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Minimally Invasive Spine Care

By West Florida Pain Management P.A.
Gerald Trimble, M.D.
Susan Samlaska, MD

Dear Patient,

We would, like to thank you in advance for entrusting us with your health care needs at West Florida Pain Management, P.A. dba Minimally Invasive Spine Care, we treat a wide variety of chronic pain conditions ranging from back pain to pain resulting from cancer.

Apart from "hurting", long standing pain can interfere with all aspects of a person's. life. Family life, employment, social activities, sleep and emotions all may be affected.

In order to care for you as effectively as possible, we need you to provide us with information about your health and pain problems. We require this information, so that we may comprehensively evaluate your pain. Please complete the enclosed questionnaire and bring any MRI and X-ray reports that you may have in your possession. **We need to know about any pain treatments in the past 6 months from any physician. We need notes if possible.**

Please complete the enclosed paperwork and bring it with you to your appointment. **If this paperwork is not completed prior to your scheduled appointment, your visit will likely be cancelled and rescheduled**

We do emphasize a program of minimizing or eliminating addictive pain medications. If this is not your goal, you should consider treatment elsewhere.

Following your initial evaluation, we will formulate a treatment program, *which will be discussed and* explained to you in detail. We hope that we can at *least reduce your pain, if* not eliminate it entirely and help you lead a normal and *productive life.*

Once again, please bring your completed paperwork to your appointment.
Our doctors and staff look forward to meeting you.

Gerald E. Trimble, M.D.

Susan Samlaska, M.D.

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Privacy Policy
Minimally Invasive Spine Care

It is the intention of **Minimally Invasive Spine Care** to respect our patient's right to privacy and to safeguard our patient' records.

The patient must sign a consent form before treatment is provided authorizing **Minimally Invasive Spine Care** to use the patient's records for treatment, payment or health care operations (including compliance efforts).

Minimally Invasive Spine Care will not reveal patient information without a signed release except for purposes of treatment, payment or health care operations (including compliance efforts). The patient must sign an authorization before West Florida Pain Management; P.A. can use or disclose their records for any purpose beyond treatment, payment, or health care operations (e.g. clinical trials).

Minimally Invasive Spine Care will make reasonable efforts to limit the use and disclosure of our patient records to the minimum necessary to accomplish the intended purpose. West Florida Pain Management may rely on the judgment of the requesting party as to minimum amount of information needed in a particular instance.

Minimally Invasive Spine Care will make a good faith attempt to provide all patients with a copy of our privacy policy at or before the time that the consent is signed.

The patients of **Minimally Invasive Spine Care** will have the right to: 1. Inspect their patient records 2. Obtain a copy of their records (see Florida Administrative code 64B8-10.003 Costs of reproduction). 3. Request in writing an amendment of their records. 4. Request an accounting of those who have accessed their records.

Minimally Invasive Spine Care anticipates your records will be used to provide medical treatment for you including consulting with other physicians and pharmacies. We also anticipate your records will be used for billing purposes. There is the possibility your record will be used in our on going compliance plan with Medicare. Should you wish to make an inquiry or complaint these should be addressed to Practice Administrator, **Minimally Invasive Spine Care** 603 7th Street South, Suite 320 St. Petersburg, FL 33701. Should you wish to make any limitation on the disclosure of your records you are asked to do so in writing to the above address.

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Name:_____ Age:_____ Date: _____

I. **Patient Data**
Family physician: _____
Who referred you to West Florida Pain Management? _____

II. **Medical History**
Have you ever, or do you now have, any of the following conditions?

__ Heart Attack
__ Irregular heart rhythm
__ Chest Pain
__ High blood pressure
__ Stomach / Intestinal Problems
__ Ulcers
__ Liver disease / Hepatitis
__ Bleeding / bruise easily
__ Emphysema
__ Asthma
__ Thyroid problems
__ Diabetes
__ Arthritis
__ Cancer
__ Stroke
__ Kidney problems
__ Epilepsy / Seizures
__ Cigarette use
__ Alcohol use

List any Surgeries you have had: Including Pain Procedures

Type of Surgery	Date	Type of Surgery	Date

List all Medications you are currently using and how often you use them. Please indicate below:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Medication Allergies:

_____
_____
_____
_____

List any tests you have had:

Tests	Date & Place done	Results	Tests	Date & Place done	Results
X-rays			CAT SCAN		
MRI			EMG		

PLEASE NOTE!
We do not perform disability ratings at this practice. Should you need this service performed, we will refer you to the appropriate physician.

III. **Social History**

What is your occupation? _____ What duties do you perform? _____
When did you last work? _____ Part or Full time? _____
Years of Education _____ Married Yes No How long? _____ # of children _____ Ages _____

IV. **SYSTEMS REVIEW**

General:		Comments
Recent chills and / or fever	__ Y __ N	
Recent night sweats	__ Y __ N	
Weight gain	__ Y __ N	
Weakness	__ Y __ N	
Weight Loss	__ Y __ N	
Skin:		
Sores	__ Y __ N	
Rash	__ Y __ N	
Change in body hair	__ Y __ N	
Skin Cancer	__ Y __ N	
Warts or moles removed	__ Y __ N	
Nodes: any change in glands	__ Y __ N	

HEENT:		Comments
Head-headaches	__ Y __ N	
Dizziness	__ Y __ N	
Eyes- glasses	__ Y __ N	
Episodic blindness	__ Y __ N	
glaucoma	__ Y __ N	
cataracts	__ Y __ N	
Ears- hearing problems	__ Y __ N	
infection	__ Y __ N	
Nose – bleeding	__ Y __ N	
allergies	__ Y __ N	
sinusitis	__ Y __ N	
Mouth – hoarseness	__ Y __ N	
pain when chewing	__ Y __ N	
ulcers	__ Y __ N	
Dentures	__ Y __ N	

Respiratory (lungs):		Comments
Shortness of breath	__ Y __ N	
Chronic cough	__ Y __ N	
Pleurisy- pain on breathing	__ Y __ N	
Cough up blood	__ Y __ N	
Asthma	__ Y __ N	
Cardiovascular:		
Have you ever been examined for heart disease	__ Y __ N	
Heart attack	__ Y __ N	
Angina	__ Y __ N	
Chest pain	__ Y __ N	
Rapid heartbeats	__ Y __ N	
Smothering at night	__ Y __ N	
Discomfort in legs when walking	__ Y __ N	
Painfully cold hands	__ Y __ N	
Blood clot	__ Y __ N	
Describe your exercise program		

Gastrointestinal:		Comments
poor appetite	__ Y __ N	
Painful swallowing	__ Y __ N	
Difficult swallowing	__ Y __ N	
Food intolerance	__ Y __ N	
Indigestion / heartburn	__ Y __ N	
Change of bowel habits	__ Y __ N	
Inability to retain stool	__ Y __ N	
Gas / bloating	__ Y __ N	
Abdominal pain	__ Y __ N	
Bleeding hemorrhoids	__ Y __ N	
Blood in stool	__ Y __ N	
Black stools	__ Y __ N	
Nausea or vomiting	__ Y __ N	
Jaundice	__ Y __ N	
Constipation	__ Y __ N	
Diarrhea	__ Y __ N	

Genitourinary:		Comments
Do you get up at night to urinate?	__ Y __ N	
Bladder, kidney infection	__ Y __ N	
Difficult urination	__ Y __ N	
Blood in urine	__ Y __ N	
Kidney stone	__ Y __ N	
Inability to retain urine	__ Y __ N	
Musculoskeletal:		
Bursitis, tendonitis	__ Y __ N	
Arthritis, rheumatism	__ Y __ N	
Sciatica	__ Y __ N	
Neck pain	__ Y __ N	
Leg pain on exertion	__ Y __ N	
Leg pain at night	__ Y __ N	

Musculoskeletal (cont):		Comments
Back pain	__ Y __ N	
Total joint replacement	__ Y __ N	
Neurologic:		
Memory problems	__ Y __ N	
Fainting or blackouts	__ Y __ N	
Depression	__ Y __ N	
Anxiety	__ Y __ N	
Stroke	__ Y __ N	
Paralysis	__ Y __ N	
Tremor	__ Y __ N	
Difficulty walking	__ Y __ N	
Frequent falls	__ Y __ N	

Family History / Blood relatives — Please list any diseases you are aware of.

	Alive?	Age			Alive?	Age	
Paternal grandfather	__ Y __ N	____		Brothers	__ Y __ N	____	
Paternal grandmother	__ Y __ N	____			__ Y __ N	____	
Maternal grandfather	__ Y __ N	____		Sisters	__ Y __ N	____	
Maternal grandmother	__ Y __ N	____			__ Y __ N	____	
Mother	__ Y __ N	____		Aunt	__ Y __ N	____	
Father	__ Y __ N	____		Uncle	__ Y __ N	____	

V. Description of Pain and Influencing Factors

Location: Mark drawing showing approximate areas of pain

Patient rates the pain. Scale used 1-10 (10= worst pain)

Worst pain gets:_____

Best pain gets: _____

1. How long have you had this problem?_____

2. Please describe how your pain first began. (e.g. accident, illness, etc.):_____

_____

3. Words that describe your pain (e.g. prick, ache, burn, throb, pull, sharp) :_____

4. What causes your pain to:

Increase?_____

Decrease? _____

Effects of pain (note-decreased function, decreased quality of life.):

Accompanying symptoms(e.g. nausea):_____

Sleep: _____

Appetite: _____

Physical activity: _____

Relationship with others (e.g. irritability):_____

Emotions (e.g. anger, suicidal, crying): _____

Concentration: _____

VI. Treatment

Treatment	Yes/No If Done	How Helpful Was This?
Interventional Pain Injections		
Surgery		
Physical therapy		
Occupational therapy		
Biofeedback		
Psychological therapy		
Other		

_____

_____

_____

_____

_____

_____

_____

Litigation

In the past, have you ever been compensated for a work-related injury or a motor vehicle accident? If so please give the date of injury and describe any injuries/ disabilities you were compensated for.

Date of Injury:_____

Description of Injury/ Disability: _____

_____

_____

_____

_____

_____

If your pain is due to an accident, is litigation (legal suit) or an insurance settlement pending?
___ Yes ___ No If yes, describe the current status of the litigation or settlement:

_____

_____

If your pain is due to a work-related injury what is you official work status as of today's date?

_____

_____

Is faith important to you in this illness?

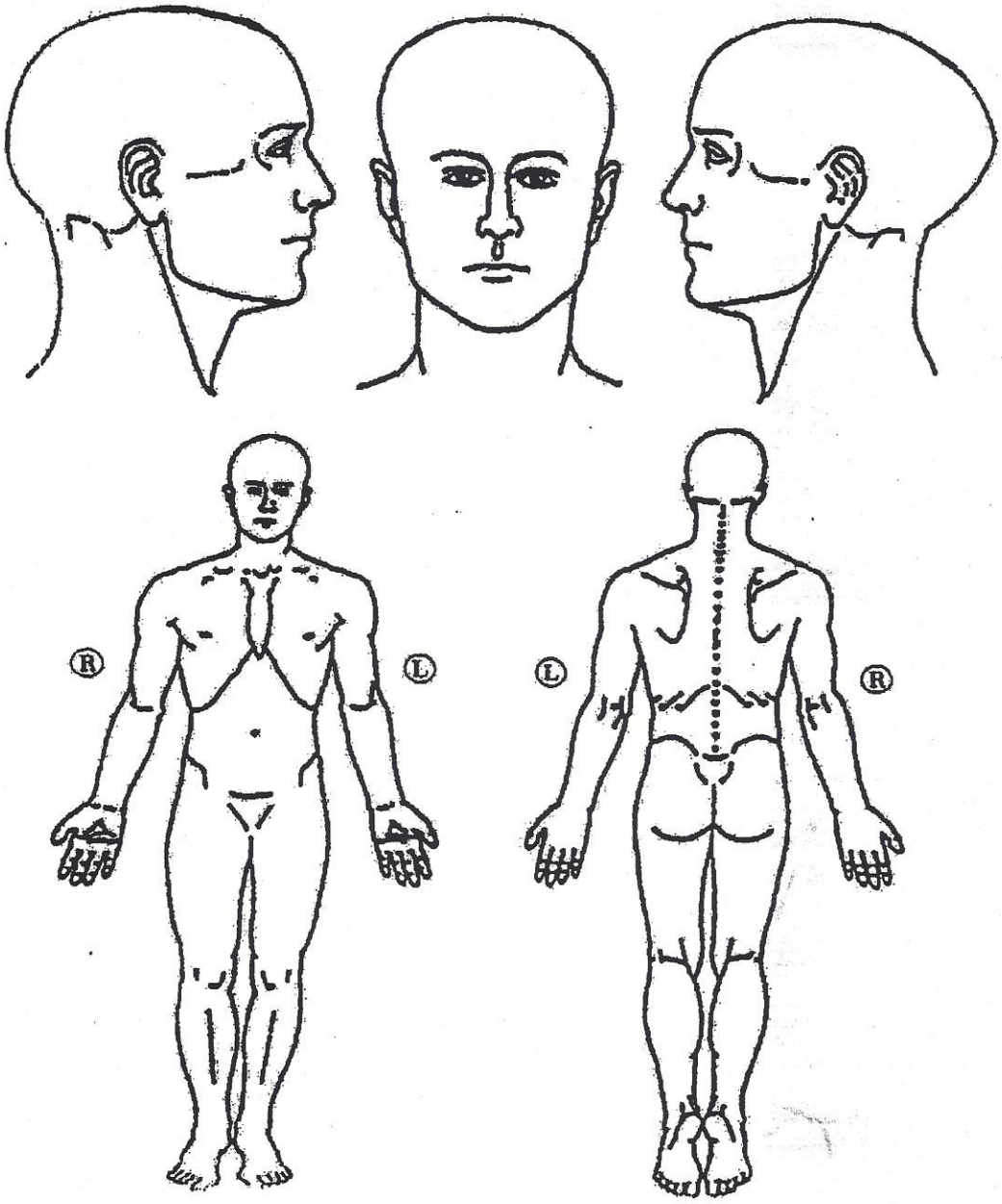
Has faith been important to you at other times in your life?

How have you coped in the past with difficult situations?

Are you hopeful that your pain can be managed or alleviated?

Signature:_____ Date:_____

Please mark approximate location of pain



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Patient Health Questionaire

Over the last 2 weeks, how often have you been Day	Not at all	Several Days	More Than Half the days	Nearly every
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having Little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

If you checked any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely Difficult ☐

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NAME:_____ **DATE:** _____

The **Opioid Risk Tool** as developed by Dr Lynn Webster

As you may know, there are several legal, medical, ethical and social issues associated with pain medicine. Because pain is subjective and just cannot be proven, the medical community has developed several questionnaires and forms to help evaluate pain. You are already familiar with the typical paperwork that you fill out at each visit. We have tried to make this form simple and clear.

In order to provide the best care, it is important that we obtain additional information about each patient. At the next several visits, you may be asked to complete an extra form as we gather more and more information. Here is today's additional form:

OPIOID RISK TOOL: Many patients are concerned about the risk of addiction to their pain medications. The risk of addiction actually is quite low when the medications are used properly for pain. Sometimes, a patient already has an addiction disorder. This does not mean that the patient is not deserving of pain control, but it does mean that we need to use extra caution so as to provide the pain control without worsening the addictive disorder. Dr. Webster formulated a questionnaire that can help us determine your risk of addiction with the medications. Please complete the ORT below honestly, and we can then discuss your level of risk of becoming addicted or having an addictive disorder, Please remember that this questionnaire is not a judgment of you as a human being and that we did not develop this questionnaire.

Directions: If you are a female complete only the **female** side of the questionnaire and if you are a **male** complete only the male side of the questionnaire.

	Female	Male
Is there a history of substance abuse in your family?	**Yes / No**	**Yes / No**
Alcohol	**Yes / No**	**Yes / No**
Illegal drugs	**Yes / No**	**Yes / No**
Prescription drugs	**Yes / No**	**Yes / No**
Have you had a history Of substance abuse?	**Yes / No**	**Yes / No**
Illegal drugs	**Yes / No**	**Yes / No**
Prescription drugs	**Yes / No**	**Yes / No**
Is your age between 16 and 45?	**Yes / No**	**Yes / No**
Is there a history of preadolescent (childhood) sexual abuse?	**Yes / No**	**Yes / No**
Do you have a history of any of the following conditions?		
ADD, OCD, bipolar, schizophrenia	**Yes / No**	**Yes / No**
Depression	**Yes / No**	**Yes / No**

I understand it is a felony to be untruthful to obtain drugs.

Signed_____ Date: _____

WF PM

WEST FLORIDA PAIN MANAGEMENT, P.A. dba **MINIMALLY INVASIVE SPINE CARE**

Diagnostic & Interventional Pain Medicine

Gerald Trimble, M.D.
Susan Samlaska, M.D.

Patient Demographics (fill in appropriate information)

Name:_____ Phone:_____

Date of Birth _____ Alternative Phone:_____

Social Security Number: (We need this for billing purposes)_____

Local Address:_____

_____

Permanent Address: _____

_____

Primary Care Doctor _____ Phone:_____

Referring Doctor _____ Phone:_____

Primary Insurance Name:_____ Policy Number _____

Secondary Insurance Name:_____ Policy Number _____

Closest Relative _____

Phone of Closest Relative _____

Is this a Work Comp Injury? _____ Body Part Injured_____

Adjuster Name_____ Phone Number_____

Date of Injury _____ W/C Insurance Co_____

Is This Auto Injury?_____ Auto Claim Number _____

Date of Accident_____ Claim Adjuster _____

Claim Adjuster Phone _____ Auto Insurance Co_____

Patient Signature_____ Date_____

Details About Your Health Information In BayCare eHX and the Consent Process:

1. How Your Health Information Will Be Used: Your health information will be used by members of the BayCare eHX only:

- To provide you with medical treatment and related services
  To check whether you have health insurance and what it covers
- To evaluate and improve the quality of medical care provided to all patients
- For administrative management of the BayCare eHX

2. What Types of Health Information About You Are Included: If you give consent, members of the BayCare eHX may access ALL of your health information available through the BayCare eHX. This includes information created before and after the date of this consent form. Your health information available through the BayCare eHX will include all of your demographic, insurance and medical information. For example, your health information may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. As part of this Consent Form, you specifically consent to the release of health information that may relate to sensitive health conditions, including but not limited to:

- Substance abuse
- HIVAIDS
- Psychiatric/mental health conditions
- Birth control and abortion (family planning)
- Genetic (Inherited) diseases or tests
- Sexually transmitted diseases

3. Where Health Information About You Comes From: Health information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid/Medicare program and other health organizations that exchange health Information electronically.

4.Who May Access Information About You, If You Give Consent: Access to the BayCare eHX will be limited to only those members of the BayCare eHX who have agreed to use the BayCare eHX consistent with your permission as set forth In this Consent Form and who have agreed to the overall terms and conditions established for use and operation of the BayCare eHX.

5. Improper Access to, or Use of, Your Information: If at any time you suspect that someone who should not have seen or received access to your health Information has done so please contact the Baycare Privacy Department at (727) 820-8024.

6. Redisclosure of Information: Any electronic health information about you may be re-disclosed by members of the BayCare eHX to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. You understand that the protected health information disclosed pursuant to this Consent Form may not be protected by federal law once it is disclosed by your physician.

7. Effective Period: This Consent Form will remain In effect until the day you withdraw your consent.

8. Withdrawing Your Consent: You can withdraw your consent at any time by giving written notice to Chris Eakes, Manager of eHX, BayCare Health System, 17757 U.S. Highway 19 N., Suite 500, Clearwater, FL 33764. Organizations that access your health information through the BayCare eHX while your consent is in effect may copy or include your health information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove your health information from their records.

9. Copy of Form: You are entitled to get a signed copy of this Consent Form after you sign it.

BayCare Health System

Electronic Medical Records

Consent to Share My Health Information With the BayCare Electronic Health Exchange

The BayCare Electronic Health Exchange (BayCareeHX)is an exciting program designed to improve your healthcare and make office visits easier and more convenient. This authorization will allow all of your doctors participating in the BayCare eHX to enroll you in the BayCare eHX and to disclose your demographic, insurance and medical information (collectively, your "health information") to the BayCare ehx so that it can be shared with other providers of health care, including doctors, nurses, health professionals, hospitals and other health care facilities. Only health care providers and authorized personnel that participate In the BayCare eHX, and others whose job it is to maintain, secure, monitor and evaluate the operation of the BayCare eHX, will be able to access your health Information. The BayCare eHX will allow your providers access to your health information more quickly and accurately than with paper charts. You may use this Consent Form to decide whether or not to allow the BayCare eHX to see and obtain access to your health information in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to other providers on the BayCare eHX for your medical treatment.

If you check the "I GIVE CONSENT box below, you are saying "Yes, members of the BayCare eHX may see and get access to all of my health Information through the BayCare eHX."

If you check the I DENY CONSENT" box below, you are saying "No, members of the BayCare eHX may not be given access to my health Information through the BayCare eHX for any purpose."

Please carefully read the Information on the back of this form before making your decision. Your Consent Choices: You can fill out this form now or In the future. You have two choices:

☐ YES, I GIVE CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.

☐ NO, I DENY CONSENT for my doctors to enroll me In the BayCare eHX and for the members of the BayCare eHX to access ALL of my health Information as set forth In this Consent Form.

_____

Printed Name of Patient/Representative Signature of Patient/ Representative Date

AUTHORITY OF REPRESENTATIVE:

I, _____do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: _____

_____

_____

Relationship to Patient: Date:

E-PRESCRIBING CONSENT FORM

ePrecribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan.

- Medication history **transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing West Florida Pain Management P.A. dba Minimally Invasive Spine Care can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to West Florida Pain Management P.A. dba Minimally Invasive Spine Care to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name

Patient DOB

Signature of Patient or Guardian

Date

Relationship to Patient

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By West Florida Pain Management, P.A.
Gerald Trimble, M.D.
Susan Samlaska, M.D.

Amended 3/17/2016

Patient Name: _____ Date: _____

Patient DOB: _____ SSN: _____

IN CONSIDERATION FOR YOUR CARING FOR ME,
I AGREE TO THE FOLLOWING:

1. YOU ARE AUTHORIZED TO RELEASE ANY INFORMATION YOU DEEM APPROPRIATE CONCERNING MY PHYSICAL CONDITION TO ANY INSURANCE COMPANY, OR ADJUSTER IN ORDER TO PROCESS ANY CLAIM FOR REIMBURSEMENT OF CHARGES INCURRED BY ME. I AM RESPONSIBLE FOR PROVIDING MY MOST CURRENT INSURANCE INFORMATION AND KEEPING MY INSURANCE INFORMATION UP TO DATE WITH THE PRACTICE.

2. YOU ARE AUTHORIZED TO RELEASE ANY INFORMATION YOU DEEM APPROPRIATE TO PROVIDE MEDICAL TREATMENT OR FOR HEALTH CARE OPERATIONS

3. I AUTHORIZE THE DIRECT PAYMENT TO WEST FLORIDA PAIN MANAGEMENT, P.A. dba **MINIMALLY INVASIVE SPINE CARE** ANY BENEFITS DUE ME FROM MY INSURANCE COMPANY AND/OR MEDICARE AND/OR FROM THE PROCEEDS OF ANY SETTLEMENT OF CASE RESULTING FROM LEGAL ACTION. I FURTHER AUTHORIZE PAYMENT TO WEST FLORIDA PAIN MANAGEMENT, P.A. FOR YOUR SERVICES

4. I UNDERSTAND THAT HEALTH INSURANCE IS A CONTRACT BETWEEN MYSELF AND THE COMPANY. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT OF MY ACCOUNT WITH WEST FLORIDA PAIN MANAGEMENT, P.A. dba **MINIMALLY INVASIVE SPINE CARE** IN ITS ENTIRETY REGARDLESS OF INSURANCE PAYMENT OR ATTORNEY SETTLEMENT. THIS PROVISION DOES NOT APPLY SHOULD THE PATIENT BE COVERED BY AN APPROPRIATE AND VALID WORKER'S COMPENSATION CLAIM.

5. I AUTHORIZE THE HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE SAID INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION AND THE HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF WEST FLORIDA PAIN MANAGEMENT, P.A. dba **MINIMALLY INVASIVE SPINE CARE,** ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF ANY MEDICAL INSURANCE BENEFITS TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

6. MY INITIALS INDICATE THAT I HAVE RECEIVED A COPY OF **MINIMALLY INVASIVE SPINE CARE** BY West Florida Pain Management, P.A.'S PRIVACY POLICY.

_____initials

Date: _____

X_____
Signature of Patient or Legally Responsible Person

X_____
Witness

Minimally Invasive Spine Care

By West Florida Pain Management, P.A.
Gerald Trimble, M.D.
Susan Samlaska, M.D.

Patient Name: _____ Date: _____
Patient DOB: _____ SSN: _____

This agreement is between myself,_____, and MINIMALLY INVASIVE SPINE CARE BY WEST FLORIDA PAIN MANAGEMENT, P.A.. It is designed to inform me fully of the manner in which my medication, *especially narcotics*, will be provided. It also outlines the criteria by which the Program Team will determine whether or not to continue to prescribe medication.

The long-term use of such substances as opoids (narcotic analgesics), benzodiazepine tranquilizers, and barbituate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as a consideration for, and a condition of, the willingness of the physician whose name appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. Pain medications, *especially of a narcotic type*, will be provided only after it is determined that all reasonable alternatives for adequate pain control have been investigated or attempted.

2. I will agree to try other approaches or techniques as felt appropriate by the team that may assist me in taking the lowest effective dose possible.

3. My "pain medication" will be prescribed by only the doctor whose name appears below and filled at **one** pharmacy. Should the need arise to change pharmacies our office must be informed. The pharmacy you have selected is: _____ Phone: _____
Any attempt, successful or not, to obtain additional medication without the permission of the Pain Management Program may result in discontinuation of medication therapy.

4. Medications will be given in fixed intervals, usually every two to four weeks, and only if I keep my appointments.

5. I may at times be requested to submit to a drug test to confirm that I am taking only those medications prescribed.

6. Medications will be continued as long as:
    a. There is associated pain relief of at least 30% to 50%;
    b. My functional activity is about what would be expected, given my physical limitations, and;
    c. There is not evidence of addiction as suggested by the need for increasing medicine.

7. Evidence of hoarding or other mismanagement of my pain medication may result in discontinuation of services.

8. Exacerbations or "flare-ups" of my pain will be handled by other therapies, such as tens, exercise, ice, heat, relaxation, or non-habit forming medications. Only when it is determined that there is a physiological basis for the "flare-up", and additional medicine required, will a brief increase be considered.

9. If it is determined that the situation may be out of control, I will agree to be hospitalized where medications and other therapies can be provided in a controlled fashion.

10. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

11. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists, family members or other professionals who provide your health care for purposes of maintaining accountability.

12. You may not share, sell or otherwise permit others to have access to these medications.

13. These drugs should not be stopped abruptly, as an abstinence syndrome (withdrawal) will likely develop.

I HAVE READ AND UNDERSTAND EACH OF THE ABOVE POLICIES. I REALIZE THAT THE PAIN MANAGEMENT PROGRAM WILL ASSUME THE RESPONSIBILITY OF ASSISTING ME IN MY THERAPY AS LONG AS I COMPLY WITH ALL OF THE ABOVE POLICIES.

Date: _____

X _____
Signature of Patient or Legally Responsible Person

X _____
Witness

Gerald E. Trimble, M.D.
Susan Samlaska, M.D.

Treating Physician

IMPORTANT POLICIES

CANCELLATION AND NO SHOW POLICY

As our goal is to meet the needs of our patients, we will make every effort to schedule your appointments as efficiently as possible. In return, it is your responsibility to make every effort to keep your appointment and to arrive promptly at the time you are instructed. In any event you need to cancel your appointment or procedure. You will need to contact us AT LEAST 24 HOURS PRIOR YOUR APPOINTMENT Failure to give a 24-hour notice, will result in a cancellation fee. Please make sure you actually speak with front office personal to ensure your appointment is cancelled and/or rescheduled.

This fee is not covered by your medical insurance policy and MUST be paid prior to being seen in our office again.

Appointment Cancellation/NO show Fee: $35.00
Procedure Cancellation/NO show fee: $50.00
Nerve Conduction Study/NO show fee: $75.00

If you fail to show on 3 occasions you will be discharged from the practice for non-compliance and an appropriate note will be sent to your referring provider.

Initial: _____

Financial Policy

It is our desire that payment of your account is easy and convenient as possible. We will assist you in any way we can to facilitate the settling of your account. In order for us to be able to keep billing fees at a minimum, it's absolutely necessary for you to provide us with accurate and up to date insurance information at each of your visits. If your insurance status changes from one visit to the next, it is your responsibility to notify us so that your insurance can be filed correctly.

Initial: _____

Payment Policy

In accordance with the agreement that you have with your insurance company, any deductible or copay is required at the time services are rendered. Required co-pays and deductibles are expected each visit and failure to keep your account current in this regard may prohibit future services until account is made current. We are not responsible for notifying you when your claims are processed, please be prepared to pay your entire balance within thirty days after your insurance has processed your claim. Payments may be made by cash, check, money order, or accepted credit cards. For any questions with your account, please call our office at 727-553-7313 and select the billing department option 4.

Initial: _____

ATTENTION
PATIENTS OF Minimally Invasive Spine Care

EFFECTIVE APRIL 1, 2004
MINIMALLY INVASIVE SPINE CARE
BY WEST FLORIDA PAIN MANAGEMENT
WILL CHARGE:

$10.00

TO THE PATIENTS WHO WISH THEIR PRESCRIPTIONS TO BE CALLED IN.

THIS CHANGE IN POLICY IS DUE TO INCREASED REQUESTS FOR THIS SERVICE.
WE ENCOURAGE YOU TO MAKE SURE YOU GET YOUR PRESCRIPTIONS AT YOUR REGULARLY SCHEDULED OFFICE VISITS.

Remember there are some medications, which due to DEA regulations, Where prescriptions cannot be called in.

_____ _____

Signed **Date**

MI SC

Minimally Invasive Spine Care

By West Florida Pain Management, P.A.
Gerald Trimble, M.D.
Susan Samlaska, M.D.

MEDICAL RECORDS RELEASE

Patient Name: _____ Date: _____

Patient DOB: _____ SSN: _____

__ I hereby authorize release of my medical records and/or x-rays for services rendered to me by **West Florida Pain Management, P.A.**

Please mail my records to:

_____

_____

__ I authorize that you discuss my medical information with:

Name_____ Relationship if any:_____

__I request that my records from _____

_____

be sent to **West Florida Pain Management, P.A.** at the address at the bottom of the page.

I realize that there will be a reasonable fee for copying medical record as set forth in the Florida Administrative Code Chapter 64B8-10.003. Records can be sent to a requesting physician at no charge.

X_____
Patient/Guardian Signature

X_____
Print Name

X_____
Witness

WF PM

WEST FLORIDA PAIN MANAGEMENT, P.A. dba **MINIMALLY INVASIVE SPINE CARE**

Diagnostic & Interventional Pain Medicine

Gerald Trimble, M.D.
Susan Samlaska, M.D.

Dear Patients,

Due to the increased number of prior authorizations and the amount of time required to complete a prior authorization for medications Dr Trimble is going to charge $50.00 to get a prior authorization. There is no guarantee that the medication will get authorized due to insurance rules and regulations, but the nurses will give it their best effort.

Please understand this is not for every medication. This is for medications that may not be on your insurance plans formulary, so they require additional authorization.

If you have questions, feel free to ask.

West Florida Pain Management

WF PM

WEST FLORIDA PAIN MANAGEMENT, P.A. dba **MINIMALLY INVASIVE SPINE CARE**

Diagnostic & Interventional Pain Medicine

Gerald Trimble, M.D.
Susan Samlaska, M.D.

Notice of Disclosure

Dear Patient of West Florida Pain Management, P.A. dba **Minimally Invasive Spine Care**

We would like to make you aware that Dr Trimble has a financial interest in:

1. Belleair Same Day Surgery Center located at 1130 Ponce De Leon Blvd., Clearwater, FL 33756.
2. Skyway Surgery Center located at 625 6th Ave. S Ste 150 St. Petersburg, FL 33701

Should you ever be scheduled at the above facilities you can have your procedure there or another local surgery center such as those listed below where Dr Trimble also has privileges:

Bayfront Same Day Surgery Center 603 7th Street South St. Petersburg, FL 33701
St. Anthony's Physicians Surgery Center 705 16th St. N St. Petersburg, FL 33705
Surg Center NE 2438 Dr MLK St N. Suite C St. Petersburg, FL 33704

Dr Trimble has an interest in Florida Neurology a neuro-monitoring company

Dr Trimble has an interest in Medical Resources Solutions a drug compounding company