



## 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 physician(s) and we're committed to providing you with the best healthcare possible. At Restore, we offer pain management, neurology, rheumatology, podiatry and physical therapy. 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. You will often meet with them, in addition to our physicians. They come from diverse backgrounds and help us to design unique treatment plans to resolve your pain. To read more about our providers, please visit our website at [www.restoremedicalpartners.com](http://www.restoremedicalpartners.com).

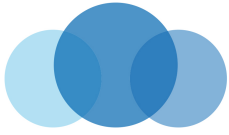
We strive to offer a very welcoming environment and ensure that our staff is committed to making your experience as pleasant as possible. Our goal is to provide excellent customer service, prompt phone call return within 24 hours, prompt scheduling, and consistently show the highest level of compassion for our patients. Finally, we look forward to your upcoming office visit and to helping you relieve your pain and get you back to living a wholesome and active lifestyle.

Sincerely,

*Restore Care Team*

333 S. Tamiami Trl., Suite 101  
Venice, FL 34285  
Phone: (941) 375-3006  
Fax: (941) 218-4825

[www.restoremedicalpartners.com](http://www.restoremedicalpartners.com)



# 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    Magazine Ad  
 Other: \_\_\_\_\_

## ALLERGIES

Do you have any drug/medication allergies?    YES    NO  
 If so, please list all medications you are allergic to:

<u>Medication Name</u>	<u>Allergic Reaction</u>
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

## FAMILY HISTORY

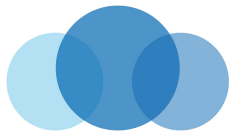
Mark all appropriate diagnoses as they pertain to your first degree relatives:

- Arthritis                                       Stroke                                               Diabetes
- Asthma                                               Chronic Obstructive Lung Disease                       Heart Disease
- Back Problem                                       Coronary Arteriosclerosis                                       Hypercholesterolemia
- Blood Coagulation Disorder                       Disorder of Thyroid Gland                                       Cancer - Type: \_\_\_\_\_
- 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:

- Thyroid Biopsy (FNA)    If so, what were the results: \_\_\_\_\_
  - Back Surgery                                       Knee Surgery                                               Other: \_\_\_\_\_
  - Cholecystectomy                                       Orthopaedic Surgery                                      \_\_\_\_\_
  - Hysterectomy                                       Shoulder Surgery
  - Neck Surgery                                      \_\_\_\_\_
  - Type: \_\_\_\_\_
- \*Medical Assistant to include approximate date of procedure.



**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? \_\_\_\_\_

**Disability:**

Temporary Disability     Permanent Disability     Retired     Unemployed

Are you currently under worker's compensation?     Yes     No

**PAST MEDICAL HISTORY**

**Do you have ANY history of Cancer?**     Yes     No    **Type:** \_\_\_\_\_

**Treatment(s):** \_\_\_\_\_

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

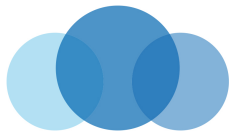
YES NO		YES NO		YES NO	
Abnormal Blood Calcium		Emphysema/COPD		Overactive Thyroid	
Acid Reflux (GERD)		Enlarged Thyroid		Parathyroid Disease	
Anemia		Fatigue		Peripheral Neuropathy	
Anxiety		Fibromyalgia		Peripheral Vascular Disease	
Asthma		Gastrointestinal Bleeding		Schizophrenia	
Bipolar Disorder		Glaucoma		Seizures	
Bone Fracture		Gout		Stroke/TIA	
Bronchitis/Pneumonia		Headaches		Thyroid Nodules	
Bursitis		Heart Attack		Thyroid Cancer	
Cancer		Head Injury		Underactive Thyroid	
Carpal Tunnel		Heart Valve Disorders		Unexplained Weight Gain	
Chills		High Blood Pressure		Unexplained Weight Loss	
Chronic Joint Pains		Infertility		Urinary Incontinence	
Chronic Kidney Disease		Insomnia			
Constipation		Kidney Stones			
Coronary Artery Disease		Liver Disease			
Depression		Low Sex Drive			
Diabetes: Type 1   Type 2		Migraines			
Dialysis		Multiple Sclerosis			
Difficulty Sleeping		Night Sweats			
Easy Bruising		Obstructive Sleep Apnea			
		<i>-If Yes, are you on CPAP/BIPAP</i>			

**Other Diagnosed OR Arthritis Condition(s):**

**RHEUMATOLOGIC (ARTHRITIS) HISTORY**

At any time have you or a blood relative had any of the following? (check if "yes")

Yourselves	Relative Name/Relationship	Yourselves	Relative Name/Relationship
<input type="checkbox"/>	Arthritis (unknown type)	<input type="checkbox"/>	Lupus or "SLE"
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Ankylosing Spondylitis
<input type="checkbox"/>	Childhood Arthritis	<input type="checkbox"/>	Osteoporosis



**SYMPTOMS**

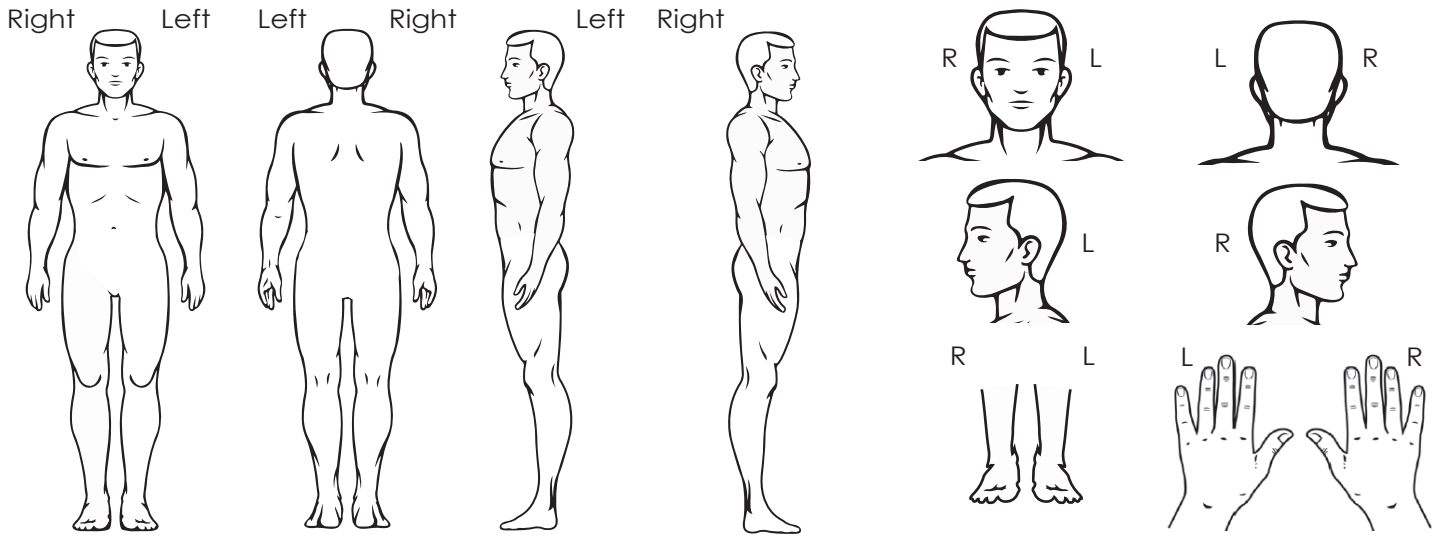
Do you suffer from any painful conditions?  Yes  No If No, skip this section.

Briefly describe your present symptoms: \_\_\_\_\_

Date Symptoms began (approximate): \_\_\_\_\_

Does this pain radiate? If so, where? Lower Extremity  Left  Right  Bilateral Groin  Left  Right Buttock  Left  Right Hip  Left  Right

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



Previous treatment for this condition (include physical therapy, surgery and injections; medications to be listed later):

\_\_\_\_\_

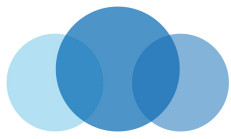
Please list the names of other practitioners or specialist(s) you have seen for this condition:

\_\_\_\_\_

**DIAGNOSTIC TESTS AND IMAGING**

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

- 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



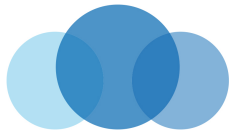
**REVIEW OF SYSTEMS**

Mark the following symptoms that you currently suffer from:

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

All other review of systems negative

Reviewer \_\_\_\_\_



**MEDICATIONS**

**Drug allergies:** No Yes If yes, please list: \_\_\_\_\_

Type of reaction: \_\_\_\_\_

**PRESENT MEDICATIONS**

(List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose: (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not At All
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

**PAST MEDICATIONS:** Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had. Record your comments in the spaces provided.

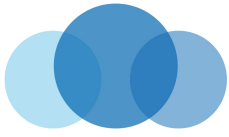
Drug names/Dose	Length of time	Please check: Helped?			Reactions	
		A Lot	Some	Not At All		
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)						
<i>Circle any you have taken in the past</i>						
Flurbiprofen	Diclofenac + misoprostil	Aspirin (including coated aspirin)			Celecoxib	Sulindac
Oxaprozin	Salsalate	Diflunisal	Piroxicam	Indomethacin	Etodolac	Meclofenamate
Ibuprofen	Fenoprofen	Naproxen	Ketoprofen	Tolmetin	Choline magnesium trisalcylate	
Diclofenac						

**Pain Relievers**

Acetaminophen					
Codeine					
Propoxyphene					
Other:					
Other:					

**Disease Modifying Antirheumatic Drugs (DMARDs)**

Certolizumab					
Golimumab					
Hydroxychloroquine					
Penicillamine					
Methotrexate					
Azathioprine					
Sulfasalazine					
Quinacrine					
Cyclophosphamide					
Cyclosporine A					
Etanercept					
Infliximab					
Tocilizumab					
Other:					
Other:					



**MEDICATIONS** CONTINUED

Drug names/Dose	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	

**Osteoporosis Medications**

Estrogen					
Alendronate					
Etidronate					
Raloxifene					
Fluoride					
Calcitonin injection or nasal					
Risedronate					
Other:					
Other:					

**Gout Medications**

Probenecid					
Colchicine					
Allopurinol					
Other:					
Other:					

**Others**

Tamoxifen					
Tiludronate					
Cortisone/Prednisone					
Hyaluronan					
Herbal or Nutritional Supplements					

**Please list supplements:**

\_\_\_\_\_

Have you participated in any clinical trials for new medications?      Yes      No

**If yes, list:**

\_\_\_\_\_

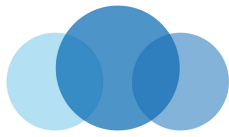
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



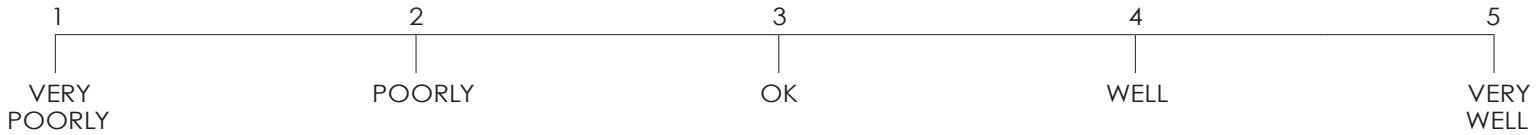
DAILY LIVING

Do you have stairs to climb? Yes No If yes, how many? \_\_\_\_\_

How many people in household? \_\_\_\_\_ Relationship and age of each \_\_\_\_\_

Who does most of the housework? \_\_\_\_\_ Who does most of the shopping? \_\_\_\_\_ Who does most of the yard work? \_\_\_\_\_

On the scale below, circle a number which best describes your situation; *Most of the time, I function...*



**Because of health problems, do you have difficulty:**  
(Please check the appropriate response for each question.)

Usually Sometimes No

Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.) .....

Walking?.....

Climbing stairs?.....

Descending stairs?.....

Sitting down?.....

Getting up from chair?.....

Touching your feet while seated?.....

Reaching behind your back?.....

Reaching behind your head?.....

Dressing yourself?.....

Going to sleep?.....

Staying asleep due to pain?.....

Obtaining restful sleep?.....

Bathing?.....

Eating?.....

Working?.....

Getting along with family members?.....

In your sexual relationship? .....

Engaging in leisure time activities?.....

With morning stiffness .....

Do you use a cane, crutches, walker or wheelchair?.....

What is the hardest thing for you to do? \_\_\_\_\_

Are you receiving disability?..... Yes No

Are you applying for disability?..... Yes No

Do you have a medically related lawsuit pending?..... Yes No

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_ Physician Initials: \_\_\_\_\_





333 S Tamiami Trl, Suite 101  
 Venice, FL 34285  
 Ph: (941) 375-3006  
 F: (941) 218-4825

**AUTHORIZATION FOR THE  
 RELEASE OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**I authorize Restore Medical Partners and any affiliates or subsidiaries to obtain/release a copy of all pertinent health and medical information described below (please make sure both circles are selected/approved) :**

- Restore Medical Partners is authorized to send my records to my care team or any medical facility associated with my care
  - This includes but is not limited to initial evaluation, most recent office visit, surgical/injection reports, allergies and medications, imaging, lab reports, follow up encounters, and all medical records
- Restore Medical Partners is authorized to obtain my records from my care team or any medical facility associated with my care
  - This includes but is not limited to my entire medical record, initial evaluation, most recent office visit, surgical/injection reports, allergies and medications, imaging, lab reports, and follow up encounters

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

1. We cannot condition our provision of services or treatment to you on the receipt of this signed Authorization;
2. You may inspect a copy of the protected health information to be used or disclosed;
3. You may refuse to sign this Authorization; and
4. We must provide you with a copy of this signed Authorization.
5. You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.
6. Unless revoked earlier or otherwise indicated, this authorization will auto renew ever 180 day from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

By signing below, I authorize Restore Medical Partners to release or obtain copies of my medical records. I understand that my record may contain information about alcohol and/or drug treatment, mental health, or psychiatric treatment, and/or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my health information, as specified, for the purpose or need as indicated above. I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under Federal law. I understand that Restore Medical Partners may utilize a medical record correspondence service and there may be a fee assessed for this service. PLEASE ALLOW 7 TO 10 BUSINESS DAYS FOR RECORDS TO BE COPIED.

\*

/ /

**SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE      RELATIONSHIP TO PATIENT      DATE (mm/dd/yyyy)**

**64B8-10.003 Costs of Reproducing Medical Records:**

Specific Authority 456.057(18), 458.309 FS. Law Implemented 456.057(18) FS. History–New 11-17-87, Amended 5-12-88, Formerly 21M-26.003, 61F6-26.003, 59R-10.003, Amended 3-9-09.

1. Any person licensed pursuant to Chapter 458, F.S., required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records.
2. Reasonable costs of reproducing copies of written or typed documents or reports shall not be more than the following:
  - a. For the first 25 pages, the cost shall be \$1.00 per page b. For each page in excess of 25 pages, the cost shall be 25 cents per additional page
3. Reasonable costs of reproducing x-rays, and such other special kinds of records shall be the actual costs. The phrase “actual costs” means the cost of the material and supplies used to duplicate the record as well as the labor cost and overhead costs associated with such duplication.

**Specific Authority 456.057(18), 458.309 FS. Law Implemented 456.057(18) FS. History–New 11-17-87, Amended 5-12-88, Formerly 21M-26.003, 61F6-26.003, 59R-10.003, Amended 3-9-09**



## **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.

### **FINANCIAL POLICY:**

We adhere to a clear and comprehensive financial policy. As a courtesy to all of our patients, it is our normal practice to:

- Verify eligibility and benefits prior to your appointment.
- File your claim with Medicare and/or commercial healthcare insurance providers.



For All Patients:

- Payment is required at the time of service unless prior arrangements have been made.
- I am responsible for knowing the terms of my policy, including deductibles, copayments, coinsurances, and any applicable referral procedures.
- I am financially responsible for all charges, whether or not covered by insurance. This includes, but is not limited to, out-of-network, laboratory, and anesthesia service charges.
- All anesthesia fees are billed independently of Restore Medical Partners and are ultimately my responsibility. This means I MAY RECEIVE A SEPARATE BILL FOR ANESTHESIA following a procedure. It is necessary to contact Spartan Anesthesia directly to resolve any billing concerns.
- All Laboratory fees are billed by Restore Medical Partners unless otherwise required by insurance, or specifically requested, and are ultimately my responsibility. I MAY RECEIVE A SEPARATE LAB BILL IF THE TEST IS SENT TO LABCORP OR QUEST. It is necessary to contact the lab directly to resolve any billing concerns if performed at an outside lab.
- Patients with overdue accounts will be sent a statement from Restore Medical Partners to the address on file. It is my responsibility to keep my address current. Every effort is made to help our patients satisfy their obligations in a reasonable manner and avoid our collections process.
- I understand and agree additional services such as labs, or in-office injections may be performed as a course of treatment. I am responsible for any additional costs these services may result in.
- In the event we are unable to verify your benefits, you cannot provide proof of coverage at the time of visit, or no authorization is on file, I can either: Reschedule my appointment, or Make payment in full. We will provide financial statements to help you pursue reimbursement of the claim (upon request). However, we will not file reimbursement for you.

### **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.

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**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	