☐	☐
Constipation	☐	☐
Coronary Artery Disease	☐	☐
Depression	☐	☐
Diabetes	☐	☐
Dialysis	☐	☐
Difficulty Sleeping	☐	☐
Easy Bruising	☐	☐
Emphysema/COPD	☐	☐
Fatigue	☐	☐
Fibromyalgia	☐	☐
Gastrointestinal Bleeding	☐	☐
Head Injury	☐	☐

	YES	NO
Headaches	☐	☐
Heart Attack	☐	☐
Heart Valve Disorders	☐	☐
High Blood Pressure	☐	☐
Hyperthyroidism	☐	☐
Hypothyroidism	☐	☐
Glaucoma	☐	☐
Kidney Stones	☐	☐
Low Sex Drive	☐	☐
Migraines	☐	☐
Multiple Sclerosis	☐	☐
Osteoarthritis	☐	☐
Osteoporosis	☐	☐
Peripheral Neuropathy	☐	☐
Peripheral Vascular Disease	☐	☐
Rheumatoid Arthritis	☐	☐
Schizophrenia	☐	☐
Seizures	☐	☐
Stroke/TIA	☐	☐
Thyroid Problem	☐	☐
Urinary Incontinence	☐	☐
Chills	☐	☐

	YES	NO
Insomnia	☐	☐
Night Sweats	☐	☐
Unexplained Weight Gain	☐	☐
Unexplained Weight Loss	☐	☐

Other Diagnosed Conditions

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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NEW PATIENT INTAKE FORM
CONTINUED

DIAGNOSTIC TESTS AND IMAGING

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

☐ MRI of the: _____ Date: _____

☐ X-Ray of the: _____ Date: _____

☐ CT Scan of the: _____ Date: _____

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

☐ Other Diagnostic Testing: _____ Date: _____

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

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 _____

PAIN HISTORY

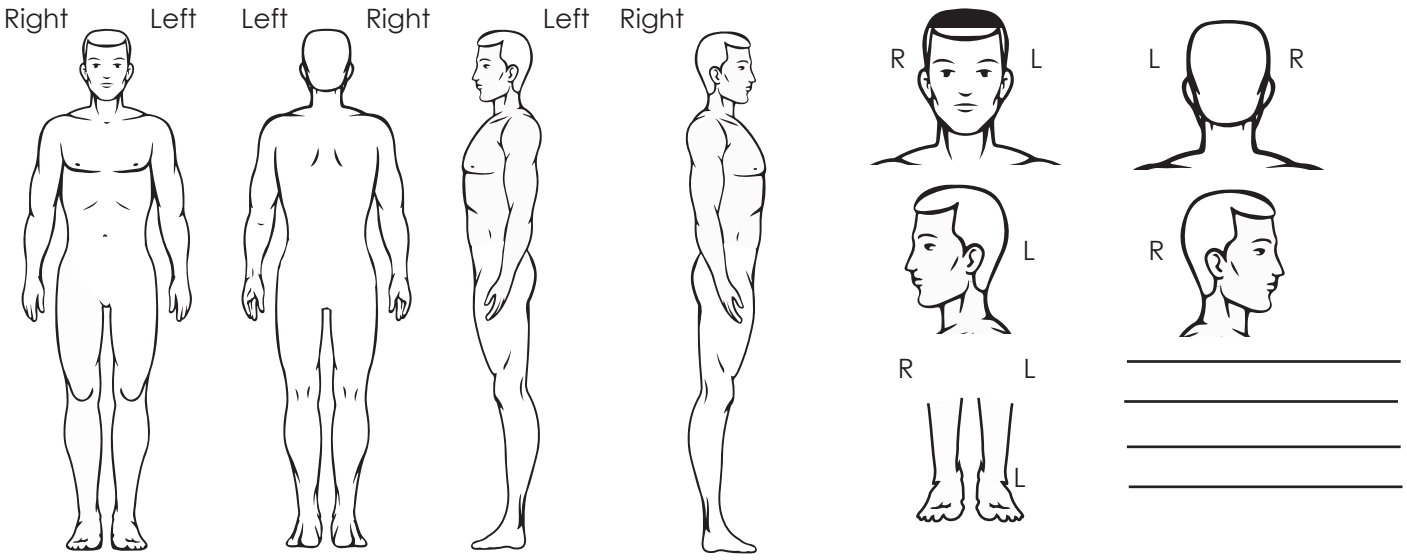
Chief Complaint (Reason for your visit today)? _____

Does this pain radiate? If so, where? ☐ No ☐ Yes
Lower Extremity ☐ Left ☐ Right ☐ Bilateral
Groin ☐ Left ☐ Right
Buttock ☐ Left ☐ Right
Hip ☐ Left ☐ Right

Please list any additional areas of pain: _____

_____

Use this diagram to indicate the area of your pain. Mark the location with an "**X**"



Previous medication(s) used for this condition and efficacy: _____

_____

_____

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NEW PATIENT INTAKE FORM
CONTINUED

PAIN DESCRIPTION

Check all of the following that describe your pain:

☐ Dull/Aching ☐ Hot/Burning ☐ Tightness ☐ Stabbing/Sharp ☐ Cramping

☐ Numbness ☐ Throbbing ☐ Tingling/Pins and Needles

How often does the pain occur? ☐ Constant ☐ Intermittent (comes and goes) ☐ Pain at Night

Severity: ☐ Worsening ☐ Interferes with Sleep ☐ Interferes with Work ☐ Middle of the night

If "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_____ The Best It Gets_____ The Worst It Gets_____

ONSET OF SYMPTOMS

Approximately when did this pain begin? _____

What Caused your current pain episode? _____

_____

How did your current pain episode begin? ☐ Sudden ☐ Gradual ☐ Chronic

Intermittent episodes lasting: _____Days _____Months _____Weeks _____Years

Since your pain began how was it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

ALLEVIATING FACTORS

Please circle any and all that apply for pain alleviation:

☐ Nothing ☐ Heat ☐ Ice ☐ Medications ☐ Sitting

☐ Standing ☐ Stretching ☐ Lying Down ☐ Position Change ☐ Rest

☐ Physical Therapy ☐ Epidural Injections ☐ Other: _____

AGGRAVATING FACTORS

Please circle any and all that apply for pain aggravation:

☐ Cannot Identify ☐ Extension ☐ Flexion ☐ Carrying ☐ Twisting

☐ Lifting ☐ Getting out of Bed ☐ Transitioning from Sitting to Standing

☐ Transitioning from Standing to Sitting ☐ Walking Up/Down Stairs

INTERVENTIONAL PAIN TREATMENT HISTORY

☐ 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

☐ MILD (Minimally Invasive Lumbar Decompression)

☐ Nerve Blocks – Area/Nerve(s) _____

☐ Radiofrequency Nerve Ablation (circle levels) Cervical/Thoracic/Lumbar

☐ Spinal Cord Stimulator (circle levels) Trial Only/Permanent Implant

☐ Trigger Point Injections Where? _____

☐ Vertebroplasty/Kyphoplasty Level(s) _____

☐ Other _____

Which of these procedures listed above have helped with your pain? _____

RESTORE MEDICAL PARTNERS

NEW PATIENT INTAKE FORM
CONTINUED

REVIEW OF SYSTEMS

Mark the following symptoms that you currently suffer from:

Constitutional:	☐ Chills ☐ Night Sweats ☐ Insomnia ☐ Unexplained Weight Gain	☐ Difficulty sleeping ☐ Fatigue ☐ Weakness ☐ Unexplained Weight Loss	☐ Easy bruising ☐ Fevers ☐ Tremors
Eyes:	☐ Recent Visual changes	☐ Dry Eyes	☐ Irritation
Ears:	☐ Difficulty Hearing	☐ Ear Pain	☐ Ear Discharge
Nose:	☐ Frequent Nose Bleeds	☐ Nose Problems	☐ Sinus Problems
Mouth/Throat:	☐ Sore Throat ☐ Dry Mouth ☐ Teeth Abnormalities	☐ Bleeding Gums ☐ Oral Abnormalities ☐ Mouth Breathing	☐ Snoring ☐ Mouth Ulcers
Cardiovascular:	☐ Chest Pain ☐ Arm Pain ☐ Shortness of Breath When Walking	☐ Heart Murmur ☐ Palpitations ☐ Shortness of Breath When Lying Down	☐ Blood Clots ☐ Swelling in feet
Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of breath
Gastrointestinal:	☐ Constipation ☐ Diarrhea	☐ Acid Reflux ☐ Nausea/Vomiting	☐ Abdominal Pain ☐ Change in Appetite
Genitourinary/ Nephrology:	☐ Urinary Loss of Control ☐ Pain When Urination ☐ Decreased Urine Flow/Frequency	☐ Difficulty Urinating ☐ Vaginal Discharge	☐ Hematuria
Musculoskeletal:	☐ Back Pain ☐ Joint Swelling ☐ Limited Motion	☐ Joint Pains ☐ Muscle Aches/Weakness ☐ Previous Injury	☐ Joint Stiffness ☐ Neck Pain ☐ Trauma
Skin:	☐ Abnormal Mole ☐ Itching ☐ Laceration ☐ Bruising	☐ Jaundice ☐ Dry Skin ☐ Growths/Lesions ☐ Insect Bites	☐ Rash ☐ Skin Lumps ☐ Redness ☐ Flaking
Neurological:	☐ Dizziness ☐ Numbness/Tingling ☐ Loss of Consciousness	☐ Headaches ☐ Restless Legs ☐ Shooting Pain	☐ Tremors ☐ Seizures
Psychiatric:	☐ Depressed Mood ☐ Suicidal Thoughts ☐ Hallucination	☐ Anxiety ☐ Insomnia ☐ Alcohol Abuse	☐ Stress Problems ☐ Restlessness
Endocrine:	☐ Fatigue	☐ Temperature Intolerance	☐ Increased Thirst
Hematologic/Lymphatic:	☐ Swollen Glands	☐ Easy Bruising	☐ Excessive Bleeding
Allergic/Immunologic:	☐ Runny Nose ☐ Hives	☐ Sinus Pressure ☐ Frequent Sneezing	☐ Itching
Chest/Breasts:	☐ Lumps	☐ Tenderness	☐ Discharge

☐ All other review of systems negative

☐ Reviewer _____

SAFE STRIDES PROGRAM

Are you afraid of falling? ☐ Yes ☐ No

Have you fallen in the past year? ☐ Yes ☐ No

Has a fall ever resulted in a fracture? ☐ Yes ☐ No If so, Where?_____

Have you completed Physical Therapy to address dizziness or falls? ☐ Yes ☐ No

When was your last bone density or dexa scan completed? _____ Where? _____

MEDICATION NAME	DOSE (mg,etc)	REGIMEN (once daily, Q12hr, etc)	DATE STARTED (month/year)

RESTORE
MEDICAL PARTNERS

REQUEST & AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Patient Information

NAME:_____ PHONE #: _____
ADDRESS: _____ CITY/STATE: _____
DATE OF BIRTH: _____ ZIP CODE: _____

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I hereby authorize the following provider(s):

Physician:_____
Hospital:_____
Diagnostic Imaging Center: _____

to use and disclose the protected health information described below to:

Restore Medical Partners, PLLC
333 South Tamiami Trail, Suite 169/171
Venice, FL 34285
Phone: (941) 375-3006
Fax: (941) 218-4825

☐ Check here to select all below

- ☐ Last Office Note Including: Medical History, List of Allergies and Medications
- ☐ All Imaging Reports
- ☐ EKG
- ☐ Procedure Notes
- ☐ Other _____

I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that I have the right to (1) Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.) (2)Refuse to sign this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority