St. Anthony Health Care, LLC

2103 S. McCall Rd. Englewood, Fl 34224
Lew Anthony Little, MD
Phone: (941) 441-9007 Fax: (941) 249-3119

New Patient Application

Lew A. Little | M.D.

Dr. Lew Little is a compassionate physician with an overwhelming will to treat patient's while simultaneously educating them to treat themselves. Both an educator and a learner, Dr. Little's education began by graduating with an A.S. of Pre-Medicine at Burlington County Community College, and with a B.S. of Chemistry at Stockton University and excelled with Cum Laude honors. Dr. Little then went on to St. George's University School of Medicine and gained a diverse international perspective at this acclaimed university in Grenada. He continued to receive an internship of internal medicine at Flushing Hospital Medical Center in affiliation with the Albert Einstein College of Medicine. Dr. Little then pursued residency in anesthesiology at SUNY - Brooklyn Downstate Medical Center. Dr. Little then went on to pursue a prestigious fellowship with the Beth Israel Deaconess Medical Center, in affiliation with the Harvard School of Medicine. Dr. Lew Little is now a member of the Florida Medical Association, American Academy of Pain Management, and the Florida Society of Interventional Pain Physicians. After becoming the Medical Director of St. Anthony Health Care in 2012, he was steadfast in becoming an addiction specialist and trained as a Suboxone/Buprenorphine provider. Following the (super)majority vote in favor of Medical Cannabis in 2016, Dr. Little was also quick to become a physician registered with the Florida Department of Health's Office of Compassionate Use. Dr. Little has received numerous commendations and accolades for an individual whom his patients proudly state is the "Most Compassionate Doctor."

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PATIENT INFORMATION FORM

NAME: _____ **AGE:** _____ **DATE OF BIRTH:** _____

Address: _____ City: _____

State: _____ Zip: _____ Social Security: _____ Sex: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Work Phone: _____

SPOUSE: _____ Date of Birth: _____ Phone Number: _____

EMERGENCY CONTACT: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

PRIMARY INSURANCE: _____

Address: _____ Phone: _____

Subscriber #: _____ ID #: _____ Group #: _____

SECONDARY INSURANCE: _____

Address: _____ Phone: _____

Subscriber #: _____ ID #: _____ Group #: _____

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Program Evaluation Supplemental Descriptor Form

PATIENT'S NAME:_____**DATE:** _____

Education (Highest level attained)		Litigation Status	
	Less than high school		Pending litigation
	Equivalent test		Case settled
	High school graduate		None/Not Applicable
	Partial college degree		
	College degree		
	Post Graduate Education		

Employment Status (present)		Primary Site of Pain (check one)	
	Employed (FT)		Head
	Employed (PT)		Neck
	Unemployed for less than 1 month		Shoulders
	Unemployed for less 1-2 months		Back
	Unemployed for less 2-6 months		Upper Extremity (arms, hands, etc)
	Unemployed for less 6-12 months		Lower Extremity (legs, feet, etc)
	Unemployed for more than 12 months		Abdomen
	Retired		Pelvic (hips, etc)
	Student		Cancer pain (anywhere)
	Not Applicable		Spasticity (MS, spinal-cord injury)

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PATIENT HEALTH HISTORY

NAME: _____

Date of birth: _____ Age: _____Male: _____ Female: _____

Where is your pain? _____

When did the pain start?_____

What makes it better? _____

What makes it worse?_____

CURRENT MEDICATIONS "Attach Med List If Needed"

Please list your current medications. strength, dose/day, prescribing physician, last date filled)

_____ _____ _____

_____ _____ _____

FAILED MEDICATIONS

List any previously taken pain medications that you stopped taking and the reasons for stopping.

_____ _____ _____

_____ _____ _____

ALLERGIES: Do you have any symptoms like red itchy eyes, general itching, shortness of breath, wheezing, fast heartbeat, feeling faint, nausea, or vomiting when exposed to any of the following:

DYE_____ **IODINE**_____ **LATEX**_____

NO KNOWN DRUG ALLERGIES: _____

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TREATMENTS: Check any treatments that you have had.

	Physical Therapy	Pain Relief? (circle one)	Yes	No	Temporary
	Massage Therapy	Pain Relief? (circle one)	Yes	No	Temporary
	Chiropractor	Pain Relief? (circle one)	Yes	No	Temporary
	Ten's Unit	Pain Relief? (circle one)	Yes	No	Temporary

Surgery: (circle one)	Neck	Back	Knee	Wrist	Elbow	Head

Pain Relief From Surgery? (circle one)	Yes	No	Temporary

Injections: (circle one)	Epidural	Steroids	Synvisc
Pain Relief from Injections? (circle one)	Yes	No	Temporary

PAIN QUALITY: Circle any that apply.

Constant Burning Sharp Cutting Throbbing Cramping

Shooting Pressure Pins/Needles Aching Numbness

PAST MEDICAL HISTORY: Have you had any of the following? Please circle all that apply.

High Blood Pressure Angina Stroke Heart Attack Diabetes Hypothyroid

Hyperthyroid Migraines Seizures Kidney Disease Liver Disease Hep A

Hep B Hep C Arthritis Alcohol/Drug Problem Stomach/Intestinal Problems

Cancer Chronic Cough COPD Asthma Emphysema Tuberculosis

HIV Anemia Psychological or Psychiatric Problems

SURGERY / PAIN PROCEDURE:

Surgery / Pain Procedure	Date	Physician	Hospital

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SOCIAL HISTORY

Employed? _____ Full Time: _____ Part Time: _____ Unemployed: _____Disabled: ____

Married: _____ Single: _____Divorced: _____ Living with significant other:_____

Number of children: _____ Oldest to youngest: _____

Smoke? _____ Cigars? _____Cigarettes? _____ How many packs daily? _____

Alcohol? _____ How many per day? _____ Per week? _____

Illegal/Street Drugs? _____ In the past? _____ Type?_____

Do you currently use Medical Marijuana for your chronic pain? Yes No

Are you interested in Medical Marijuana therapy? Yes No

FAMILY HISTORY: Please list any pertinent family medical history.

_____

_____

_____

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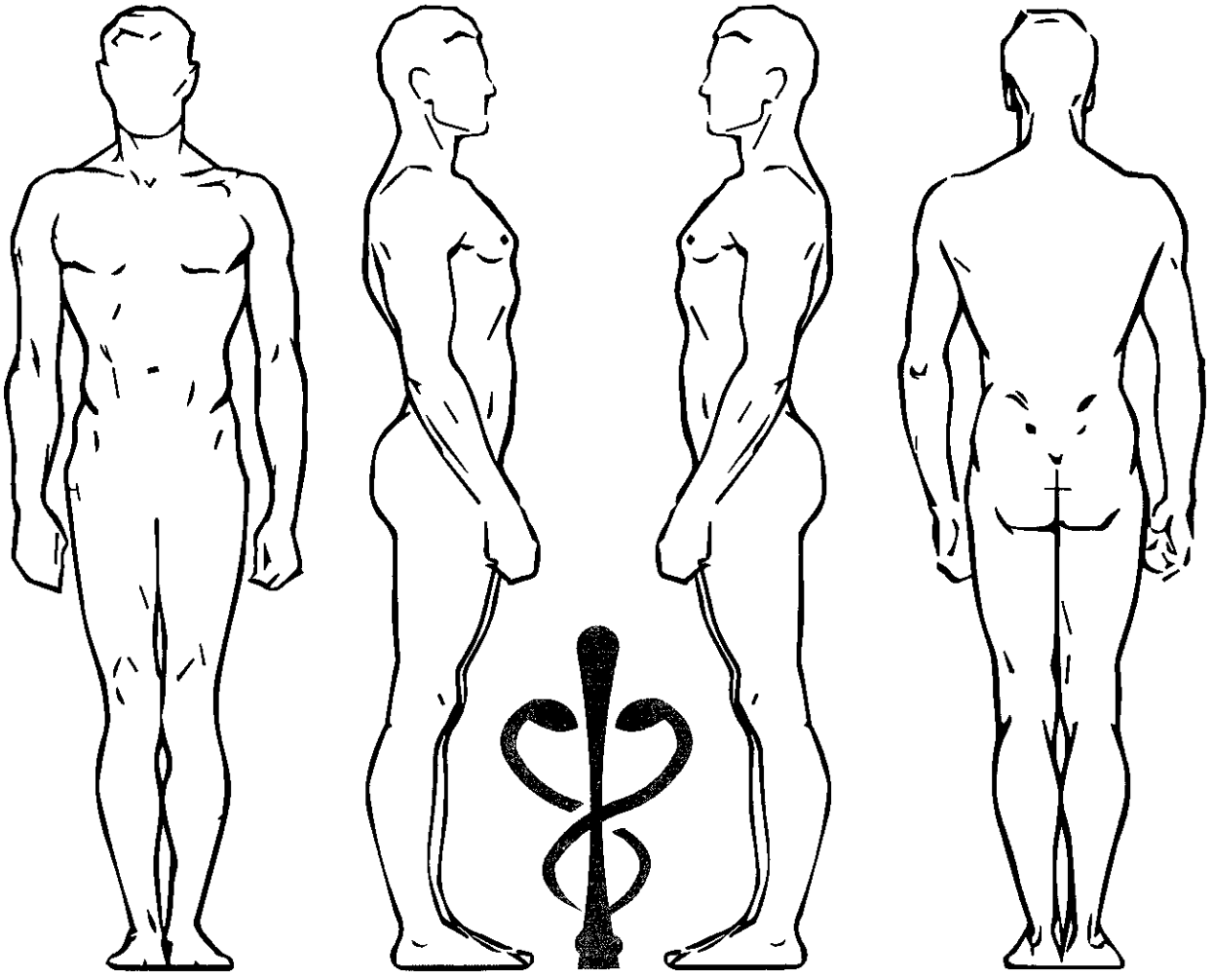

Mark with an X your pain on body outlines.

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HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name:_____DOB:_____

Address:_____ State:_____ Zip_____

Home Phone:_____Cell Phone:_____ Last 4 digits of SS#:_____

(1) Doctor's Name:_____State:_____Last Visit:_____

Phone Number:_____ Fax Number:_____ ⬅ MUST HAVE FAX#

(2) Doctor's Name:_____State:_____Last Visit:_____

Phone Number:_____ Fax Number:_____ ⬅ MUST HAVE FAX#

(3) Doctor's Name:_____State:_____Last Visit:_____

Phone Number:_____ Fax Number:_____ ⬅ MUST HAVE FAX#

(4) Doctor's Name:_____State:_____Last Visit:_____

Phone Number: _____ Fax Number: _____ ⬅ MUST HAVE FAX#

IF POSSIBLE, PLEASE FAX THE FOLLOWING MEDICAL RECORDS BEFORE_____

Last 2 Visit Notes: ✖ All Imaging Reports: ✖ Discharge Note: ✖

Please send only the records requested above.

I, the undersigned authorize the above information to be sent to: St Anthony Health Care located at 2103 S McCall Rd in Englewood Florida 34224 This authorization extends to history of illness, diagnosis, and therapeutic information: including any treatment for drug and alcohol abuse, HIV testing and/or AIDS related information. In compliance with Florida Statute 397.507(7), 394, 4615, and Federal Law CFR 4.2. I may revoke this authorization at any time in writing, but if I do, it will not have an effect, or any actions taken prior to receiving the revocations, if not revoked his authorization will expire in 180 days from date of signature below.

Signature of Patient/Guardian: _____ Date: _____

Relationship if not signed by patient_____

WE MUST HAVE THE MEDICAL RECORDS FAX NUMBERS TO GET YOUR RECORDS.

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80/20 Equianalgesic Pharmacotherapy Opioid Dosing Addendum

I have agreed to use narcotics as part of my treatment for my chronic pain. I understand that these drugs are very useful but have potential for misuse and are therefore closely controlled by the local, state, and federal government(s). I verify I have read, understood, and signed the Pain Management/Treatment Agreement. Because my physician is prescribing such medication to help manage my pain, I agree to the following conditions/regulations set forth by the Federal and State Governments, without reservations:

I agree to comply with new federal guidelines/rules setting balance of long-acting to short-acting pharmacotherapy opioid intake. The ratio as part of a daily dose of narcotic medication is 80% long-acting to 20% short-acting (breakthrough).

I also understand that this is a strict balance that is beyond the discretion of my physician and I must comply with this rule without exception. If I do not follow this rule and do not take my medication as prescribed, I understand I risk discharge from this Practice.

I, _____ have read and all pages of the pain management/narcotic treatment contract or it has been read to me and all my questions regarding the treatment of pain with narcotic/pain medicines have been answered to my satisfaction. I confirm I have signed the prior-mentioned agreement without reservations. I hereby communicate my understanding and agreement with State and Federal Regulations regarding opioid treatment.

_____ _____

PATIENT SIGNATURE: DATE:

_____ _____

PHYSICIAN SIGNATURE: DATE:

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PAYMENT POLICY
Payment is Due at Time of Services.

INSURANCE BILLING SERVICES:
As a service to our patients with insurance, we fill out and send your insurance claim info into your insurance carrier. Upon admission into St. Anthony Health Care, LLC, you have contractually agreed to pay for services rendered to you. If you have health insurance coverage, St. Anthony Health Care, LLC will agree to file your initial claim(s) provided we have complete information at the time of service. However, your health insurance contract(s) is between you and your insurance carrier. Because of this relationship, you have a primary responsibility to pay for the services and provide follow up communication with your health insurance carrier(s) if necessary. Should your insurance reject your claim, for any reason, you are financially responsible. If your health insurance coverage requires you pay a deductible, percentage and/or co-pay, these amounts will be due the day of service. We will try to give you an estimate of the amount you may owe before your visit upon your request. If we are contracted providers with your plan, you are not eligible for any additional discounts beyond the discount agreed upon with your health insurance carrier.

YOUR RESPONSIBLITY IS TO KNOW YOUR PLAN:
Know your yearly deductible and when it is due.
Know your maximum allowed fee for services in a calendar year.
Know what the percentage is that your coverage pays for our services.
Know that you have to follow up on claims submitted to your insurance company.

WE REQUIRE:
Balance paid in full by patient sixty (60) days after the processing of claim(s) by insurer.

NON-INSURED PATIENTS:
We do not accept attorney liens. All services must be paid on the day of your appointment. No payment plans are available at this time.

I have read and understand the office policy on payment for services rendered at St. Anthony Health Care, LLC. I have also signed the Condition of Medical Service and Agreement form and agree to the contents of both forms.

Printed Name: _____

Patient Signature:_____ Date:_____

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Patient Name: _____ Date: _____

Opioid Risk Tool (ORT)

Mark each box that applies		Female	Male
1.	**Family Hx of substance abuse**		
	Alcohol	☐ 1	☐ 3
	Illegal drugs	☐ 2	☐ 3
	Prescription drugs	☐ 4	☐ 4
2.	**Personal Hx of substance abuse**		
	Alcohol	☐ 3	☐ 3
	Illegal drugs	☐ 4	☐ 4
	Prescription drugs	☐ 5	☐ 5
3.	**Age between 16 & 45 yrs**	☐ 1	☐ 1
4.	**Hx of preadolescent sexual abuse**	☐ 3	☐ 0
5.	**Psychologic disease**		
	ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
	Depression	☐ 1	☐ 1

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PAIN MANAGEMENT/NARCOTIC TREATMENT AGREEMENT

I have agreed to use narcotics as part of my treatment for my chronic pain. I understand that these drugs are very useful but have potential for misuse and are therefore closely controlled by the local, state, and federal government(s). Because my physician is prescribing such medication to help manage my pain, I agree to the following conditions, without reservations:

1. I am responsible for my pain medication. I agree to take the medication **ONLY AS PRESCRIBED**. I understand that increasing my dose without authorization and supervision of my physician could lead to drug overdose, causing severe sedation, respiratory depression, onset of hypersensitivity pain, and/or death.
2. I will not request or accept controlled substance medication **FROM ANY OTHER PHYSICIAN** or individual while I am receiving such medication from St. Anthony Health Care, LLC.
3. I understand the side effects, relayed to narcotic medication, include **nausea and vomiting, drowsiness, constipation**, mental slowing, flushing, sweating, itching, and urinary difficulty. It is my responsibility to notify my physician of any side effects that continue or are severe. **I will also inform all of my other treating physician(s) of this agreement to avoid prescription duplication.**
4. **I understand the pain medication is strictly for my own use**. Pain medicines should never be given to others, including family members who are being treated for pain.
5. I understand medications like Valium, Ativan, Xanax, Florinal, or Ambien, certain muscle relaxants like Soma, antihistamines like Benadryl, or Atarax, and alcohol may produce profound sedation, respiratory depression, blood pressure drop, and even death when taken inappropriately.
6. I understand that mind-altering drugs, including marijuana, cocaine, ecstasy, etc., are especially dangerous and deadly, and **should never be used.**
7. I understand that pain prescriptions will not be mailed. I will pick up my refill prescriptions at St. Anthony Health Care, LLC every month or as designated by my physician.
8. **I am responsible for my narcotic/pain prescriptions**. I understand that refill prescriptions: **Can only be written for a one-month supply for most medications and will be filled at the same pharmacy**. The allowance of refills on prescriptions is at the discretion of my physician, but also dictated by the governing laws of the state. Prescription refills for pain medication need to be made **Monday through Thursday, 8:00am to 3:00pm**. Please do not wait until you have only one pill left before calling for a prescription refill as refill requests may take 72-96 hours to fulfill. **No refill prescriptions will be written after 3:00pm, on holidays, or on weekends. I am responsible for the safety of my medications. Refills will not be made for lost, stolen, or misplaced medications**. If I run out of my medications early because I took more medicine than I was prescribed by my physician, not only will my refills be denied, but also, I run the risk of dismissal from my physician's practice. I will be allowed to take less than prescribed if my medicine is not needed, but not more without the permission of my physician. Medications can only be filled by a pharmacy in the State of Florida, even if I am a resident of another state.
9. If my physician changes my pain medication, I will turn into the clinic the appropriate balance of medication, before picking up my new prescription. The type and quantity of the turned in medication will be recorded in my patient chart. I will not dispose of or flush the medication down the toilet on my own. Hoarding of old medications is prohibited.
10. **I understand that narcotic/pain medications, along with all medications, pose a danger to children and I will safeguard these in my home.**
11. **While physical dependence is to be expected after a long-term use of narcotic pain medication, signs of addiction (and psychological dependence) shall be interpreted as a need for weaning and detoxification.** Physical dependence is common to many drugs such as blood-pressure medication, anti-seizure medicines, and narcotics. It results in biochemical changes such that abruptly stopping these drugs can cause a withdrawal response. Addiction is a psychological and behavioral disease that is recognized when a patient abuses the drug to obtain mental numbness and euphoria. When the patient shows a craving behavior or "doctor shopping", when the

drug is quickly escalated without correlation to pain relief and/or when the patient shows a manipulative or abusive attitude towards the physician to obtain the drug. If the patient exhibits such behavior, the drug will be tapered; such a patient is not a candidate for the narcotic medication, and he/she may be referred to a narcotic detoxification program and/or be discharged from the practice.

12. I understand that if I participate in any illegal, deceitful, or fraudulent activities, I will be discharged from the practice and appropriate criminal/legal action will be invoked. This includes "dealing" prescription drugs and forging or altering prescriptions in any manner or form.
13. If it appears to the physician that there is no improvement to my daily function or quality of life from the prescribed medications, they will be discontinued. I will gladly taper the medicine as instructed by the physician.
14. **I agree to submit to supervised/witness urine and blood screening at any time as determined by my physician or his designee to detect the use of both prescribed and non-prescribed medications, and I will be financially responsible for the test regardless of the payer source.**
15. **I authorize the release** of any information and hospital records by the pain physician or his/her designee to other healthcare providers, my insurance company, or other reimbursing agencies. I also authorize any pharmacy, hospital, medical clinic, law enforcement agency, and physician to release medical information to my pain physician.
16. I understand that, if in the opinion of my physician, I did not follow the above conditions, my physician may determine that narcotic therapy is no longer appropriate for me. I will then be gradually taken off these medications and other therapies will be used, or I may be discharged from my physician's care.

I also agree to hold St. Anthony Health Care, LLC and my treating physicians free of any liability or responsibility should I violate any of the above conditions.

I, (PRINT NAME)_____

(PRINT DATE OF BIRTH)_____, have read all pages of the pain management/narcotic treatment contract or it has been read to me and all my questions regarding the treatment of pain with narcotic/pain medicines have been answered to my satisfaction. I hereby give my consent to participate in narcotic/pain medication therapy.

_____ _____

PATIENT SIGNATURE: DATE:

_____ _____

PHYSICIAN SIGNATURE: DATE:

_____ _____

WITNESS SIGNATURE: DATE:

PHARMACY NAME:_____ Location:_____ Phone:_____

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Authorization for Verbal Release of Protected Health Information or Treatment Records

NAME: _____ **AGE:** _____ **DATE OF BIRTH:** _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

I _____ give my permission to:

St. Anthony Healthcare LLC

to release information regarding appointment dates/times and my protected health information, my treatment record from (date)_____ to _____(date) maintained or created by the provider named below to the recipient named below.

Name of Person: _____	Name of Person: _____
Entity: _____	Entity: _____
Relationship to Patient: _____	Relationship to Patient: _____
Exceptions: _____	Exceptions: _____

I understand that:

- I may revoke this Authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this Authorization. Unless revoked, the automatic expiration date will be 12 months from the date of the signature.
- Unless the purpose of this Authorization is to determine payment of a claim or benefits, the provision of treatment or payment for my care may not be conditioned upon my signing of this Authorization.
- Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. Student treatment/education records may retain continuing privacy protections in accordance with 34 CFR Pan 99.
- THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR A NONCOMMUNICABLE DISEASE.
- The information authorized for verbal release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released

X_____ _____ Date:_____

Signature or patient, Parent, or Legally Authorized Representative Relationship