St. Anthony Health Care

St. Anthony Health Care, LLC
2103 S. McCall Rd. Englewood, FL 34224
Phone: 941-441-9007 Fax: 941-249-3119

NEW PATIENT APPLICATION

Welcome to St. Anthony Healthcare Pain Management Clinic!

To ensure a smooth and efficient establishment to our practice, please see below to better understand our intake process.

- **Referral Required**: You must have a referral from your primary care physician or another healthcare provider (regardless of insurance).
- **Complete the Packet**: Fill out this application packet in its **entirety** to begin the intake process.
- **Imaging & Medical Records**: All relevant imaging reports and medical records must be available for review by our referral team, before any appointments are scheduled. *We will assist in obtaining these records for you.*
- **Review by Referral Team**: Once we receive and review your records, our referral coordinator will contact you to schedule your first and second appointment.
- **Initial Visit**: The first appointment will be with our Physician's Assistant and will take approximately 60 minutes.
- **Second Visit**: Approximately one month later you will follow up with Dr. Little.
- **Transfer Patients**: If you are transferring from another pain management office, we will require a discharge letter from their office.

PATIENTS THAT HAVE A MME (MORPHINE MILLIGRAM EQUIVALENT) HIGHER THAN 90 WILL NOT BE ACCEPTED WITHOUT AGREEING TO A REDUCTION IN MME. WE DO NOT WRITE HIGH DOSES OF NARCOTICS, PATIENTS WILL BE LOWERED TO WHAT THE DOCTOR FINDS ACCEPTABLE FOR YOUR CONDITION.

PATIENT NAME:_____

DATE OF BIRTH:_____

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PAYMENT & INSURANCE POLICY

Payment is Due at Time of Service

Insurance Billing Services:

As a service to our patients with insurance, we will complete and submit your insurance claim to your insurance carrier. Upon admission to St. Anthony Healthcare, LLC, you have contractually agreed to pay for services rendered. If you have health insurance coverage, St. Anthony Healthcare, LLC will file your initial claim(s) provided we have complete information at the time of service.

However, your health insurance contract is between you and your insurance carrier. As such, you have the primary responsibility to pay for the services and communicate with your insurance carrier for any follow-up. Should your insurance reject your claim for any reason, you are financially responsible. If your insurance coverage requires you to pay a deductible, percentage, or co-pay, these amounts will be due on the day of service. We will attempt to give you an estimate of the amount you may owe before your visit, upon request. If we are contracted providers with your plan, you are not eligible for additional discounts beyond those agreed upon with your health insurance carrier.

Your Responsibility 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 the percentage your coverage pays for our services.
- Know that you are responsible for following up on claims submitted to your insurance company.

We Require:

- Balance paid in full by the patient within sixty (60) days after the processing of claims by your insurer.

Non-Insured Patients:

We do not accept attorney liens. **We don't not accept self-pay patients.** All services must be paid on the day of your appointment. Payment plans are not available at this time.

I have read and understand the office policy on payment for services rendered at St. Anthony Healthcare, LLC.

Printed Name: _____

Patient Signature: _____ **Date**: _____

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DEMOGRAPHICS:	**CONTACT INFORMATION:**
Name:_____	Cell Phone:_____
DOB:_____	Home Phone: _____
Sex:_____	Email:_____
SSN:_____	
Address:_____	**Emergency Contact:_____**
City:_____	**Phone #_____**
State:_____ Zip: _____	**Relationship:_____**
PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
Company:_____	Company:_____
ID #_____	ID #_____
Group #_____	Group #_____
Address:_____	Address:_____
_____	_____
Phone #_____	Phone #_____
Are you the Policy Holder? ☐ Yes ☐ No	Are you the Policy Holder? ☐ Yes ☐ No
If No, complete information below	***If No, complete information below***
Policy Holder Name: _____	Policy Holder Name: _____
Birth Date: ____/_____/_____	Birth Date: ____/_____/_____
Relationship: _____	Relationship: _____
SSN: _____	SSN: _____
Phone: _____	Phone: _____

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MEDICATION AND SOCIAL HISTORY

CURRENT MEDICATIONS (ATTACH LIST IF NEEDED)

MEDICATION	DOSAGE	FREQUENCY

FAILED MEDICATIONS FOR PAIN

MEDICATION	REASON FOR FAILURE

DRUG ALLERGIES

MEDICATION	REACTION

_____ CHECK HERE IF YOU HAVE NO KNOWN DRUG ALLERGIES

SOCIAL HISTORY

Do you use tobacco products? **Y / N** Frequency/Type:_____

Do you consume alcohol? **Y / N** Frequency:_____

Do you have a history of illegal/street drug use? **Y / N** Type:_____

Do you currently use Medical Marijuana for your chronic pain? Y/ N

Are you interested in Medical Marijuana therapy? Y / N

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MEDICAL HISTORY *Please list all medical conditions that you are aware of*	**SURGICAL HISTORY** *Please list all surgical procedures you have had*	
	SURGERY	YEAR

TREATMENT HISTORY

Have you tried any of the following treatments for your chronic pain, if yes, what was the result?	
Physical Therapy	
Massage Therapy	
Chiropractor	
Ten's Unit	

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PAIN QUESTIONNAIRE

PRIMARY SITE OF PAIN (CHECK ONE)		PAIN QUALITY (CHECK ALL THAT APPLY)	
	HEAD		CONSTANT
	NECK		BURNING
	SHOULDERS		SHARP
	BACK		CUTTING
	UPPER EXTREMITY		THROBBING
	LOWER EXTREMITY		CRAMPING
	ABDOMEN		SHOOTING
	PELVIC (HIPS, ETC)		PRESSURE
	CANCER PAIN		PINS/NEEDLES
	SPASTICITY (MS, SPINAL-CORD INJURY)		NUMBNESS
			ACHING

Have you ever had an interventional pain procedure? If yes, please list what type and if that procedure provided you with pain relief.		
PROCEDURE	**DID YOU EXPERIENCE PAIN RELIEF?**	**YEAR**

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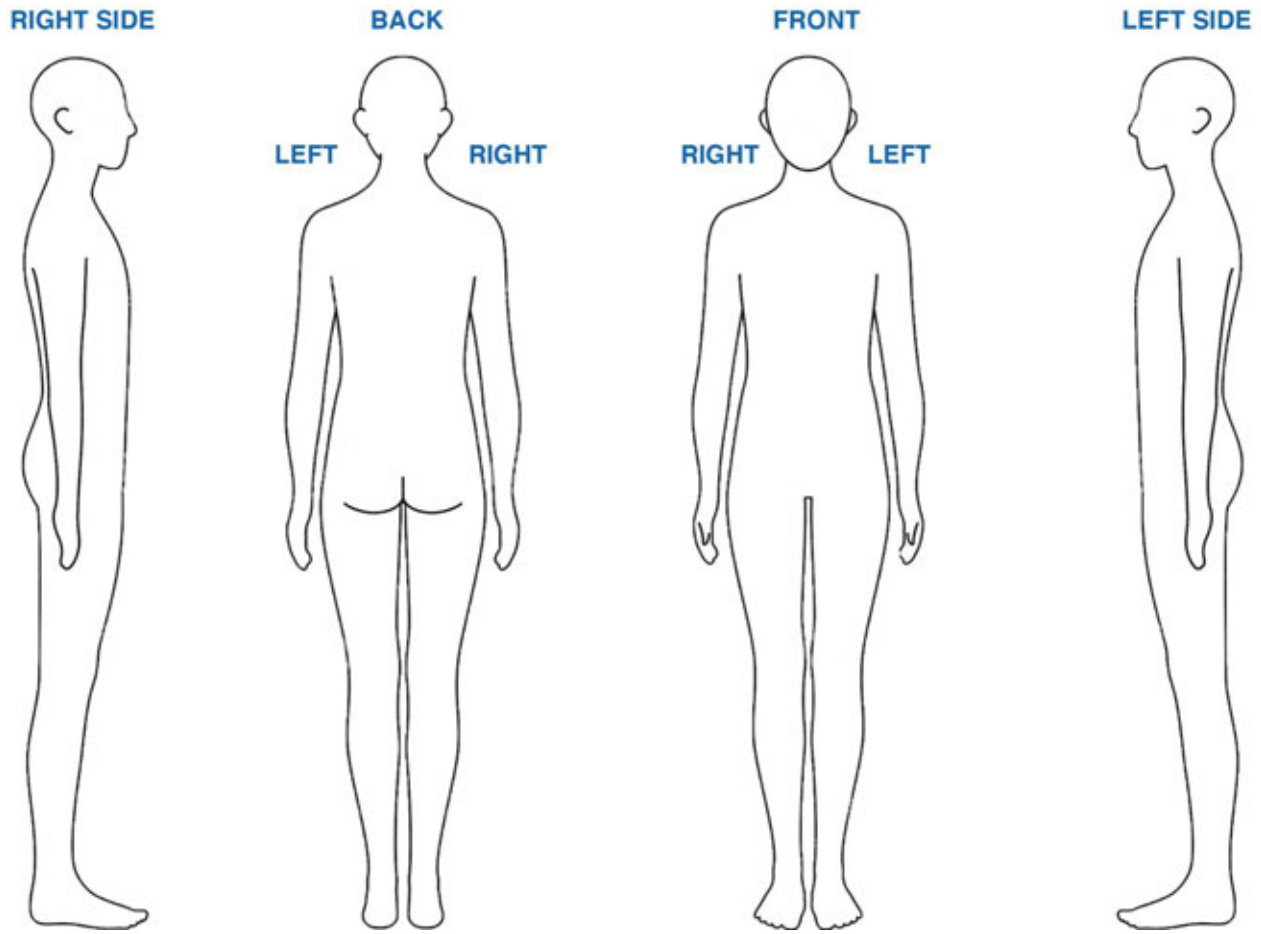
Mark with an X where your pain is below



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AUTHORIZATION FOR RELEASE OF RECORDS

Patient Name:_____ DOB:_____
Address:_____ State:_____ Zip:_____
Phone Number:_____ Last 4 of SS#_____

1. Previous Pain Doctor:_____ 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 #

5. 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: __X__ ALL IMAGING REPORTS:__X__ DISCHARGE LETTER:_X_

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 *testi*ng 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. IF WE CANNOT OBTAIN YOUR RECORDS, WE WILL BE UNABLE TO SCHEDULE YOUR NEW PATIENT APPOINTMENT.

Authorization for Verbal Release of Protected Health Information or Treatment Records

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Authorization for Verbal Release of Protected Health Information of Treatment Records

Name:_____ DOB: _____ Phone Number:_____
Address: _____City: _____ State: _____ Zip: _____

I, _____, give my permission to **St. Anthony Healthcare LLC** to release information regarding appointment dates/times and my protected health information, including my treatment record from (date) _____ to (date) _____, maintained or created by the provider named below, to the recipient(s) named below.

Name of Person:_____	**Name of Person:_____**
Relationship to Patient: _____	**Relationship to Patient: _____**
Exceptions (if any): _____	**Exceptions (if any): _____**

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, this Authorization will automatically expire 12 months from the date of signature.
- The provision of treatment or payment for my care is not conditioned upon my signing of this Authorization, unless the purpose of the Authorization is to determine payment of a claim or benefits.
- Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations. However, student treatment/education records may retain continuing privacy protections according to 34 CFR Part 99.
- The information authorized for release may include information which may indicate the presence of a communicable or non-communicable disease.
- The information authorized for verbal release may include drug/alcohol abuse treatment records. These records are protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information from making further release unless 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 the use of this information to criminal investigations or prosecutions involving alcohol or drug abuse patients. As a result, by signing below, I specifically authorize any such records to be released.

Signature of Patient or Legal Authorized Representative: _____ **Date**: _____

Relationship to Patient (if applicable): _____

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80/20 EQUIANALGESIC PHARMACOTHERAPY OPIOID DOSING ADDENDUM

I have agreed to use narcotics as part of my treatment for chronic pain. I understand that while these medications are very effective, they also have the potential for misuse and are therefore closely controlled by local, state, and federal governments. I confirm that I have read, understood, and signed the Pain Management/Treatment Agreement.

Because my physician is prescribing these medications to help manage my pain, I agree to the following conditions and regulations set forth by the Federal and State governments, without reservation:

- I agree to comply with new federal guidelines regarding the balance of long-acting and short-acting pharmacotherapy opioid intake. The ratio for daily narcotic medication should be 80% long-acting and 20% short-acting (for breakthrough pain).
- I understand that this is a strict balance that is beyond the discretion of my physician, and I must adhere to this rule without exception. If I fail to follow this guideline and do not take my medication as prescribed, I understand that I risk being discharged from this practice.

I have read and understood all pages of this pain management/narcotic treatment contract, or it has been read to me. All of my questions regarding the treatment of pain with narcotic medications have been answered to my satisfaction. I confirm that I have signed the aforementioned agreement without reservation. I hereby acknowledge and agree to comply with the State and Federal regulations regarding opioid treatment.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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PAIN MANAGEMENT NARCOTIC TREATMENT AGREEMENT

I have agreed to use narcotics as part of my treatment for chronic pain. I understand that these medications are very effective but have the potential for misuse and are therefore closely controlled by local, state, and federal governments. Because my physician is prescribing such medications to help manage my pain, I agree to the following conditions, without reservation:

1. **Responsibility for Medication**: I agree to take my medication **ONLY AS PRESCRIBED**. I understand that increasing my dose without authorization and supervision of my physician could lead to drug overdose, severe sedation, respiratory depression, hypersensitivity pain, and/or death.
2. **No Requests for Additional Medication**: I will not request or accept controlled substance medication from any other physician or individual while receiving such medication from St. Anthony Healthcare LLC.
3. **Understanding Side Effects**: I understand that narcotic medications may have side effects, including nausea, vomiting, drowsiness, constipation, mental slowing, flushing, sweating, itching, and urinary difficulty. It is my responsibility to notify my physician if any side effects persist or are severe. I will also inform all other treating physicians of this agreement to avoid prescription duplication.
4. **Medication Use**: I understand that pain medications are strictly for my personal use and should **NEVER** be given to others, including family members who may also be treated for pain.
5. **Avoiding Dangerous Combinations**: I understand that combining narcotic medications with drugs such as Valium, Ativan, Xanax, Fiorinal, Ambien, certain muscle relaxants (e.g., Soma), antihistamines (e.g., Benadryl, Atarax), or alcohol may cause profound sedation, respiratory depression, dangerously low blood pressure, and even death.
6. **No Use of Illegal Drugs**: I understand that using mind-altering drugs, including marijuana, cocaine, ecstasy, etc., is dangerous and should **NEVER** be used.
7. **Refill Process**: I am responsible for my narcotic prescriptions. Refill prescriptions will only be written for a one-month supply and will be filled at the **same pharmacy**. Refills are at the discretion of my physician and governed by state laws. Prescription refills must be requested Monday through Thursday, between 8:00 am and 3:00 pm. Refill requests may take 72-96 hours to process. No refills will be made after 3:00 pm, on holidays, or weekends. **Lost, stolen, or misplaced medications will not be refilled**, and taking more medication than prescribed could result in denied refills and potential dismissal from the practice.
8. **Medication Changes**: If my physician changes my pain medication, I agree to turn in the remaining medication before picking up the new prescription. The type and quantity of turned-in medication will be recorded in my patient chart. I will not dispose of or flush the medication on my own. Hoarding old medications is prohibited.
9. **Safeguarding Medications**: I understand that narcotic medications, like all medications, pose a risk to children. I will safeguard them in my home.

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10. **Dependence vs. Addiction**: I understand that physical dependence is expected after long-term use of narcotic pain medication, and withdrawal symptoms may occur if these medications are stopped suddenly. However, if I exhibit signs of addiction (e.g., escalating doses without correlation to pain relief, "doctor shopping," manipulative behavior), my medication will be tapered, and I may be referred to a detoxification program or discharged from the practice.

11. **Illegal or Fraudulent Activities**: If I engage in illegal or fraudulent activities, such as "dealing" prescription drugs or altering prescriptions, I will be discharged from the practice, and appropriate criminal/legal action will be taken.

12. **Failure to Improve**: If my physician determines that the prescribed medications are not improving my daily functioning or quality of life, they will be discontinued. I agree to taper the medication as instructed by my physician.

13. **Drug Testing**: I agree to submit to supervised urine screenings at any time, as determined by my physician, to detect both prescribed and non-prescribed medications. I will be financially responsible for these tests, regardless of the payer source.

14. **Release of Information**: I authorize the release of any information and hospital records from my physician or their designee to other healthcare providers, insurance companies, 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.

15. **Non-Compliance**: I understand that if I do not follow the conditions outlined above, my physician may determine that narcotic therapy is no longer appropriate for me. I will then be gradually tapered off these medications and may be referred for alternative therapies or discharged from my physician's care.

I agree to hold St. Anthony Healthcare LLC and my treating physicians harmless from any liability or responsibility should I violate any of the above conditions.

I, **(PRINT NAME)** _____,(**DOB**): _____,
have read all pages of the Pain Management/Narcotic Treatment Agreement, or it has been read to me, and all my questions regarding treatment with narcotic/pain medications 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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No Show & Cancellation Policy

At St. Anthony Healthcare, LLC, we value your time and strive to keep our schedule running smoothly in order to provide the best possible care to all of our patients. To help us maintain this goal, we have implemented a **No Show Policy** for missed appointments.

A **no show** is defined as any missed appointment where the patient fails to notify the practice at least **24 hours in advance**. This includes cancellations, rescheduling, or arriving late for an appointment.

- **Missed Appointment Fee**: If you do not show up for your scheduled appointment or fail to give **24 hours' notice** of cancellation or rescheduling, a **$25 fee** will be charged. This fee is **not covered by insurance** and must be paid before your next visit.
- **Procedure Day Appointment No Show**: For missed procedure day appointments, the **no show fee is $100** due to the specialized equipment and staffing required for these procedures.

To avoid any fees, please contact us **at least 24 hours prior** to your appointment if you need to cancel or reschedule.

We understand that unforeseen circumstances can arise, and we are happy to work with you in those situations. However, **repeated no shows** may result in termination of care from our practice.

Thank you for your understanding and cooperation. We look forward to seeing you at your next appointment!

Patient Signature:_____ **Date:**_____

Office Coordinator Signature:_____**Date:**_____