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 ____________________

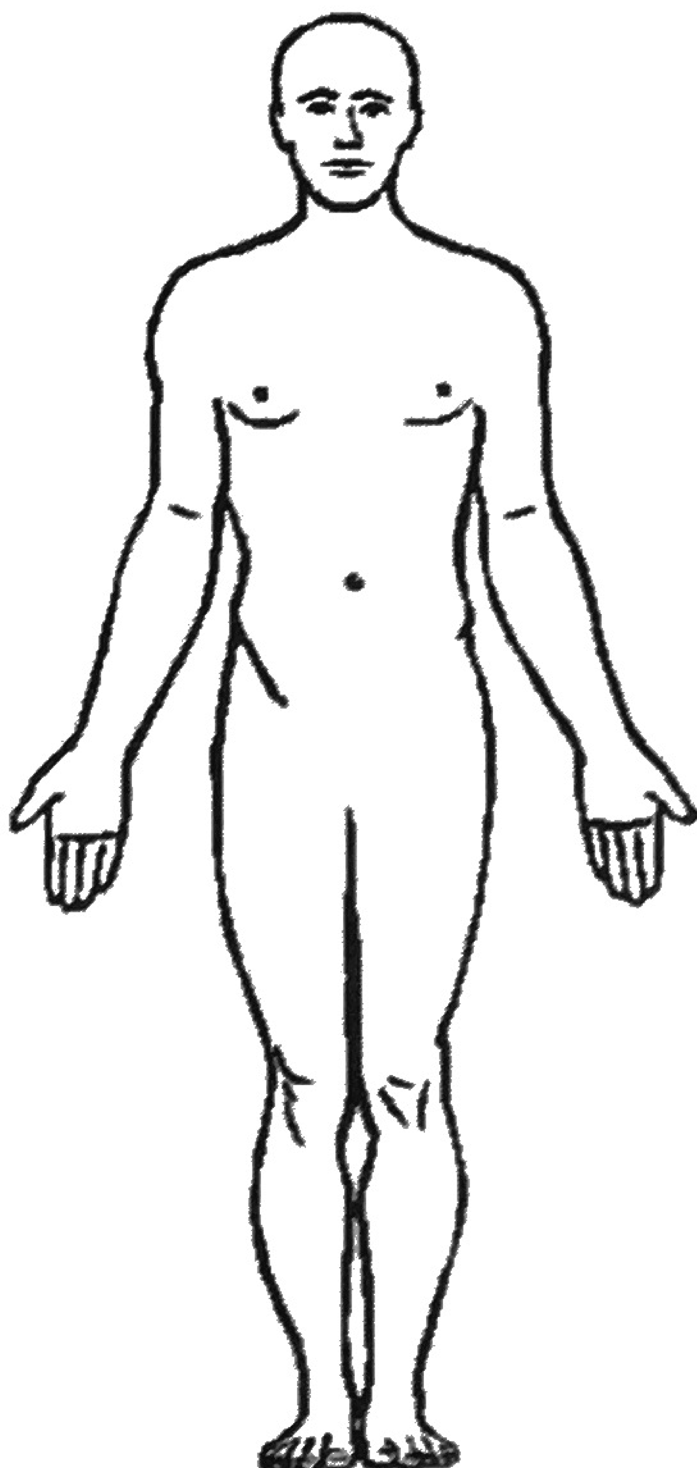
Allergies: Check here if none ☐

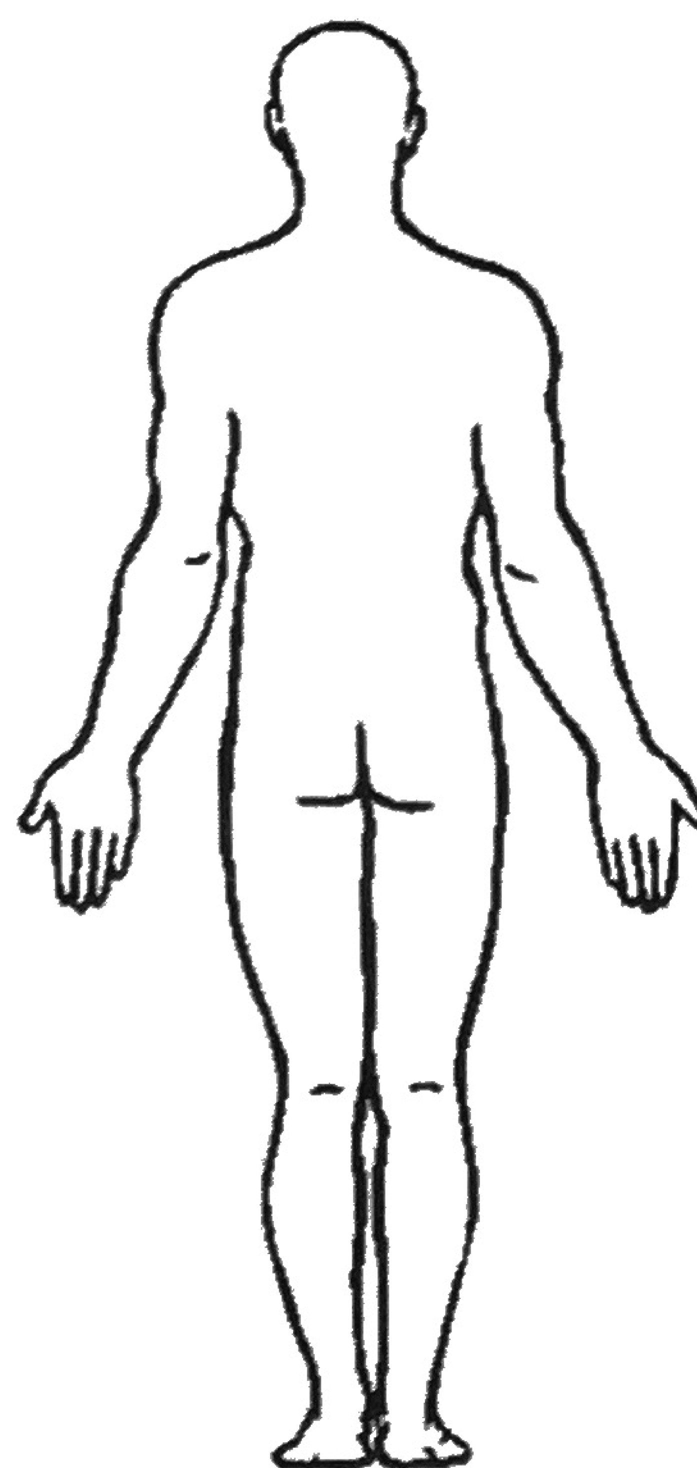
Foods ________________________ ☐ Iodine ☐ I V Dye ☐ Latex ☐ Adhesive Tape
☐ Penicillin ☐ Sulfa ☐ Others ______________________________________

Current Medications:

Name of drug	Dose and direction

PLEASE MARK PAINFUL AREA





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

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

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 give my consent to Jacksonville Pain Center, and all its agents to make report to or otherwise co-operate with any law enforcement officials or regulatory agencies in any investigation which may arise as a result of treatment or related to my receiving prescriptions as a patient of Jacksonville Pain Center or if Jacksonville Pain Center or its agents suspect illegal activity. I waive any and all rights of privacy and privilege in this regards and these authorities may be given full access to my records held by Jacksonville Pain Center without order of clerk or court.

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

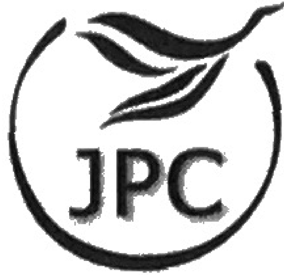
Assignment and Release

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, opioids 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 have a potential for dependency and abuse.
2. All controlled substances must come from the physician whose signature appears below or, during his absence, by the covering physician, unless specific authorization is obtained for an exception.
3. All controlled substances must be obtained at 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 these medications.
6. Unannounced urine 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 will 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 our records of controlled substances administration.
11. Early refill will 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 will 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

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

Office Policies

Appointments:

- ☐ Please call (904) 268-8200 for appointments, scheduling, rescheduling and cancellation.
- ☐ We requires 24 hr. notice for cancellation of appointments
- ☐ Please write down the day and time of your appointments. At this time, it is not our office procedure to call patients and remind them of appointments.
- ☐ Missed appointments may results in $ 25.00 fee, which must be paid in full prior to scheduling your next appointment.
- ☐ Please be on time for your appointment. If you are running late, please call office to find if rescheduling your appointment is more advisable.

Financial Obligations:

- ☐ Payment (Including Co-Payments and deductible) is expected when service is rendered.
- ☐ There will be $ 15.00 fee per page to complete any disability, parking permit or any forms. The forms may not be ready same day. Please call office to find, when the forms are ready to be picked up.
- ☐ There will be $ 35.00 charge for any returned check in addition to the amount of the check. Once you have had a returned check, we will no longer be able to accept personal checks. You will be required to pay with cash or money order.

Phone Calls:

- ☐ For all emergencies, please call 911 or report to nearest emergency room.
- ☐ Please leave message for any question or concern and the call will be returned as soon as possible. Please do not call repeatedly throughout the day.

Medication refills:

- ☐ Please call your pharmacy for prescription refill. They will send us fax authorization and Dr. Shah will authorize refill based on your chart review.
- ☐ If you need a written prescription, please call office and allow us 24-48 hour for the refill.
- ☐ If you have someone else picking up the prescription, you must sign and date a note stating your approval to them to do so. Please include the name of person in the note, who will be picking up your prescription. They must present the note and a picture ID each time to the front desk when picking up prescriptions.
- ☐ Early refills on medication will not be given.

Insurance:

- ☐ If your insurance plan requires a "referral" from your primary care physician, you will need to contact your PCP for the referral. This is the patient's responsibility, NOT the responsibility of this office. Treatment provided by our office without the required referral will serve as your consent for treatment not covered by your insurance and will be payable upon receipt of a statement from our office..
- ☐ In the event that your health plan determines a service to be "not covered", you will be responsible for the negotiated rate for the service performed. Payment is due upon receipt of a statement from our office.

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