

Anesthesiology of Jupiter d/b/a Jupiter Pain Management
1002 South Old Dixie Highway
Inside the Krupa Building – Suite 302
Jupiter, Fl 33458
T: 561-223-6288 F: 561-223-6266

Attached please find your new patient paperwork that is necessary for you to complete prior to your upcoming appointment. You **MUST** fill out these forms and return them to our office at least 2 days prior to your appointment. If we do not receive these forms, the provider may ask that we reschedule your appointment.

You can fax them to: 561-223-6266 or email them to JPM@shcr.com

Your New Patient Consultation has been scheduled on _____

With:

- _____ Alyzza Forte, ARNP
- _____ Elizabeth Pectol, ARNP
- _____ Florine Alexis-Samson, ARNP-C, DNP
- _____ Kathy Davis, ARNP
- _____ Lawrence Deziel, MD
- _____ Nathaniel Drourr, MD
- _____ Zahidul Huq, MD

At this visit an examination and consultation will be performed. A procedure will not be performed on this visit.

There will be one of our physicians available, to discuss plan of treatment.

****PLEASE NOTE****

IT IS OUR PROVIDERS DISCRETION WHETHER OR NOT THEY CONTINUE TO PRESCRIBE ANY MEDICATIONS THAT YOU ARE CURRENTLY PRESCRIBED BY ANY OUTSIDE PHYSICIAN

Please arrive 20 minutes before your appointment time to allow for processing of paperwork.

JUPITER PAIN MANAGEMENT

PLEASE PRINT

Name: _____ Date of Birth: _____
LAST FIRST MIDDLE

Local Address: _____ City: _____ State: _____

Zip Code: _____ Telephone: _____ Cell: _____ Email: _____

Ethnicity: _____ Race: African American Caucasian Other Decline

Sex: Male Female Marital Status: Single Married Widowed Divorced Separated

Employer: _____ Telephone: _____

Referring Physician: _____ Telephone: _____

Primary Care Physician (PCP): _____ Telephone: _____

Cardiologist: _____ Telephone: _____

Who is responsible for payment? _____ Health Insurance _____ Auto Insurance _____ Workers Compensation _____ Self Pay

Date of Injury: _____ Claim Number: _____ Adjuster: _____

Primary Insurance Name: _____ Telephone: _____

Name of Insured: _____ ID /Group Number: _____

Secondary Insurance Name: _____ Telephone: _____

Name of Insured: _____ ID /Group Number: _____

Pharmacy: _____ Location: _____ Telephone: _____

In case of emergency, who should be notified? _____ Telephone: _____

Permission to release health information to: _____

CONSENT FOR E-PRESCRIBING & MEDICATION HISTORY

I understand that as a part of my electronic health record, Anesthesiology of Jupiter a/k/a Jupiter Pain will transmit my prescriptions electronically as permitted, to the pharmacy that I designate as my primary pharmacy provider. Additionally, JPM will obtain the history of all of my past prescriptions dating back two years from pharmacy benefit managers and I understand that the prescription history will become a part of my electronic health record. By signing below I hereby give consent to the above actions.

Signature of Patient or Legal Representative: _____ Date: _____

RECORD RELEASE & ASSIGNMENT OF INSURANCE

I hereby authorize Anesthesiology of Jupiter a/k/a Jupiter Pain to re-release any and all medical information that has been previously requested from any physician, hospital, or clinic where I have been treated. I also understand that **this authorization to re-release medical information shall only be valid for the purposes of second opinions or referral from Anesthesiology of Jupiter a/k/a Jupiter Pain additional specialist evaluation.** I acknowledge that I have received a copy of the "Notice of Privacy Practices" which sets forth Anesthesiology of Jupiter a/k/a Jupiter Pain privacy practices and my rights regarding privacy of my PHI. I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full, at the time of service, **unless other arrangements are made in advance.** I hereby authorize the payment of benefits of my insurance policy, if any, to be paid directly to Anesthesiology of Jupiter a/k/a Jupiter Pain for services rendered. I further authorize the release of any medical information required by my insurance carrier. I understand that I am financially responsible for any charges incurred in the collection of this account, should I default on payment. Such charges include, but are not limited to legal fees, collections fees, interest charges or late charges.

Signature of Patient or Legal Representative: _____ Date: _____

Patient Name: _____ Today's Date: _____

Date of Birth _____ Height: _____ Weight: _____ Sex: Male Female

CURRENT MEDICATIONS:	NAME	STRENGTH	FREQUENCY
Example	Motrin	800mg	2 times a day

FAMILY HISTORY Please check (A) Alive (D) Deceased

	Father __ (A) / (D) __	Mother __ (A) / (D) __	Siblings	History
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

PAST MEDICAL HISTORY

- __ High/Low Blood Pressure __ Chest Pain/MI/Heart Disease __ Lung Disease __ Thyroid Problems
- __ Stroke/TIA __ Anxiety __ Kidney/Bladder problems __ Heart Arrhythmia
- __ Liver Disease __ Diabetes: Insulin/Pills/Diet __ Seizures/Neuro/Epilepsy __ Shortness of Breath
- __ Ulcer Disease __ Heart Murmur __ Cancer _____

Other relevant past medical history _____

ALLERGIES: List All Medications, Herbal remedies and Foods you are Allergic to and type of reaction to each:

SURGICAL HISTORY (Surgery and Year)

SOCIAL HISTORY

Current Smoker __ Yes __ No How many cigarettes per day _____ How often __ Everyday __ Not everyday

How soon after you wake up do you smoke your first cigarette? (Minutes) _____

Interested in quitting? __ Yes __ No _____

Drink Alcohol? __ Yes __ No How much and how frequently _____

Have you used drugs other than those for medical reasons in the past 12 months? _____ Yes _____ No

If yes, which drug and when was it last used _____

REVIEW OF SYSTEMS

(Please circle if you currently have any of the following conditions)

General: appetite change, fever, chills, sweats, weight gain or loss

Hematologic: bruising, skin rashes, history of bleeding disorder, blood clots

Cardiovascular: palpitations, vertigo, angina, chest pain, heart murmur

Respiratory: shortness of breath, cough, sleep apnea, wheeze

Endocrine: fatigue, increased thirst, heat/cold intolerance

Gastrointestinal: abdominal pain, nausea, vomiting, diarrhea, constipation, black/bloody stool, rectal bleeding, acid reflux

Genitourinary: urination hesitancy/frequency, painful urination, kidney stone

Rheumatologic: joint pain, rash

Neurological: seizure, muscle weakness, headaches, memory loss

Psychiatric: depression, anxiety, suicidal ideation

Musculoskeletal: back pain, neck pain, joint pain, muscle pain, spasm

When did your Pain Begin? _____ Days ago _____ Weeks Ago _____ Years Ago

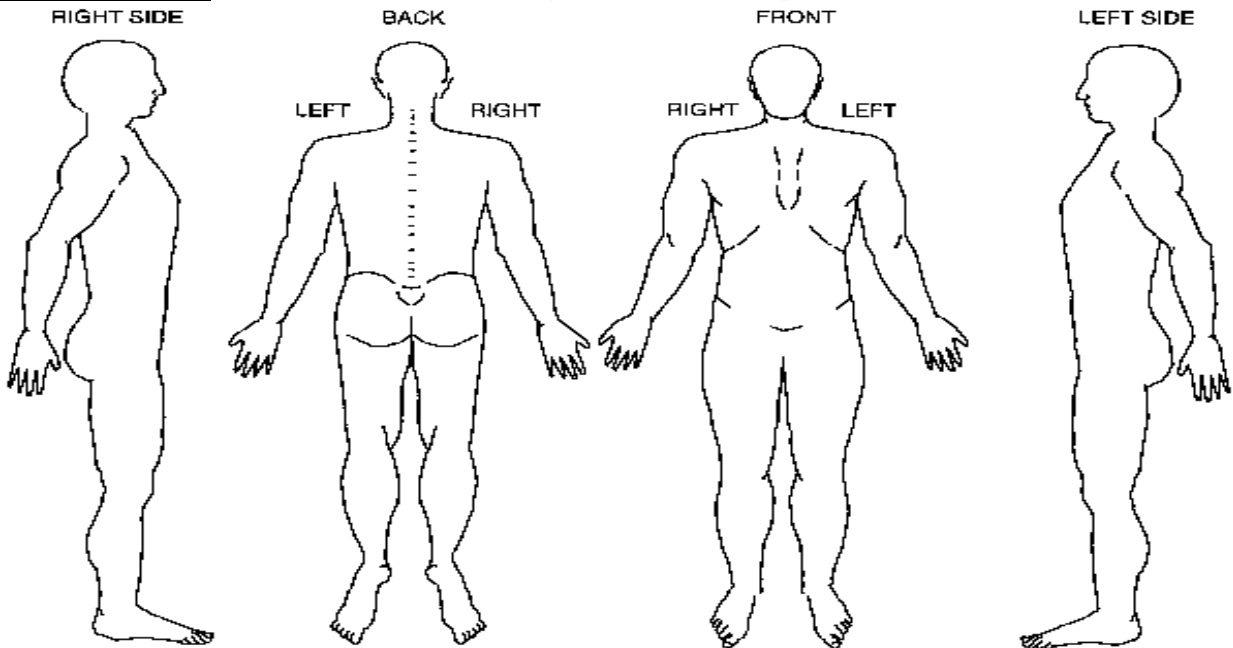
What caused your pain? Car Accident Lifting Work Related Trauma Sports Injury
 After Surgery Malignancy Fall Spontaneous After an Illness

Please explain: _____

Please circle your pain level using this scale: 1-10 scale, 10 being the worst pain you've ever felt.

1	2	3	4	5	6	7	8	9	10
No Pain				Medium Pain			Worst Pain		

WHERE IS YOUR PAIN- Mark the area on the diagrams where your pain is located



How Frequent is your Pain? ____ Occasional ____ Intermittent ____ Constant

What is the progression of your Pain since it began? ____ Worsening ____ Stable, no change ____ Improving

Have you had physical therapy, chiropractic or acupuncture in the last 6 months? Yes ____ No ____

If yes, did the physical therapy, chiropractic or acupuncture make your pain worse? Yes ____ No ____

Do you have a Home exercise Program? Yes ____ No ____

If you have a home exercise Program, did you get it from a physical therapist or Physician? Yes ____ No ____

Have you had Previous Injection Therapy? Epidurals ___Y___N___ When _____ % relief _____
Other treatment _____ When _____ % relief _____

Please check the appropriate words that best describe your pain

- ___ ACHING ___ SHOOTING ___ DULL ___ BURNING ___ TINGLING ___ TIGHT ___ CRAMPING
- ___ HOTNESS ___ HEAVY ___ BRIEF ___ NUMBING ___ COLDNESS ___ INTENSE ___ STINGING
- ___ SORENESS ___ STABBING ___ SHARP ___ TRANSIENT ___ CONSTANT ___ RADIATING ___ UNBEARABLE
- ___ SEVER ___ ANNOYING ___ EXCRUCIATING

Please check any of the following activities that make your pain BETTER:

- ___ SITTING ___ LYING FLAT ___ STANDING ___ LYING PRONE (BELLY DOWN) ___ KNESS FLEXED
- ___ CHANGING POSITION ___ REST ___ WALKING ___ BETTER IN AM ___ BETTER IN PM
- ___ BENDING OR STOOPING

Please check any of the following activities that make your pain WORSE:

- ___ SITTING ___ STANDING ___ KNESS FLEXED ___ WALKING ___ STRAINING ___ LYING FLAT
- ___ BENDING OR STOOPING ___ HANGING POSITION ___ WORSE IN MORNING ___ LIGHT EXCERISE
- ___ COUGHING OR SNEEZING ___ "BEARING DOWN" ___ LYING PRONE (BELLY DOWN)
- ___ WORSE IN AFTERNOON

Does pain interfere with your sleep? Yes ____ No ____ Explain: _____

Please check any Previous (P) or Current (C) treatments you are participating in:

- | | | | | |
|---|--|--|---|--|
| <u>P</u> <u>C</u> | <u>P</u> <u>C</u> | <u>P</u> <u>C</u> | <u>P</u> <u>C</u> | <u>P</u> <u>C</u> |
| <input type="checkbox"/> <input type="checkbox"/> None | <input type="checkbox"/> <input type="checkbox"/> Surgery | <input type="checkbox"/> <input type="checkbox"/> Medication | <input type="checkbox"/> <input type="checkbox"/> Biofeedback | <input type="checkbox"/> <input type="checkbox"/> Hypnosis |
| <input type="checkbox"/> <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> <input type="checkbox"/> Epidural Blocks | <input type="checkbox"/> <input type="checkbox"/> Nerve/Steroid Blocks | <input type="checkbox"/> <input type="checkbox"/> Acupuncture | <input type="checkbox"/> <input type="checkbox"/> TENS |
| <input type="checkbox"/> <input type="checkbox"/> Cortisone Pills | <input type="checkbox"/> <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> <input type="checkbox"/> Exercise | <input type="checkbox"/> <input type="checkbox"/> Heat | <input type="checkbox"/> <input type="checkbox"/> Ice |
| <input type="checkbox"/> <input type="checkbox"/> Osteopathic/Chiropractic Manipulation | <input type="checkbox"/> <input type="checkbox"/> Mental Health Counseling | <input type="checkbox"/> <input type="checkbox"/> Trigger Point Injections | | |

If current, please tell us where you are receiving treatment: _____

Please check any Diagnostic Testing you have had: ____ MRI ____ CT Scan ____ EMG ____ X-Rays ____ Other

Are you Currently Working? ___Yes ___ No **If Yes,** How Many Hours Per day _____ Per week _____

ADDITIONAL COMMENTS: _____

Patient Signature _____ Date _____

2021 Annual MIPS Questionnaire General

Patient Name: _____ Date: _____

1. Do you have little or no interest in doing things? No
 Yes, please check one: Several Days More than half the days Everyday

2. Are you feeling down, depressed or hopeless? No
 Yes, please check one: Several Days More than half the days Everyday

If you answered YES to question 1 or 2, then complete the following table. If you answered No to both question 1 and 2 then you DO NOT have to complete the table, skip to question 3 below

	Not at all (0)	Several days (1)	More than half the days (2)		Everyday (3)
3. Do you have trouble falling or staying asleep or sleeping too much?					
4. Do you feel tired or have little energy?					
5. Do you have poor appetite or overeating?					
6. Do you feel bad about yourself, feel like a failure, or feel you have let yourself or your family down?					
7. Do you have trouble concentrating on things, such as reading the newspaper or watching television?					
8. Do you move or speak so slowly that other people could have noticed? Or the opposite? Are you fidgety or restless and move around more than usual?					
9. Do you have thoughts that you would be better off dead and/or have thoughts of hurting yourself in some way?					

3. **Have you fallen in the past year? (Answer only if you are 65 years old and older.)**

NO Yes : 1 fall with injury 2 or more falls with injury
 1 fall without injury 2 or more falls without injury

Anesthesiology of Jupiter d/b/a Jupiter Pain Management

PATIENT FINANCIAL & OFFICE POLICIES

We are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policies as an essential element of your care and treatment. We are more than willing to provide care within the guidelines of your insurance plan. It is however, your responsibility to know and understand those guidelines.

OFFICE HOURS

The office is open Monday – Thursday from 8:00 a.m. – 4:30 pm
Friday from 8:00 a.m. – 4:00 pm.

**Telephones are answered between 9 a.m. to 12 p.m. then from 1 pm to 4:00 p.m. Monday – Thursday
Friday from 9:00 a.m. to 12:00 pm**

PRESCRIPTIONS FOR NARCOTICS

Patients who receive Narcotic Medications are required to have a signed Controlled Substance Agreement in their Medical Record. Prescriptions for narcotics will not be released without completing this agreement.

Do not allow yourself to run out of medication.

Your medication is your responsibility. Do not call us and say that you are out of medication and need a prescription today, we will not be able to assist you as your physician may not be in the office or available.

**IF YOU ARE REQUESTING A REFILL TO BE CALLED TO YOUR PHARMACY ON ALLOWABLE MEDICATIONS,
WE REQUIRE 72 HOURS NOTICE TO PROCESS YOUR REQUEST.**

There will be no Class II Narcotic medications called in to any pharmacy at any time. This is a Florida State law and a law regulated by the DEA (Drug Enforcement Administration).

HEALTH INSURANCE

You must be prepared to provide your health insurance card at every visit. **ALL HEALTH INSURANCE DEDUCTIBLES AND CO-PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.** This office files primary health insurance for those which we participate. If you have a secondary health insurance payor, we will also file a medical claim to them as well. It is your responsibility for knowing your policy information such as co-payments, co-insurances and deductibles. We will not become involved in disputes between you and your health insurance carrier. In the event your health plan determines any service to be 'not covered,' you will be responsible for the complete charge. Payment is due at the time of service.

AUTO INSURANCE

We will file a claim to your auto insurance carrier if Personal Injury Protection (PIP) Benefits are still available. **We will not file PIP to any third parties.** You will be responsible for the 20% co-insurance on your PIP insurance at the time of service, unless you provide us with health insurance, which will be filed as a secondary payor or a Letter of Protection signed by both you and your representing attorney. _____ (initial)

LETTER OF PROTECTION

If you do not have health insurance or PIP insurance and are seeking care with our office under legal representation, **before your first visit**, it is your responsibility to make sure that we have a signed Letter of Protection from your Attorney. You will need to make sure that your Legal Counsel sends us this letter unless other arrangements have been made. You have a responsibility to contact that office and inform them that you are seeking medical care from this practice. Once your legal case has settled, your Legal Counsel will hold funds from your settlement and send to us in an effort to resolve any unpaid balances. _____ (initial)

MISSED APPOINTMENTS

WE REQUIRE 24 HOUR NOTICE FOR ALL CANCELLATIONS. **Our policy is to charge \$50.00** for those who miss their appointments and/or no-show for their appointment. Please help us serve all our patients better by keeping your scheduled appointments.

APPOINTMENTS

We do not see any walk-in patients, EVERYONE IS REQUIRED TO HAVE AN APPOINTMENT.

This office will call the two days ahead of time to confirm your scheduled appointment. Please remember that this is a courtesy and is not required, however, if you are scheduled and you do not get a phone call two days ahead of time, please call us to confirm. It is your responsibility to be here on time for your appointments. If you are more than 15 minutes late to your scheduled appointment we may ask that you re-schedule for another date and time.

We are located on the grounds of Jupiter Medical Center, directly behind the hospital inside "The Krupa Building". 3rd Floor – Suite 302.

PERSONAL INFORMATION

It is imperative that our office be provided with current information on you. We must be able to contact you. Please keep us updated of new addresses, phone numbers, place of business and insurance information. We will require you to fill out an updated patient information sheet on an annual basis or anytime there are changes to your personal information.

DISABILITY, DRIVING & OTHER FORMS

If you have a disability, financial or similar forms that needs to be completed by our office, please remember that we need at least 7 – 10 days for processing these forms.

MEDICAL RECORD REQUESTS

All medical record requests require a signed written release of information present in the patient chart. If a release is not signed the patient will be required to sign a release before processing begins. A copy of our release can be mailed or faxed. All requests for records will be processed within 15 business days. A processing fee of \$1.00 for the first page and \$.50 per page thereafter, plus any applicable postage will apply (pursuant to Florida Statute, Chapter 395). Payment is due prior to the release of records.

Signature of Patient or Legal Representative: _____ Date: _____

**AUTHORIZATION FOR THE REQUEST OF PATIENT HEALTH INFORMATION FROM
OUTSIDE HEALTH CARE PROVIDERS**

Please print clearly

Patient Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____

Dates of Service: From _____ thru _____

I, _____ hereby request and authorize the release of the

Following records from: _____

(Physician/Facility PHI being requested from)

Phone Number/Fax Number

Street _____ City _____ State _____ Zip Code _____

_____ Consultation _____ OP Report _____ History & Physical

_____ Doctors Office Visit Notes _____ MRI / CT / X-Ray Reports _____ MRI/ CT/ X-Ray films

_____ Drug/ Alcohol Testing _____ Medication Lists _____ Lab Results

_____ Any & All Records not otherwise listed

This information is for continuity of care, unless otherwise noted: _____

Anesthesiology of Jupiter d/b/a Jupiter Pain Management

Nathaniel Drourr, MD ♦ Lawrence Deziel, MD ♦ Zahidul Huq, MD

Elizabeth Pectol, ARNP * Florine Alexis-Samson, ARNP-C, DNP * Alyzza De Le Forte, ARNP * Kathy Davis, ARNP

1002 South Old Dixie Highway – Suite 302

Jupiter, FL 33458

Phone (561) 223-6288 Fax (561)223-6266

Patient or Authorized Signature _____ Date _____

Relationship to Patient: _____

Pursuant to Florida law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, the record may be given only to the person designated and it may be used only for the purpose listed on this form. Charges are in compliance with Florida law. I understand that once my information is disclosed to the recipient above, it may be re-disclosed to individuals not subject to HIPAA and may no longer be protected by HIPAA. I understand that signing this authorization is voluntary and will not affect my receipt of treatment. I understand that I may revoke this authorization at any time, in writing, to the address listed above provided that the information has not yet been released. This authorization expires in six (6) months unless another date is written here _____.

PLEASE FAX MEDICAL RECORDS ASAP TO (561) 223-6266

JUPITER PAIN MANAGEMENT

Thank you for choosing our practice to assist you with your care.

We appreciate your trust and are committed to providing you with high quality, compassionate care.

We value our patients and tailor their treatment plans according to their unique needs, in doing so, we allocate time for each appointment accordingly. We realize that circumstances may occur beyond your control that may not allow you to provide 24 notification. Failure of a patient to notify the office to cancel or change their appointment without 24 hour notice is considered a “No-Show”. To help remind patients of their appointments we have implemented an automated reminder system. Please assure we have your correct and most up to date phone numbers or email address at all times throughout the course of your treatment to allow us to better serve you.

The “no show “appointments will be documented in the patient record.

Charges for “no-show appointments are as follows:

Office visit \$50.00

Procedure or surgical center visit \$100.00

This letter will serve as notice about the office no show policy and fees.

I acknowledge that I have read and understand the policy.

Print Name

Signature

Date