**FLORIDA PAIN MANAGEMENT ASSOCIATES**
**INTERVENTIONAL PAIN MANAGEMENT**
**(772) 388-9998 FAX (772) 388-9742**
**13825 US HIGHWAY ONE**
**SEBASTIAN, FLORIDA 32958**

**960 37th Place SUITE 102**
**VERO BEACH, FLORIDA 32960**

**HAROLD J. CORDNER, M.D.**
**BOARD CERTIFIED**
**PAIN MANAGEMENT AND ANESTHESIA**

# NEW PATIENT INFORMATION
# WELCOME TO FLORIDA PAIN MANAGEMENT

**The purpose of your first visit is for consultation. During your first visit, you will have the opportunity to discuss your pain and its treatment alternatives. This may include information about procedures, alternative therapies, and the advantages and disadvantages of each. This will allow you to choose, with your doctor, the treatment plan that is best for you.**

**Please take the time to fill out the patient information and the pain assessment form included with this letter. It is important to fill out all forms in their entirety as it will allow us to more thoroughly address your concerns and allow more valuable examination time.** ***We make a concentrated effort to keep all of our patients waiting time to a minimum.*** **THIS MAY REQUIRE RESCHEDULING AN APPOINTMENT IF THESE FORMS ARE NOT FILLED OUT PRIOR TO YOUR VISIT.**
**In addition, please provide any documentation from your doctor- (i.e. MRI's, X-Rays, CT Scans) and reports of any testing you have had done, and ALL office notes pertaining to the reason for your visit. PLEASE OBTAIN AND BRING THE *ACTUAL* PHYSICAL FILMS AND MRI CD'S WITH YOU TO THE APPOINTMENT. These records and films are necessary in assessing your condition. If you are having your physician fax your records, please verify their receipt BEFORE your scheduled appointment. If you show up to your appointment without all the proper documents we may not be able to properly diagnosis you and your condition, and your appointment may have to be rescheduled.**

**We would like to thank you for the opportunity to serve you and we look forward to seeing you soon.**

**Your appointment is scheduled for _____ at _____ in our _____ office.**
**Please arrive 15 minutes prior to your appointment time. Thank you.**

**Attn Patient**:

The Purpose of this letter is to tell you about our general practice policies and position on using controlled substances, such as opioids (narcotics), to treat pain. We want you to be aware that Dr. Harold Cordner specializes in **Interventional** Pain Management he does **not** do long term medication management. It is up to his discretion if he wants to take over any medications that you are currently on. If he does decide to take over your medications they will ***NOT*** be given at your first visit We give this letter to all of our patients. *After you read this letter, tell your doctor if you have any questions*.

We will explore ALL medical treatment options within the scope of our medical practice to help you regain function and lead an active and healthy life, using a variety of treatment methods to accomplish treatment goals, including physical therapy, basic injection procedures, heat and/ or cold therapy, a home exercise program, non-controlled medications and, in some cases, controlled medications. We expect you to obtain your medical records from your primary care doctor and any other doctor who has treated you.

**If** your healthcare practitioner decided to prescribe controlled medications to you as part of your overall treatment plan, he/she *must and will* follow federal and state laws and regulations governing controlled substance prescribing. Here are just a few of the things we may ask you to provide for us in connection with our patient selection and treatment process:

1. Get information from you and your other doctors about your medical history and your past pain treatments, including a list of all medications you take to treat your pain;
2. Ask you whether you or anyone in your family has had a problem with alcohol, illegal drugs, legal drugs, or tobacco; and
3. Ask you to provide a urine sample for testing as part of the initial patient selection process. **If** we accept you into our pain management and rehabilitation program, we may ask you to submit additional urine sample as part of your ongoing treatment program. All urine samples are requested at the discretion of your healthcare practitioner and you will be asked to cooperate with us or we may need to find a way to treat you without controlled medications.

We will monitor your medical condition and supervise your use of medication using various tools in addition to urine drug testing, including medication counts, family conferences, psychological consultations, etc. We do not intend to offend you when we use these tools in our practice.

We want you to know that we are committed to treating you and doing what is medically acceptable and appropriate for you to help you control your pain.. We look forward to serving you and helping you control your pain.

Sincerely,

_____

Dr. Harold J. Cordner

**Patient Signature: _____ Date : _____**

# FLORIDA PAIN MANAGEMENT ASSOCIATES

**To help us meet all of your healthcare needs, please answer the following questions as completely as possible. Thank you.**

**PATIENT INFORMATION:** **DATE:_____**

**NAME:_____ SEX: M F AGE:_____**

**SSN:_____ BIRTHDATE:_____ MARITAL STATUS:_____**

**STREET:_____CITY/ STATE:_____ ZIP:_____**

**HOME #: _____ CELL #: _____ WORK #: _____**

**E-MAIL ADDRESS: _____**

**DO YOU HAVE A LIVING WILL ON FILE: YES OR NO**

**PRIMARY DR : _____ SOURCE OF REFERRAL:_____**

**ARE YOU PRESENTLY: EMPLOYED / RETIRED / DISABLED / UNEMPLOYED**

**WHAT WAS OR IS YOUR OCCUPATION? _____**

**IS THERE A LAWYER INVOLVED WITH YOUR INJURY? _____**
**NAME OF LAWYER: _____**

**PERSON TO CONTACT IN CASE OF EMERGENCY: _____**
**PHONE #: _____**
**RELATION: ___ _____**

**PHARMACY NAME: _____ LOCATION:_____ PHARMACY PHONE#:_____**

**CIRCLE ONE: MEDICARE AUTO WORK COMP SELF-PAY OTHER**
***Please bring your insurance cards and a photo ID with you to your appointment***

**Primary Insurance: _____ Secondary Insurance:_____**

***IF AUTO OR WORK COMP. PLEASE FILL OUT INFORMATION BELOW:**
**Auto/ Work Comp Insurance:_____**
**Adjuster Name: _____**
**Phone #: _____ Ext._____**
**Billing Address: _____ City:_____ Zip Code:_____**
**Claim #: _____ Date of Accident: _____**

**I AUTHORIZE THE RELEASE OF NEEDED INFORMATION TO MY INSURANCE CARRIER, AND I AUTHORIZE PAYMENT OF MY INSURANCE BENEFITS TO FLORIDA PAIN MANAGEMENT ASSOCIATES.**

**_____ _____ PATIENT**
**SIGNATURE DATE**

**FLORIDA PAIN MANAGEMENT**

**Patient Name:_____ Date:_____**

**Height_____ Weight_____**

**___ Yes ___ No** **Problems with Anesthesia?**

**___ Yes ___ No** **Diabetes? Controlled with (circle): Insulin Pills Diet**

**___ Yes ___ No** **Heart Problems? Circle the one that applies:**
**Heart attack (year)_____; Coronary heart disease;**
**Pacemaker/Defibrillator; Irregular heart beat; Palpitations;**
**Other_____**

**___ Yes ___ No** **High Blood Pressure?**

**___ Yes ___ No** **Breathing Problems? (circle) On oxygen; Asthma; COPD;**
**Emphysema; Chronic Cough; Sleep Apnea; Bronchitis;**
**Other_____**

**___ Yes ___ No** **Smoker? _____ packs per day**

**___ Yes ___ No** **Stomach or Digestion problems? GERD/ Reflux**

**___ Yes ___ No** **Stroke: year of stroke_____ Weakness-where_____**

**___ Yes ___ No** **Seizures? How often?_____**

**___ Yes ___ No** **Kidney/ Urinary Problems? Describe: _____**

**___ Yes ___ No** **Liver/ Thyroid Problems? Describe:_____**

**___ Yes ___ No** **Blood Thinners?(circle) Coumadin Pradaxa Warfrin Plavix**
**Aspirin 81mg / 325mg Fish Oil Vitamin E Other_____**

**___ Yes ___ No** **Do you have Cancer? Where?_____ When?_____**
**Undergoing treatment now?_____**

**___ Yes ___ No** **Arthritis? _____**

**___ Yes ___ No** **Psychiatric Problems?_____**

**___ Yes ___ No** **Substance Abuse?_____**

**___ Yes ___ No** **Drink Alcohol? _____ drinks per day _____ per week**

FLORIDA PAIN MANAGEMENT ASSOCIATES
DR. HAROLD CORDNER

13825 US HWY 1, SEBASTIAN, FL
960 37TH PLACE, SUITE 104, VERO, FL

**MEDICATION/DOSAGE** **PRESCRIBED BY** **DIRECTIONS**

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____
12._____
13._____
14._____
15._____
16._____
17._____
18._____
19._____
20._____

PATIENT NAME: _____ DATE: _____

PATIENT ALLERGIES:

_____

_____

**FLORIDA PAIN MANAGEMENT ASSOCIATES**

**PLEASE CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR ANSWERS TO THE FOLLOWING STATEMENTS**

**WHEN YOUR PAIN IS AT ITS WORST**

**0 1 2 3 4 5 6 7 8 9 10**
**NO PAIN MILD DISCOMFORTING DISTRESSING HORRIBLE EXCRUCIATING**

**WHEN YOUR PAIN IS AT ITS LEAST**

**0 1 2 3 4 5 6 7 8 9 10**
**NO PAIN MILD DISCOMFORTING DISTRESSING HORRIBLE EXCRUCIATING**

**WHEN YOUR PAIN IS AT ITS AVERAGE**

**0 1 2 3 4 5 6 7 8 9 10**
**NO PAIN MILD DISCOMFORTING DISTRESSING HORRIBLE EXCRUCIATING**

**WHAT MAKES YOUR PAIN WORSE-(i.e. walking, standing, lifting)_____**

**WHAT MAKES YOUR PAIN BETTER-(i.e. heat, medicine, rest)?_____**

**WHAT TREATMENTS, MEDICATIONS, ETC. HAVE YOU TRIED TO RELIEVE YOUR PAIN? HAVE ANY OF THEM WORKED? _____**

**REASON FOR YOUR CONSULTATION TODAY:**

**Is there any other medical problem we should know about?**

**List Surgeries:**

**_____YR. _____ _____YR. _____**
**_____YR._____ _____ YR. _____**
**_____YR._____ _____YR._____**

FLORIDA PAIN MANAGEMENT

# PAYMENT AGREEMENT & CANCELLATION POLICY

Please read the following agreement. It explains your financial obligations while under our care and our policies regarding cancellations.

- **Co-pays are always due at the time of service**

- We do accept **SELF-PAY patients (i.e. Patients with *NO* insurance)**, however:
    - **An initial consultation is $250 that is due at the time of service**
    - Follow up visits are either $100 or $135 based off the level of service and is also collected at the time of service.
    - If a procedure is scheduled- a fee schedule will be discussed with you prior to the appointment day. The amount discussed will be due at the time of service.

- **Regretfully, we have been forced to institute this policy due to a large volume of last-minute cancellations, scheduling changes, and "no-shows."**

- We have a very busy practice. Assuring that all our established patients have access to their doctor when necessary is a constant challenge. When you cancel or reschedule at the last minute, or fail to show for your appointment, you are depriving another patient the care they need.

- New patient visits require our doctor to block out large time slots, making last-minute cancellations and rescheduling of visits even more problematic. We provide a large amount of time and attention with each and every one of our new patients because we are committed to providing the highest quality care.

- **All new patients are required to verbally confirm their appointment 24 to 48 hours' prior**. If you fail to verbally confirm your appointment during our normal office hours your appointment will be cancelled.

    - **New Patient Appointments**:
        - If you fail to show for your appointment you will be charged $50.

    - **Follow- Up Visits**:
        - If you fail to show for your appointment without notification you will be charged $35.
        - If you continue to cancel, reschedule, or fail to show up for your scheduled appointments you may be discharged from our practice

By signing this payment agreement & cancellation policy, you are indicating that you understand and agree to the terms of service explained above.

Patient Signature: _____ Date: _____

FLORIDA PAIN MANAGEMENT

# CONFIDENTIALITY STATEMENT-HIPAA

Your privacy is important to us. All medical records and interactions between doctor and patient are entirely confidential.

Outlined below is a brief summary of your rights and protections under the Health Insurance Portability and Accountability Act (HIPAA). You can learn more about your right from the website at http://www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used or shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Request where you would like to be contacted
- Ask that your information not be shared. For example, you could ask your doctor not to share your medical record with other doctors in the office.

If you believe your rights are being denied or your health information isn't being protected, you can:

- File a complaint with your doctor.
- File a complaint with the U.S. Government.

If it is necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public, your doctor has the obligation to disclose and relevant information.

Patient Name/ Legal Guardian: _____

Patient Signature: _____ Date: _____

FLORIDA PAIN MANAGEMENT

# MY PROTECTED HEALTH INFORMATION AUTHORIZATION

1. I authorize the use and/or disclosure of my protected health information for whatever Dr. Harold Cordner deems necessary for my medical care. To include but not limited to: Pharmacies, Hospitals, Physicians Referred To, Physicians Referred By, Diagnostic Facilities, Nursing Home, Insurance Companies, Work Comp Carriers, Health Facilities, and Family Members.

2. If you would like to EXCLUDE anyone from obtaining your health information (i.e. Facilities, Family Members) Please list them below:

_____
_____
_____
_____
_____

3. I understand that I have the right to revoke this authorization at any time. My revocation must be in writing and I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

4. I understand that I have the right to inspect and copy my own protected health information to be used or disclosed. [In accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. (164.524)]

5. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Dr. Harold Cordner, nor will it affect my eligibility for benefits.

Patient Signature_____ Date:_____

**FLORIDA PAIN MANAGEMENT ASSCOCIATES**

***FAX #: (772) 388-9742***

# Medical Records Release Form

**Patient Name: _____ D.O.B. : _____**

**Phone #: _____**

**I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by initialing this form; I am specifically authorizing the release of this information**.

**Initial: _____ Date: _____**

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

**Release my protected health information to the following person(s)/entity:**

**Name: DR. HAROLD CORDNER**

**Street: 13825 US Highway 1**

**City: SEBASTIAN State: FL Zip: 32958**

**I <u>DO</u> give permission for these records to be faxed to the above entity.**

**The reasons or purposes for this release of information are as follows:**

**Office notes, MRI, CT and/ or actual X-Ray films, Procedure notes**

**Patient Signature [or parent, guardian or legal representative] Date**

To our patients,

With the present climate of healthcare and declining reimbursements, it has become necessary to change certain policies in our practice. Because of these issues and a large amount of patients with unpaid balances, we will be making the following changes to enable us to maintain our practice.

Effective immediately, we will be **requiring all patients** to have a credit card on file. We will bill your balance by our usual statements. If the balance is not paid in one month's time, we will charge your credit card on file.

For patients with payment plans, we will have to change the parameters of the payment plans. We will be requiring the balance to be paid off within three months, as we can no longer afford to continue to finance the large amount of accounts outstanding that we have. We understand this is a drastic change in our policy, but it is a necessary change needed to implement in order for Florida Pain Management to continue to survive and to give you the quality care that you are accustomed to.

Please contact our billing department with any concerns regarding this policy.

Thank you for your understanding in this matter.

Harold J Cordner, MD and staff

Name on Card:_____ D.O.B:___/___/____

Credit Card Billing Address:_____

City:_____ State:_____ Zip:_____

Telephone: (_____) _____ - _____ Cell: (_____) _____ - _____

American Express___ Discover___ MasterCard___ Visa___

Credit Card #:_____ Exp Date: ___/_____ CVC:_____

Print Name:_____ Date:___/___/_____

Signature:_____ Date:___/___/_____