JPC
JACKSONVILLE
PAIN CENTER
.....Center for excellent care

Hemant Shah, M.D.
Medical Director
Board Certified in Pain Management
Board Certified in Anesthesiology

PATIENT REGISTRATION INFORMATION

Date:_____ SocSec#_____

Name: Last_____ First_____ MI_____

Home Address:_____City_____ State_____Zipcode_____
DOB_____

Home #_____Cell#_____Work#_____

Patient
Occupation:_____Status:Married_____Single_____Widowed_____Divorced_____

Referring Physician:_____

Pharmacy:_____Pharmacy#_____

Patient Employer:_____

Address:_____City_____State_____ZipCode_____

In case of an emergency, please notify:_____

Relationship to Patient:_____Phone:_____

Address:_____City_____State_____ZipCode_____

Purpose of Visit:_____

Insurance Information:

Primary Insurance:_____

Identification #:_____Group #:_____

Policyholder's Name:(if different from patient)_____Phone_____

Policyholder's S.S.#:_____Date of Birth:_____

Address: Street_____City_____State_____ZipCode_____

Secondary Insurance: _____

Identification #:_____Group #:_____

Policyholder's Name:(if different from patient)_____Phone_____

Policyholder's S.S.#:_____Date of Birth:_____

Address: Street_____City_____State_____ZipCode_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the rendered physician or supplier for services. I hereby authorize payment for my medical services to Jacksonville Pain Center. I agree to pay any charges not covered by insurance. I herby authorize Jacksonville Pain Center to release to my insurance company any information required for payment, including diagnosis information and records required in the course of my examination or treatment.

_____ _____

Signed Date

JACKSONVILLE
PAIN CENTER
.....Center for excellent care

Health Care Designation Form

With respect to the privacy of your health care information and the HIPAA privacy laws, you can designate an authorized person for the following purposes:

1. **Schedule/Cancel Appointments**
2. **Pick up scripts for medication**
3. **Discuss your medical care and treatment**
4. **Other:** _____

Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

SIGNATURE: _____ DATE: _____
PRINT: _____ DOB: _____

9421 Waypoint Place, Jacksonville, Florida 32257
1201 Monument Rd., # 301, Jacksonville, FL 32225
Phone: (904) 268-8200 // Fax: (904) 268-8298 // Email: jaxpaincenter@yahoo.com
www.jacksonvillepaincenter.com

JACKSONVILLE
PAIN CENTER
..Center for excellent care

Hemant Shah, M.D.
Medical Director
Board Certified in Pain Management
Board Certified in Anesthesiology

Records Release Authorization

I hereby authorize_____ to Release any information requested including the diagnosis and records of any treatment, examination notes, and imaging that can further assist the Doctor with my medical care. You may fax or send my medical information to Jacksonville Pain Center, the office of Dr. Hemant Shah, M.D. Thank-you for your time in assisting me with my care.

Signature _____ **Date** _____

Print _____ **Date of Birth** _____

This request form will expire one year from the date signed.

• 9421 Waypoint Place, Jacksonville, Florida 32257
• 1201 Monument Rd., # 301, Jacksonville, Florida 32225
Mailing Address: P.O. Box 600290 • Jacksonville, Florida 32260
phone: 904.268.8200 • *fax*: 904.268.8298
www.jacksonvillepaincenter.com

JACKSONVILLE PAIN CENTER

9421 Waypoint Place• Jacksonville, FL 32257
1201 Monument Road, Suite 310• Jacksonville, FL 32225
Phone: 904.268.8200 • *Fax*: 904.268.8298
www.jacksonvillepaincenter.com

PATIENT DATA SHEET

Date:_____

Name: _____ Age: _____ Height: _____ Weight: _____

Family Physician: _____ Referring Physician: _____

Lawyer: ☐ Yes ☐ No Name: _____

Chief Complaint: (Reason for visit) _____

Medical History: Check here if all are negative ☐

☐ High Blood Pressure
☐ Heart disease
☐ Heart attack
☐ Irregular heart rhythm
☐ Stroke
☐ Seizures
☐ Glaucoma
☐ Fibromyalgia
☐ Hepatitis/liver disease
☐ Kidney Problems
☐ Thyroid Disease
☐ Diabetes
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Depression _____
☐ Other _____
☐ Phlebitis/blood clots
☐ Stomach Ulcer Disease
☐ Bleeding Disorder
☐ Asthma
☐ Emphysema/COPD
☐ Cancer (What kind) _____
_____
_____

Surgical History: Check here if none ☐

☐ Low Back Surgery (when) _____
☐ Heart Surgery (year) _____
☐ Joint replacement (which) _____
☐ Neck Surgery (when) _____
☐ Cancer Surgery _____
☐ Appendix ☐ Hernia ☐ Gallbladder ☐ Others _____

Allergies: Check here if none ☐

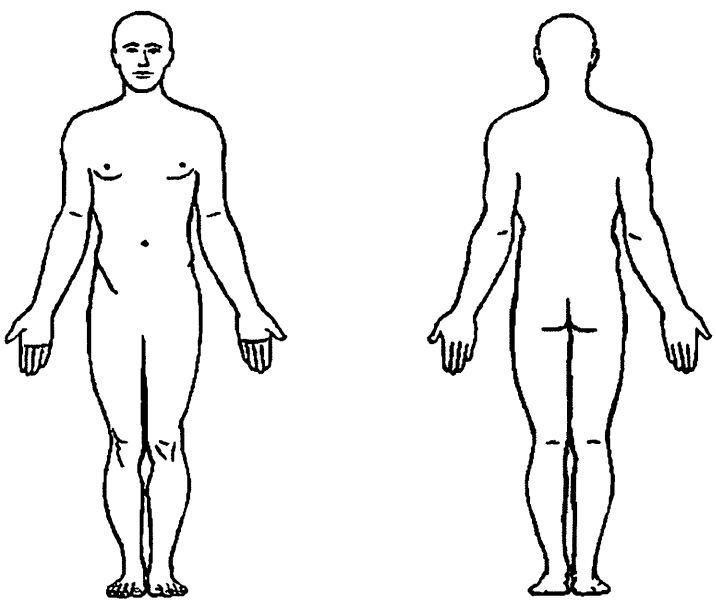
Foods _____ ☐ Iodine ☐ I V Dye ☐ Latex ☐ Adhesive Tape

☐ Penicillin ☐ Sulfa ☐ Others _____

PLEASE MARK PAINFUL AREA

Current Medications:

Name of drug	Dose and direction



JACKSONVILLE PAIN CENTER

9421 Waypoint Place• Jacksonville, FL 32257
1201 Monument Road, Suite 310• Jacksonville, FL 32225
Phone: 904.268.8200 • *Fax*: 904.268.8298
www.jacksonvillepaincenter.com

Patient Name: _____ **Date:** _____

Social History:

Occupation: _____ ☐ Full Time ☐ Part Time ☐ Disabled
Spouse's Occupation: _____ ☐ Full Time ☐ Part Time ☐ Disabled
Education: _____grade ☐ High School ☐ College ☐ Post Graduate
Single ☐ Married ☐ Divorced ☐ Other ☐ Children: _____
Tobacco: ☐ Never ☐ Stopped _____Year ☐ Currently smoking # Packs per day _____ Age Started _____
Alcohol: ☐ None ☐ Daily ☐ Few per week ☐ 1 per week ☐ few per month ☐ rare
Illegal Drug Use: ☐ None ☐ THC ☐ Cocaine
Exercise: ☐ None ☐ Daily ☐Few times per week ☐ 1 /week ☐ 1 / month ☐ Other _____

Family History:

Father : ☐ Alive ☐ Deceased...Age____ Cause/medical conditions _____
Mother : ☐ Alive ☐ Deceased...Age____ Cause/medical conditions _____

Review of Systems:

Possibly Pregnant: ☐ Yes ☐ No

☐None General: ☐Numbness/tingling ☐local weakness ☐new incontinence (urine/stool)

☐None Constitutional:☐fever ☐weight loss ☐tiredness ☐weight gain

☐None Eyes: ☐blurred vision ☐glaucoma ☐double vision

☐None Ear Nose Throat: ☐deafness ☐ringing ☐dizziness ☐vertigo

☐None Heart: ☐chest pain ☐Irregular heart beat ☐high blood pressure ☐pounding in chest

☐None Lungs: ☐shortness of breath ☐wheezing ☐cough ☐cough up blood ☐COPD

☐None Abdomen:☐diarrhea ☐constipation ☐black stools ☐bloody stools heartburn ☐stomach bleeding

☐None Urinary: ☐burning ☐loss of urine ☐blood in urine ☐kidney disease

☐None Menstrual: ☐regular ☐irregular ☐severe pain ☐post menopausal

☐None Musculoskeletal: ☐sprains ☐Rheumatoid arthritis ☐swelling ☐stiffness

☐None Skin/Breast: ☐rash ☐sores ☐lumps ☐masses

☐None Neurologic: ☐balance problems ☐memory problems ☐falls

☐None Behavioral: ☐depression ☐anxiety ☐sleep disturbance ☐hallucinations

☐None Endocrine: ☐sleeps all the time ☐hyperactive

☐None Blood/lymphatic: ☐easy bruising ☐bleeding problems ☐anemia ☐Sickle cell

☐None Immunologic: ☐itching ☐frequent colds/infections

JACKSONVILLE
PAIN CENTER
.....Center for excellent care

Insurance information consent

I certify that the insurance information I have given to the Jacksonville Pain Center and Dr. Hemant Shah is current. I understand that if there are any changes in my insurance, I must notify Jacksonville Pain Center and Dr. Hemant Shah immediately. If I fail to notify as mentioned above, I accept responsibility for any charges incurred for non-authorization or non-covered services.

Patient Signature _____ Date _____

• 9421 Waypoint Place, Jacksonville, FL 32257
• 1201 Monument Rd., Suite 301, Jacksonville, FL 32225
Phone: (904) 268-8200; Fax: (904) 268-8298 ; Email: jaxpaincenter@yahoo.com

JACKSONVILLE
PAIN CENTER
.....Center for excellent care

Receipt of Notice of Privacy Practices / Written Acknowledgement Form

I have received a copy of Jacksonville Pain Center's Notice of Privacy Practices.

Patient Signature _____ Date _____

• 9421 Waypoint Place, Jacksonville, FL 32257
• 1201 Monument Rd., Suite 301, Jacksonville, FL 32225
Phone: (904) 268-8200; Fax: (904) 268-8298 ; Email: jaxpaincenter@yahoo.com

JACKSONVILLE
PAIN CENTER
.....Center for excellent care

Insurance Disclaimer form

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Hemant Shah for any services furnished to me by the physician and/ or clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. For the Medicare patients having secondary insurance, we will bill active secondary insurance except Medicaid and Humana or other insurance where we are not in network. It is patient's responsibility to incur any charges remaining from Medicare in such cases.

Patient's Full name _____ Date _____ Dr. Hemant Shah _____

Patients' Signature _____

• 9421 Waypoint Place, Jacksonville, FL 32257
• 1201 Monument Rd., Suite 301, Jacksonville, FL 32225
Phone: (904) 268-8200; Fax: (904) 268-8298 ; Email: jaxpaincenter@yahoo.com

JACKSONVILLE
PAIN CENTER
.....Center for excellent care

Release of information consent

I authorize Jacksonville Pain Center to release any information acquired in the course of my examination or treatment to my insurance company, to a hospital, to which I am admitted or to a referral physician or other physician, and permit payments to be made directly to them, at their election, of any benefit due me for the services rendered.

I accept and recognize responsibility for any balance remaining after the payment of such benefit. I also understand that a copy of this statement can be used as valid proof.

The assignment of insurance monies does not alter the undersigned obligation to pay. I understand that all charges resulting from said treatment are due when statements are presented- including that portion of that charges covered by that insurance company, given reasonable length of time.

I, the undersigned, agreed to pay all cost of collection, and suit be necessary to enforce collection, pay all cost of said suit to gather with a reasonable attorney fee and court cost.

_____ _____

Patient Signature Date

Assignment and Release

I, the undersigned, have insurance with _____ and assign directly to Dr. Hemant Shah all medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor to release all information necessary to secure payment of the benefit. I authorized the use of the signature in all my insurance submissions.

_____ _____

Patient / responsible party Signature Date

• 9421 Waypoint Place, Jacksonville, FL 32257
• 1201 Monument Rd., Suite 301, Jacksonville, FL 32225
Phone: (904) 268-8200; Fax: (904) 268-8298 ; Email: jaxpaincenter@yahoo.com

JACKSONVILLE
PAIN CENTER
.....Center for excellent care

Controlled substance (Medication) agreement

We are committed to doing all we can to treat your chronic pain condition. In some cases, in addition to interventional therapy (Injection techniques), Opioid and other controlled substances are used as a therapeutic option in the management of chronic pain and related conditions, all of which are strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper controlled substance use.

1. All controlled substances (Pain medication) have a potential for side effects, dependency, addiction and/or abuse.
2. All controlled substances must come from Dr. Hemant Shah, his associate physician, or during their absence, by the covering physician, unless specific authorization is obtained for an exception.
3. All controlled substances must be obtained from the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be notified. The pharmacy that you have selected is: _____ Phone: _____
4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacies or other professional who provide your health care for purpose of maintaining accountability.
5. You should not share, sell, or otherwise permit others including spouse or family members to have access to your medications. Take medications only as prescribed or advised.
6. Unannounced urine, buccal or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may result in your discharge from the facility.
7. You will not consume alcohol in conjunction with narcotics, nor will use, purchase, or otherwise obtain any illegal drugs.
8. If you are on controlled substance / Pain Medication, you cannot drive or operate machinery as medication can cause change in your alertness.
9. Medications may not be replaced if they are lost, get wet, are destroyed, left on the airplane or vacation places, etc. If your medication has been stolen, it may not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told to Dr. Shah is not enough.
10. If the responsible legal authorities have questions concerning treatment, as might occur, (for example, if you were obtaining medication at several pharmacies), all confidentiality is waived and these authorities may be given full access to your medical records of controlled substances administration.
11. Early refill may not be given. Renewals are based upon keeping scheduled appointments with Dr. Hemant Shah. Please do not phone for prescriptions after hours or on weekends.
12. In the event, you are arrested or incarcerated related to legal or illegal drugs, refills on controlled substances may not be given.
13. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or discharge from the facility.
14. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understood, and accept all of its terms.

_____	_____	_____
Patient's Full name	Date	Dr. Hemant Shah

_____
Patients' Signature

• 9421 Waypoint Place, Jacksonville, FL 32257
• 1201 Monument Rd., Suite 301, Jacksonville, FL 32225
Phone: (904) 268-8200; Fax: (904) 268-8298 ; Email: jaxpaincenter@yahoo.com