GENESIS
MEDICAL CLINIC

PATIENT REGISTRATION

PATIENT NAME _____
Last First Initial

HOW DID YOU HEAR ABOUT US? _____

Home Address

_____

City _____ State ____ Zip _____ Date of Birth_____

Mailing Address (if different) _____

Male/Female _____Social Security Number _____ Marital Status _____

Home Phone _____ Cell Phone_____

Employer _____Occupation _____ Telephone_____

Friend or Relative not living With You:
Name _____ Relationship _____

Address _____ Telephone _____

Medical Insurance Information:
Primary Insurance _____Policy Holder_____

DOB:_____ SSN#:_____

2. Secondary Insurance _____ Policy Holder _____

Name of Spouse or (if a minor) parent

_____

Spouse's/Parent's Employer _____ Telephone _____

Authorization and Assignment
I hereby authorize my insurance carrier, attorney or any third-party payer to pay directly to Superior Medical Clinic, LLC dba Genesis Medical Clinic all charges submitted for services incurred by me. I understand I will be responsible for any and all charges not paid by my insurance company. I authorize Superior Medical Clinic, LLC dba Genesis Medical Clinic to release information concerning my medical condition to my insurance company, employer, hospital, physician or attorney for the purpose of processing a claim. I assign payment directly to the physicians at Superior Medical Clinic, LLC dba Genesis Medical Clinic which may be due from the Medicare program or any other insurance company, including supplemental insurance, which may cover in whole or part medical services which I have received. The authorization and assignment shall be valid until I notify Superior Medical Clinic, LLC dba Genesis Medical Clinic in writing of the cancellation. A photocopy of this authorization shall be valid as the original copy.

_____ _____ _____ _____
Signature Date Signature (WITNESS) Date

HIPAA is an acronym for the **Health Insurance Portability & Accountability Act** of 1996, a federal law.

9780 N 56th Street • Temple Terrace, FL 33617 • PHONE 813-549-7465 • FAX 813-549-7399

GENESIS
MEDICAL CLINIC

Administrative Simplification section of this Act is of Concern to our practice and requires us to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals and employers
- Healthcare Transactions & Code Sets for transmitting electronic data
- Privacy Regulations over disclosure and use of health information
- Security Regulations over protections of electronic health information

All of these rules have been developed by the Department of Health & Human Services and will become final in a staged manner.

It will be the policy of **Genesis Medical Clinic** to release confidential information with signed consent by home telephone, answering machine, work telephone, voicemail and cellular phones. Whenever returning telephone calls and the answering machine picks up, it is our policy **NOT** to leave confidential information if there is no recorded message identifying the residence. Confidential information will **NOT** be left with an unauthorized person who may answer your telephone. If you would like to have your medial information released to someone other than yourself, please complete the following:

I authorize **Genesis Medical Clinic** to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Home Telephone	□ Yes □ No
Answering Machine	□ Yes □ No
Work Telephone	□ Yes □ No
Voice Mail	□ Yes □ No
Cellular Phone	□ Yes □ No

Please List authorized persons:

Spouse/Fiancé: _____

Parent/Guardian: _____

Brother/Sister: _____

Son/Daughter: _____

Friend/Other: _____

_____ _____

FINANCIAL POLICY

In order for us to be able to continue to deliver high quality of care, it is necessary to provide a

financial policy. PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. Please present your insurance card(s) at each visit. It is your responsibility to provide us with the correct information so that we may submit to your insurance. Failure to do so may make you liable for denied claims.
2. We will collect your deductible, co-payment or payment for non-covered services, along with any patient balance due the time of your visit. We accept cash, checks, Visa, MasterCard , American Express and Discover. We cannot bill you for co-pays; they must be made at the time of your appointment.
3. If we do not participate with your insurance, we will file your claims as a courtesy and ask that you follow-up to make sure payment is made to us in a timely manner. If we do not receive payment from them within 45 days, you will be billed for any unpaid balance, AND 1.5% monthly interest will begin to accrue on your account. Balances are expected to be paid in full within 30 days. If payment on your account is not done in a timely manner, your account may be referred to a collection agency and reported to the credit bureau.

4. **MEDICARE PATIENTS:** We will submit to Medicare for all your covered services. If you have a supplemental insurance, we will also submit that for you as a courtesy. If payment is not received from your supplemental insurance within 30 days of being submitted, we will ask for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.

5. **MEDICAID PATIENTS:** We are not participating providers with Medicaid. We ask that you pay for your services at the time of your visit.
6. **HMO-PPO PATIENTS:** If we participate with your plan, we will submit your services to your insurance for you. Your co-payment will be collected at the time of service—no exceptions. If your plan requires you to choose a primary care physician, it is your responsibility to make sure your insurance company has the physician you are seeing in our office as your PCP. If your plan requires you to have an authorization to see a specialist, you will need to obtain that from our office prior to seeing the specialist. 72 hours notice is required to obtain all referrals. We cannot obtain retroactive referrals. If we do not participate with your plan, we will verify your out-of-network benefits, file your services, and we expect payment of your portion of the services at the time of your visit.

7. **SELF-PAY PATIENTS**: Patients without insurance coverage will be expected to pay at the time of service. If you will not be able to pay in full, you must contact our billing department prior to seeing the doctor to make payment arrangements.

8. **NO SHOW OR MISSED APPOINTMENTS**: We understand there may be times when you are unable to keep an appointment. 24 hours notice must be provided to prevent incurring a cancellation fee. If two appointments are missed without proper notice you will be charged a $25.00 fee for routine visits and $50.00 for physicals. Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your services.

If you have any questions regarding our financial policy, please contact our billing department or practice administrator.

I have read and acknowledge the above financial policy of Genesis Medical Clinic

_____ _____

Signature (Patient or Guardian) Date

Patient Consent Form

GENESIS
MEDICAL CLINIC

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.
I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.
I understand that **Genesis Medical Clinic** may include consent at satellite offices under common ownership.
I, the undersigned, acknowledge that **Genesis Medical Clinic** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.
A photocopy of this consent shall be considered as valid as the original.

Consent for Insurance Policy:
Genesis Medical Clinic will submit claims to the insurance companies that they are contracted with. I understand that I am responsible for all deductibles, copays, and charges not covered by insurance at the time of service. I also understand that I will need to bring my Insurance card at each visit along with my cost that the insurance does not pay.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Genesis Medical Clinic.**
I acknowledge that I have been given the **Genesis Medical Clinic** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: _____
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) Signature ***Date***

GENESIS
MEDICAL CLINIC
9780N 56th Street

Temple Terrace, FL 33617

Tel 813-549-7465 Fax 813-549-7399

Date:_____

Patient Name:_____ ___ DoB:_____ M/F

I hereby state that by signing this informed consent disclosure document below, that I fully understand I am being prescribed METHADONE, and since I am taking METHADONE, I state and verify by my signature below that there are certain risks involved with this therapy . I understand the major risks include severe respiratory depression and heart rhythm changes, both of which can be acutely fatal. By signing below, I agree that I have been fully informed of these risks and further state that I am taking this medication of my own free will.

I further agree that I must have an EKG done at a facility of my choice within thirty (30) days or before my next scheduled doctors office appointment, and I also understand if I do not have a EKG performed within the time allowed, my Methadone prescription WILL NOT be refilled. If I have any questions or concerns, my signature also verifies that I have spoken with the doctor or staff regarding same prior to signing this informed consent disclosure document.

Signed: _____ _____

Patient's signature Patient's printed name

GENESIS
MEDICAL CLINIC

Treatment Attestation for Pain Management

I,_____, am seeking healthcare services for the treatment of my painful condition from Genesis Medical Clinic. I understand that my accuracy, completeness and truthfulness in reporting my history and symptoms will directly contribute to the development of my treatment plan and the improvement in my painful condition. I acknowledge that I intend to provide previous healthcare information so Genesis Medical Clinic may receive my previous healthcare records from other clinicians. I know that if I am not accurate, complete and truthful in providing my history and symptoms Genesis Medical Clinic cannot safely treat me for my painful condition.

I intend to disclose the name of all prior treating practitioners and inform

Genesis Medical Clinic about all current prescribers of controlled substances. I do not intend to seek medications for any purposes other than personal medical needs. I will not deliberately misrepresent my history, prevent Genesis Medical Clinic from obtaining my previous medical records fails to inform Genesis Medical Clinic about the existence of other sources of prescription medication, or allow any one than myself to take medications prescribed to me. I understand that obtaining controlled substances (Prescription medicines) through false representations is a crime and that I will be reported to law enforcement officials for attempting to fraudulently obtain these medications for non-therapeutic purposes.

I am seeking treatment for the purpose of reducing or relieving my pain. I am not appearing to seek care from Genesis Medical Clinic as part of an ongoing investigation of Genesis Medical Clinic. I am a legitimate patient voluntarily seeking healthcare services for a painful condition.

_____ _____

(Patients Signature) (Physician Signature)

_____ _____

(Patient printed Name) Date (Physician printed Name) Date

9780 N 56th Street • Temple Terrace, FL 33617 • PHONE 813-549-7465 • FAX 813-549-7399

GENESIS
MEDICAL CLINIC

Date_____

This office provides only outpatient services. Therefore, doctors will not be available after hours, weekends or holidays. Should you have an emergency, you must contact your primary care physician, go to the nearest hospital emergency room or call 911

If you do not have a primary care physician you should endeavor to obtain one. The physicians in this practice will provide evaluations and treatment exclusively for those patients with neurological and pain disorders and weight loss management. They will not admit any patients to a hospital.

I have read and completely understood the above statement. I agree to consult a primary care physician for all other medical concerns.

_____

Patient's signature

_____

Patients Name Printed

9780 N 56th Street • Temple Terrace, FL 33617 • PHONE 813-549-7465 • FAX 813-549-7399

GENESIS
MEDICAL CLINIC

FEE FOR CONFIRMING FALSIFIED OR WITHHELD DOCUMENTS

All pain documentation brought into our office will be confirmed to ensure compliance with our guidelines. If a patient alters any documents brought in, with holds crucial information, of if the document is found to be falsified/tampered with in any way or if the patient is found to be doctor shopping (going to more than one pain management facility, hospital, or primary care doctor and receives pain medication within a thirty(28) day period) the patient will be denied service from Genesis Medical Clinic and will be reported to a law enforcement agency.

The patient will be refunded his/her money with the exception of $100.00, for all the time and efforts our staff puts into verifying the documentation a patient brings in or discovering that the patient with held information.

Thank you,

_____

Office staff at Genesis Medical Clinic

_____

Patients signature **Date**

9780 N 56th Street • Temple Terrace, FL 33617 • PHONE 813-549-7465 • FAX 813-549-7399

GENESIS
MEDICAL CLINIC

A consent/Agreement form,

Dr. _____is prescribing opioid medicine, sometimes called narcotic analgesics, to me for a diagnosis of .----------
This decision was made because my condition is serious or other treatments have not helped my pain.
___I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.
I am aware that combining the prescribed medication with alcohol, street or illegal drugs, taking more medication than that prescribed will produce the above effect and may cause cardiac arrest, coma or possibly death.
I am aware that consuming alcohol with Tylenol or any acetaminophen containing medication greater than 2 gram per day will increase my chance of liver toxicity and possibly death.

____I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed included:----------
---

_____I will tell my doctor about all other medicines and treatments that I am receiving.
I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working
in unprotected heights or being responsible for another individual who is unable to care for himself or herself.
_____I am aware that certain other medicines such as nalbuphine (Nubain ™), pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines or alcohol, street or illegal drugs and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

GENESIS
MEDICAL CLINIC

_____I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

_____I understand that physical dependence is a normal, expected result of using these medicines for a long time.
I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.
_____I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

GENESIS
MEDICAL CLINIC

____(**Males only**) I am aware that chronic opioid use has been associated with low testosterone levels in males.
This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

_____(**Females Only**) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon Opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

_____I have read this form or have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.

Patient Signature and Date_____

Patient's Name_____

Witness Signature _____

Witness Name _____

Physician Signature and Date_____

Physician's Name_____

9780 N 56th Street • Temple Terrace, FL 33617 • PHONE 813-549-7465 • FAX 813-549-7399

GENESIS
MEDICAL CLINIC

NARCOTIC AGREEMENT

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged.
For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment or toxicity leading to death.)
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:
Pharmacy Name:_____ phone:
Fax#_____, Address_____

3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take. You are to inform our office within 48 hrs of any visit to the emergency room or admission to the hospital.

4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists, primary care physician, designated family member, significant other, caregiver and other professionals who provide your health care for purposes of maintaining accountability.

5. You must not share, sell, or otherwise permit others to have access to these medications or buy these medications through the internet.

6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop. You agree to go to a detox center should abrupt cessation occur.

7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.

8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

9. Original containers of medications should be brought in to each office visit.

10. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

11. Medications will not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, you must wait for your next office visit.

12. You must not use these medications in a manner inconsistent with its labeling. You must not snort, shoot, inject any of these medications into your body.

13. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.

14. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

16. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

GENESIS
MEDICAL CLINIC

17. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

18. The risks and potential benefits of these therapies are explained elsewhere [and you acknowledge that you have received such explanation].

19. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

20. You agree to visit other specialists or other health care providers when referred by your doctor.

Physicians Name:_____

Physician Signature: _____
Date:_____

Patient's Name:_____

Patient Signature:_____
Date:_____

Witness Name:_____

Witness Signature:_____
Date:_____

GENESIS
MEDICAL CLINIC

Addendum To Narcotic Agreement:

Drug abuse and diversion is a threat that we at Genesis medical clinic take very serious. It is our goal to offer you the best medical service available.

Your safety and well-being is our utmost concern, a task that we take very seriously. In order to serve you better and be fully compliant with all federal and state statutes and the standards of care, the following changes are being made as a result of our continuous quality assurance programs. Initial each number at the space indicated, sign and date the last page.

1. ----We are introducing new forms. All questions must be filled in completely. Write N/A if it does not apply to you but do not leave any question blank.
2. ------You must present documented evidence of failed alternative therapy for the management of your pain. It could be a consultation note or letter from your Physical Therapist, Chiropractor, Spine Doctor, Neurologist, Orthopedic or another appropriate specialist that injections, physical therapy, surgery or other alternate treatment modalities are not enough to adequately control your chronic non-cancer intractable pain without adding narcotic analgesics. These documents are required within 28 days in order for you to continue being treated here and continue to get your medications. If you have none of the above, you will be referred for specialist consultation and alternate treatment modalities and consultation notes from the referrals must be received by our office before your next visit or you will not be seen.
3. -----You will be tested every 3 months or sooner as determined by your doctor, for both active drugs and metabolites to make sure that you are compliant with your Narcotic Agreement.
4. -------Your MRI/CT scan must be renewed every 2 to 3 years.
5. -------Your blood work must be done once yearly (or more often if deemed necessary by your doctor) and the report should be received by our office within 28 days of issuance of blood work script. If blood work is abnormal, you will be required to repeat your blood test within a certain time as determined by your doctor, or referred to an appropriate specialist and compliance with the above is necessary to continue pain management.
6. --------This is a smoke free medical environment. Smoking is not allowed anywhere within or outside the clinic or parking areas.

GENESIS
MEDICAL CLINIC

7. --------You will agree to do your best to either lose weight or cease smoking as may be recommended by your doctor.
8. -------You must have a primary care physician for follow up for your other non-pain related medical conditions. If your doctor refers you to another specialist during the course of your treatment, consultation with that specialist is necessary for continuation of your treatment at this clinic.
9. -------It is the current understanding within the medical community that opioid medications in excess of 200 morphine equivalent dose will pose greater danger to your health, increase your risk of serious adverse effects like overdose, difficulty breathing or depression and increased pain perception. This risk is further increased with obesity, smoking, abnormal liver or kidney function, sleep apnea, severe lung disease, older age and some other medications if taken in combination, at any opioid dose. YOUR MEDICATIONS AND CO-EXISTING MEDICAL CONDITIONS WILL BE REVIEWED BY YOUR DOCTOR AND YOUR OPIOID MEDICATIONS MIGHT BE TAPERED DOWN SLOWLY OVER A PERIOD OF TIME IF DEEMED NESECCESSARY BY YOUR DOCTOR, TO COMPLY WITH THIS CURRENT UNDERSTANDING WITHIN THE MEDICAL COMMUNITY. You might also be referred to an appropriate specialist by your doctor if necessary to assist with this slow tapering down of your medications to a safer dose.

Physicians Name:_____

Physician Signature: _____
Date:_____

Patient's Name:_____

Patient Signature:_____
Date:_____

Witness Name:_____

Witness Signature:_____
Date:_____

GENESIS
MEDICAL CLINIC

PERSONAL HISTORY

Name:_____Date_____S.S.#_____

Address:_____

City: _____ State _____ Zip code _____

Home phone _____ Cell _____ Other:_____E-Mail_____

Date of Birth _____ Age _____ Sex ☐ Male ☐ Female

Business/Employer _____

Address _____

Type of Work _____ Years Employed _____

Check One ☐ Married ☐Single ☐ Widowed ☐ Separated ☐ Divorced ☐ # of Children _____

Name of Emergency Contact _____ Relation _____ Phone _____

Who is responsible for your bill? ☐ Self ☐ Spouse ☐ Workmans' Comp ☐ Medicare ☐ Medicaid ☐ Auto ☐ Commercial

☐ Personal Health Insurance ☐ Other _____

Please answer the following Government Question:

What is your race: ☐ Caucasian ☐ Black ☐ Asian ☐ Pacific Islander ☐ Hispanic ☐ Refused to answer

What is you Religion: _____ What is your Native language? _____

CURRENT HEALTH CONDITION

Purpose of this Appointment _____

_____

Hospital or doctors seen for this condition _____

_____

When & how did this condition begin (describe)_____

_____

If disabled from work please give dates_____

☐ Job related ☐ Auto related ☐ Other_____

Are you presently taking any medication ☐ Yes ☐ No _____

_____

GENESIS
MEDICAL CLINIC

Patient History

Patient Name:_____ Date:_____

Date of Birth:_____

Domestic Situation

With whom are you living?_____

Are there any substance abuse issues in the household? ☐Yes ☐No

Are you able to take care of yourself? ☐Yes ☐No

If not, please enter the name of your caregiver_____

Work History

How many Job Years did you worked?_____ Why did you leave?_____

Legal Matters

Are you presently involved in a lawsuit? ☐Yes ☐No If yes please explain

_____

Substance use

Which of the following drugs or substances, if any, have you used in the past? (Mark all that applies)

	Occasionally	frequently	continuously	in the past	present
Alcohol					
Cocaine					
Heroin,					
Barbiturates					
Amphetamines					
Marijuana					
Other-					

Do you presently smoke cigarettes or use tobacco in any form? ☐Yes ☐No

If not, did you ever smoke cigarettes or used tobacco in any form? ☐Yes ☐No

For how many years? _____ How many years ago did you quite? _____

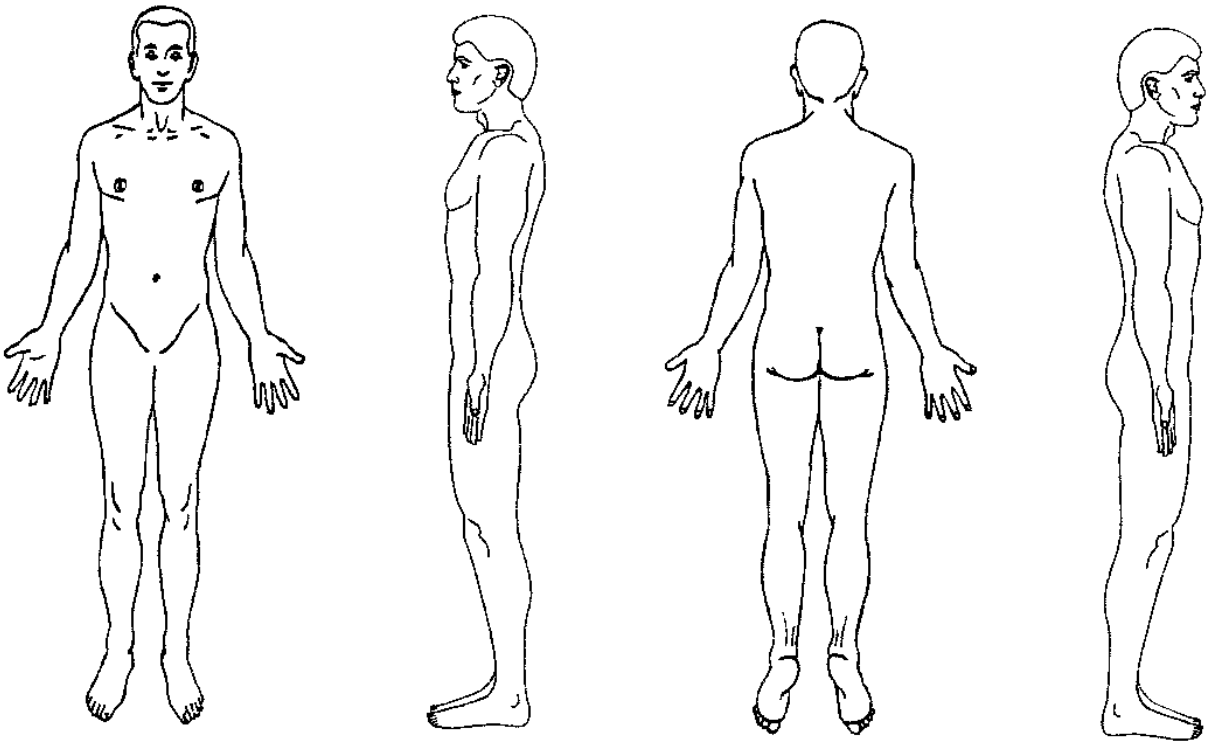
How many packs do (did) you smoke a day? _____

GENESIS
MEDICAL CLINIC

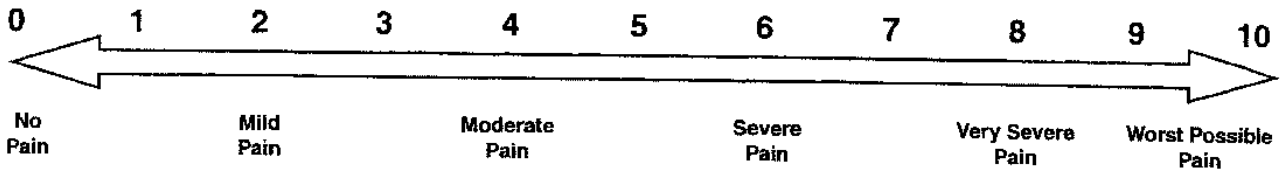
PAIN HISTORY & ASSESSMENT

Patient Name: _____ Age: _____ Date: _____

1. Please circle the areas of your body where you feel pain:



2. In the circles you've drawn, please indicate the intensity of pain with a number that corresponds to the scale below:



3. Please answer the following questions:

	Yes	No	Please Describe
Are you in pain today?	☐	☐	_____
Is the pain always there?	☐	☐	_____
Does it get worse when you move in certain ways?	☐	☐	_____
Do other things make it better or worse?	☐	☐	_____

Has your pain effected: ☐ Mobility ☐ Sleep ☐ Work ☐ Exercise ☐ Concentration ☐ Appetite ☐ Social Activities ☐ Relationships with others ☐ Emotions ☐ Other: _____

Please describe all past treatments for your pain including over-the-counter and prescription medications, herbal and vitamin supplements, surgery and alternative therapy:

_____

_____

GENESIS
MEDICAL CLINIC

Medical History

Past Medical History

Please check if you have had any of the following:

□ Alcoholism
□ Anemia
□ Anxiety
□ Arrhythmia
□ Arthritis
□ Asthma
□ Atrial Fibrillation
□ Bronchitis
□ CAD
□Cancer Type:_____
□ Cardiovascular Disease
□ CHF
□ Crohn's Disease
□ Cirrhosis
□ Colitis
□ Constipation
□ COPD
□ CRF
□Other_____

□ CVA
□ Dementia / Alzheimer's
□ Disc Disease
□ DJD
□ Depression
□ DM Type I
□ DM Type II
□ Emphysema
□ Epilepsy
□ Fracture
□ GERD
□ Glaucoma
□ Hepatitis
□ High Cholesterol
□ Hyperlipidemia
□ Hypertension
□ Implanted Medical Devices
□ Kidney Disease
□ Allergies _____

□ Liver Disease
□ Migraine
□ Multiple Sclerosis
□ Nephrolithiasis
□ Obesity
□ Osteoarthritis
□ Osteoporosis
□ Prior MI
□ Pulmonary Disease
□ Rheumatoid Arthritis
□ Seizures
□ Sickle Cell Disease
□ STD
□ Thyroid Disease
□ TIA
□ Tuberculosis
□ Ulcers
□ Valve Problems

Reaction _____

Is there any chance you may be pregnant? □ Yes □ No Last date of menses: _____

Past Surgical History

Please check if you have had any of the following:

□ No prior surgical history
□ Appendectomy
□ D&C
□ Hysterectomy
□ Knee Arthroscopy
□ Mastectomy
□ Shoulder surgery
□ Spinal Surgery
□Tonsillectomy
□ Total Knee Replacement
□ Total Hip Replacement
□ Tubal Ligation
□ Other _____

Preventive Care

Have you had any of the following? If so, please provide the date.

□ Last Complete Physical Exam ___/___/___
□ Colonoscopy ___/___/___
□ Flexible Sigmoidocopy ___/___/___
□ PSA ___/___/___
□ Stool Occult Blood ___/___/___
□ Stress Test ___/___/___
□ Routine Eye Exam ___/___/___
□ Dilated Eye Exam ___/___/___
□ Foot Exam ___/___/___
□ HPV
□ Other _____

□ Bone Density ___/___/___
□ Mammography ___/___/___
□ Chlamydia Screening ___/___/___
□ HIV Testing ___/___/___
□ Flu Vaccine ___/___/___
□ Pneumovax ___/___/___
□ Zoster Vaccine ___/___/___
□ Tdap Vaccine ___/___/___
□ TD ___/___/___
□ Tuberculin PPD ___/___/___

General Family History

□ Ankylosing Spondylitis
□ Arthritis
□ Alcoholism
□ Anemia
□ Anxiety
□ Asthma
□ Bleeding Disorder
□ CAD
□ MI's
□ CHF
□ Other _____

□ Colitis
□ COPD
□ Crohn's Disease
□ CVA / TIA
□ Depression
□ Diabetes
□ Epilepsy
□ GERD
□ Gout
□ Hypertension

□ Kidney Disease
□ Liver Disease
□ Osteoarthritis
□ Osteoporosis
□ Psoriasis
□ Pulmonary Disease
□ Renal Disease
□ Rheumatoid Arthritis
□ SLE
□ Thyroid Disease

Name:_____ Date:_____

GENESIS
MEDICAL CLINIC

Review of Systems

Please check if you have the following symptoms:

Constitutional

□ Loss of appetite □ Recent change in weight □ Fatigue (Tired)
□ Fever □ Chills □ Night Sweats
□ Able to perform ADL's independently □ Change in sleep habits
□ Other symptoms _____

Head & Neck

□ Headache □ Vision Problems □ Eye Pain
□ Ear pain □ Hearing difficulty □ Sinus Problems
□ Difficulty Swallowing □ Neck Stiffness □ Goiter
□ Other symptoms _____

Cardiovascular

□ Chest Pain □ Ankle edema □ Cold hands or feet
□ Palpitations □ Heart murmur □ Claudication
□ Other symptoms _____

Respiratory

□ Persistent cough □ Productive cough □ Shortness of breath
□ Dyspnea (Difficulty Breathing) □ Orthopnea □ Chest congestion
□ Other symptoms _____

Gastrointestinal

□ Nausea □ Vomiting □ Diarrhea
□ Constipation □ Hematochezia □ Abdominal Pain
□ Other symptoms _____

Genitourinary

□ Frequency □ Burning on urination □ Incontinence
□ Hesitancy □ Dysuria □ Urgency
□ Other symptoms _____

Endocrine

□ Polyuria (Frequent Urination) □ Polydysia (Excessive Thirst) □ Sexual Complaints
□ Heat intolerance □ Cold intolerance
□ Other symptoms _____

Musculoskeletal

□ Joint Pain □ Radiculopathy □ Fractures
□ Back Pain □ Joint Stiffness □ Sudden unexplained fractures
□ Other symptoms _____

Neurological

□ Ataxia □ Seizures □ Dizziness
□ Numbness □ Tingling □ Confusion
□ Speech Difficulties □ Motor Disturbances □ Sensory Disturbances
□ Other symptoms _____

Psychiatric

□ Anxiety □ Depression □ Panic Attacks
□ Suicidal Thoughts □ Suicide Attempts □ Sleep Disturbances
□ Mood Disorders □ Emotional Problems □ Depression Screening Completed
□ Other symptoms _____

Hematology / Immunology

□ Easy Bleeding tendency □ Easy Bruising tendency □ Swollen Nodes
□ Environmental Allergies □ Frequent Infections □ Food Allergy
□ Other symptoms _____

GENESIS
MEDICAL CLINIC

Periodic Treatment Review

Patient Name _____ DoB_____

1. On average, how bad was your pain last week? (circle number)

   0= no pain 10= worst possible pain 0 1 2 3 4 5 6 7 8 9 10

2. What activities are most difficult because of pain? Activities may include sitting, standing, walking, reaching overhead, climbing stairs, etc.

   Pick 2 activities and mark the changes from your last doctor visit.
   Please use the same activities each time you complete this form.

   Activity 1: _____ I can do: ☐ more ☐ less ☐ no change

   Activity 2: _____ I can do: ☐more ☐ less ☐ no change

PROGRESS REPORT (check all that apply)

☐ Estimate patient function on opioids (circle number)
0 1 2 3 4 5 6 7 8 9 10
0= severe impact on function 10= returned to level of function prior to injury

☐ Patient has a signed opioid agreement within past 6 months Last date of agreement._____ (If new agreement, please submit copy)

☐ Is there concern about opioid use? ☐Yes ☐No **If yes, check all that apply**
☐Misuse ☐Tolerance ☐ Dependence ☐ Toxicity/side effects

☐ Have you requested a random drug test? If so, please submit a copy

Random drug screening is recommended and does not require pre-authorization

Physical Exam: BP _____ HR _____ RR_____ SaO2 on room air_____.

HEENT: Pupils: _____mm Response to Light: (☐ Reactive ☐ Min. Reactive ☐ Nonreactive)

Heart: ☐ RRR ☐irregularity _____ Lungs: ☐ CTAP ☐_____

Impression: 1.
_____
_____
_____

RECOMMENDATION/TREATMENT PLAN (check all that apply)

☐ Patient has reached maximum medical improvement (MMI)
☐ I will continue to prescribe opioids and monitor
☐ I have started to wean patient from opioids and will finish by _____
☐ I referred Patient for consultation. _____Date: _____
☐ I need additional resources to assist me in managing this worker's pain. Please specify:

_____

☐ Other (Please explain)

_____

_____ _____
Provider Date

GENESIS
MEDICAL CLINIC

Patient Name _____ DoB_____

OPIOID RISK TOOL

		Mark box that applies	each Item Score If Female	Item Score If Male
1.	**Family History of Substance Abuse**			
	Alcohol	☐	1	3
	Illegal Drugs	☐	2	3
	Prescription Drugs	☐	4	4
2.	**Personal History of Substance Abuse**			
	Alcohol	☐	3	3
	Illegal Drugs	☐	4	4
	Prescription Drugs	☐	5	5
3.	**Age** (Mark box if 16 – 45)	☐	1	1
4.	**History of Preadolescent Sexual Abuse**	☐	3	0
5.	**Psychological Disease** Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	☐	2	2
	Depression	☐	1	1

TOTAL _____ _____

Total Score Risk Category
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk > 8

Addiction behaviors—within current visit

1. Patient appears sedated or confused (e.g., slurred speech, unresponsive)	Y	N	NA
2. Patient expresses worries about addiction	Y	N	NA
3. Patient expressed a strong preference for a specific type of analgesic or a specific route of administration	Y	N	NA
4. Patient expresses concern about future availability of narcotic	Y	N	NA
5. Patient reports worsened relationships with family	Y	N	NA
6. Patient misrepresented analgesic prescription or use Y N NA			
7. Patient indicated she or he ‘‘needs’’ or ‘‘must have’’ analgesic meds	Y	N	NA
8. Discussion of analgesic meds was the predominant issue of visit	Y	N	NA
9. Patient exhibited lack of interest in rehab or self-management	Y	N	NA
10. Patient reports minimal/inadequate relief from narcotic analgesic	Y	N	NA
11. Patient indicated difficulty with using medication agreement	Y	N	NA

_____ _____
Provider Date

Current Opioid Misuse Measure (COMM)®

The Current Opioid Misuse Measure (COMM)® is a brief patient self-assessment to monitor chronic pain patients on opioid therapy. The COMM was developed with guidance from a group of pain and addiction experts and input from pain management clinicians in the field. Experts and providers identified six key issues to determine if patients already on long-term opioid treatment are exhibiting aberrant medication-related behaviors:

- *Signs & Symptoms of Intoxication*
- *Emotional Volatility*
- *Evidence of Poor Response to Medications*
- *Addiction*
- *Healthcare Use Patterns*
- *Problematic Medication Behavior*

The COMM will help clinicians identify whether a patient, currently on long-term opioid therapy, may be exhibiting aberrant behaviors associated with misuse of opioid medications. In contrast, the Screener and Opioid Assessment for Patients with Pain (SOAPP®) is intended to predict which patients, being considered for long-term opioid therapy, may exhibit aberrant medications behaviors in the future. Since the COMM examines concurrent misuse, it is ideal for helping clinicians monitor patients' aberrant medication-related behaviors over the course of treatment. The COMM is:

- A quick and easy to administer patient-self assessment
- 17 items
- Simple to score
- Completed in less than 10 minutes
- Validated with a group of approximately 500 chronic pain patients on opioid therapy
- Ideal for documenting decisions about the level of monitoring planned for a particular patient or justifying referrals to specialty pain clinic.
- The COMM is for clinician use only. The tool is not meant for commercial distribution.
- The COMM is **NOT** a lie detector. Patients determined to misrepresent themselves will still do so. Other clinical information should be used with COMM scores to decide if and when modifications to particular patient's treatment plan is needed.
- It is important to remember that all chronic pain patients deserve treatment of their pain. Providers who are not comfortable treating certain patients should refer those patients to a specialist.

 The Current Opioid Misuse Measure (COMM)® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

Current Opioid Misuse Measure (COMM)®

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	O	O	O	O	O
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	O	O	O	O	O
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	O	O	O	O	O
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	O	O	O	O	O
5. In the past 30 days, how often have you seriously thought about hurting yourself?	O	O	O	O	O
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	O	O	O	O	O

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
7. In the past 30 days, how often have you been in an argument?	O	O	O	O	O
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	O	O	O	O	O
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	O	O	O	O	O
10. In the past 30 days, how often have you been worried about how you're handling your medications?	O	O	O	O	O
11. In the past 30 days, how often have others been worried about how you're handling your medications?	O	O	O	O	O
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	O	O	O	O	O
13. In the past 30 days, how often have you gotten angry with people?	O	O	O	O	O
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	O	O	O	O	O
15. In the past 30 days, how often have you borrowed pain medication from someone else?	O	O	O	O	O
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	O	O	O	O	O
17. In the past 30 days, how often have you had to visit the Emergency Room?	O	O	O	O	O

Scoring Instructions for the Current Opioid Misuse Measure (COMM)®

To score the COMM, simply add the rating of all the questions. A score of 9 or higher is considered a positive

Sum of Questions	COMM Indication
> or = 9	**+**
< 9	**-**

As for any scale, the results depend on what cutoff score is chosen. A score that is sensitive in detecting patients who are abusing or misusing their opioid medication will necessarily include a number of patients that are not really abusing or misusing their medication. The COMM was intended to over-identify misuse, rather than to mislabel someone as responsible when they are not. This is why a low cut-off score was accepted. We believe that it is more important to identify patients who have only a possibility of misusing their medications than to fail to identify those who are actually abusing their medication. Thus, it is possible that the COMM will result in false positives – patients identified as misusing their medication when they were not.

The table below presents several statistics that describe how effective the COMM is at different cutoff values. These values suggest that the COMM is a sensitive test. This confirms that the COMM is better at identifying who is misusing their medication than identifying who is not misusing. Clinically, a score of 9 or higher will identify 77% of those who actually turn out to be at high risk. The Negative Predictive Values for a cutoff score of 9 is .95, which means that most people who have a negative COMM are likely not misusing their medication. Finally, the Positive likelihood ratio suggests that a positive COMM score (at a cutoff of 9) is over 2 times (2.26 times) as likely to come from someone who is actually misusing their medication (note that, of these statistics, the likelihood ratio is least affected by prevalence rates). All this implies that by using a cutoff score of 9 will ensure that the provider is least likely to miss someone who is really misusing their prescription opioids. However, one should remember that a low COMM score suggests the patient is really at low-risk, while a high COMM score will contain a larger percentage of false positives (about 34%), while at the same time retaining a large percentage of true positives. This could be improved, so that a positive score has a lower false positive rate, but only at the risk of missing more of those who actually do show aberrant behavior.

COMM Cutoff Score	Sensitivity	Specificity	Positive Predictive Value	Negative Predictive Value	Positive Likelihood Ratio	Negative Likelihood Ration
Score 9 or above	.77	.66	.66	.95	2.26	.35

Genesis Medical Clinic
9780 N. 56th St
Tampa, Florida 33617
Phone: (813) 549-7465 Fax: (813) 549-7399

FLORIDA STATUTES

YOU WILL BE PRESCRIBED ONLY NON-NARCOTIC MEDICATIONS IF YOUR URINE IS POSITIVE FOR COCAINE, MARIJUANA, HEROIN, NON-PRESCRIBED MEDICATION OR IF YOUR URINE TEST IS NEGATIVE FOR PRESCRIBED MEDICATION.

YOU WILL BE REFERRED TO AN ADDICTION SPECIALIST AND MUST HAVE A CONSULT AND CLEARANCE BEFORE DR. MERCED OR DR. SIRNA WILL DECIDE IF YOU CAN RETURN AS A PATIENT.

THERE WILL BE NO EXCEPTIONS!

_____ _____

Patient Signature Date

GENESIS
MEDICAL CLINIC

PAIN FOLLOW UP HISTORY

Patient Name:	**Date of birth:**
Physician:	**Today's Date:**

NATURE AND INTENSITY OF PAIN			
1. Where is your pain? Please mention all parts of your body where you have pain:			
2. Check all words that describe your pain and mention part of body next to them:			
	Aching		Cramping
	Dull		Stiffness
	Sharp		Tender
	Throbbing		Exhausting
	Shooting		Tiring
	Radiating		Numbness
	Stabbing		Tingling
	Burning		Heaviness
	Gnawing		Mild
	Penetrating		Moderate
	Stinging		Severe
	Nagging		Excruciating
	Soreness		Unbearable
	Tightness		Miserable
3. Check how often you have pain and mention part of body:			
	Constant		Occasional
	Off and on		Brief
4. What time of day is your pain worst?			
	Morning		Afternoon		Evening		Nighttime

On a scale of 0 (no pain) to 10 (extreme pain)	0	1	2	3	4	5	6	7	8	9	10
5. What was your pain at its worst since last visit?											
6. What was your pain on average since last visit?											
7. What was your average pain with medication?											
8. What is your pain right now?											

9. What makes your pain better?
10. What makes your pain worse?

9780 N 56th St. Suite C • Temple Terrace, FL 33617 • PHONE 813-549-7465 • FAX 813-549-7399

GENESIS
MEDICAL CLINIC

EFFECT OF PAIN ON PHYSICAL AND PSYCHOLOGICAL FUNCTION							
11. What things in your daily life are affected by pain? Check below:							
	Work		Getting out of bed		Taking shower		Wearing clothes
	Doing laundry		Cleaning house		Cooking		Doing dishes
	Doing yard work		Mowing the lawn		Taking out trash		Appetite
	Walking		Climbing stairs		Driving		Grocery shopping
	Going out to eat		Going to beach		Enjoyment of life		Going to school
	Sleep		Concentration		Mood		Sex life
	Relationship with spouse				Relationship with parents		
	Taking care of kids				Taking care of parents or other family		
	Relationship with siblings				Interaction with friends		
	Interaction with coworkers				Interaction with roommate		
	Taking care of pet				Other:		
	Other:				Other:		
12. Does pain affect your sleep?			No		Yes, describe:		
13. Does pain affect your mood?			No		Yes, describe:		
14. Do you have pain related anxiety?			No		Yes, ask staff for anxiety questionnaire		
15. Do you have pain related depression?			No		Yes, ask staff for depression questionnaire		
16. Do you get pain related panic attacks?			No		Yes		
17. Do you have suicidal thoughts?			No		Yes		
18. Does pain make you irritable?			No		Yes		
19. Does pain make you cry?			No		Yes		
20. Does pain make you angry?			No		Yes		

COEXISTING DISEASES AND CONDITIONS, AND PSYCHOSOCIAL HISTORY					
21. What other medical problems do you currently have?					
22. What psychiatric problems do you currently have? Check below:					
	Anxiety		Panic attacks		Depression
	Bipolar disorder		Attention deficit disorder		Obsessive compulsive disorder
	Schizophrenia		Other:		Other:
23. Do you have history of current or past alcohol abuse?		No		Yes, explain:	
24. Do you have history of current or past substance abuse?		No		Yes, explain:	

GENESIS MEDICAL CLINIC

25. Do you have family history of alcohol or substance abuse?		No		Yes, explain:

CURRENT TREATMENTS FOR PAIN								
26. What treatments other than medications are you currently using for your chronic pain?								
	Massage	Where?					Dates:	
	Physical therapy	Where?					Dates:	
	Chiropractic manipulation	Where?					Dates:	
	Injections:	Where?					Dates:	
	Acupuncture	Where?					Dates:	
	VAX-D	Where?					Dates:	
	Hot pack	How many times a day on average?						
	Cold/ice pack	How many times a day on average?						
	TENS unit	How many times a day on average?						
	Daily stretching exercises		Neck		Back		Other joint(s):	
	Other exercises	Describe:						
	Yoga	Describe:						
	Other	Describe:						
27. Are these alternate treatments enough to help your pain so you can physically, socially and psychologically function without using opioid medications?							No	Yes
28. What medications or supplements are you currently using for your pain? Write below:								

Medication or supplement (prescription and over the counter)	Dose	Times per day

GENESIS
MEDICAL CLINIC

PAST TREATMENTS FOR PAIN									
29. What treatments other than medications have you tried for your chronic pain in past?									
	Massage	Where?						Dates:	
	Physical therapy	Where?						Dates:	
	Chiropractic manipulation	Where?						Dates:	
	Injections:	Where?						Dates:	
	Surgery:	Where?						Dates:	
	Acupuncture	Where?						Dates:	
	VAX-D	Where?						Dates:	
	Hot and cold packs								
	TENS unit or electrical stimulation								
	Daily stretching exercises		Neck		Back		Other joint(s):		
	Other exercises	Describe:							
	Yoga	Describe:							
	Other	Describe:							
30. Were these alternate treatments enough to help your pain so you were able to physically, socially and psychologically function without using opioid medications?								No	Yes
31. What medications or supplements have you used for your chronic pain in past? Write below:									
Medication or supplement (prescription and over the counter)							Dose	Times per day	
Patient's signature:									
Physician's signature:									