

# Brevard Pain Management, Inc.

Todd B. Jaffe, M.D.

*Board Certified, Pain Management*

1832 Garden Street  
Titusville, Florida 32796  
(321) 264-1961  
Fax (321) 264-0472

8095 Spyglass Hill Rd.,  
Unit # 1  
Melbourne, Florida 32940  
(321) 757-0577  
Fax (321) 757-0474

Mailing Address  
P.O. Box 129  
Titusville, Florida  
32781-0129

## Welcome to Brevard Pain Management.

The purpose of your first visit is for consultation and evaluation. This will be with a physician assistant. During your visit, you will have the opportunity to discuss your pain and its treatment alternatives with the physician assistant. This may include information about medications, procedures, alternative therapies, and the advantages or disadvantages of each. This will allow you to choose, with the physician assistant, the treatment plan that is best for you. If needed a follow up appointment will be made with the physician once you have completed ANSAR testing in our office. It is Brevard Pain Management's policy not to prescribe any narcotic medications on your first visit, and possibly not at all. If you do not wish to see the physician assistant on your first visit, you need to call our office for an alternate appointment date.

Please take the time to fill out the patient information and the brief pain assessment form included with this letter. It is important to completely fill out all forms in their entirety as it will allow us to more thoroughly address your concerns and will not waste valuable examination time. We make a concentrated effort to keep all of our patients waiting time to a minimum. This may necessitate rescheduling an appointment if these forms are not filled out prior to your visit.

In addition, please provide any documentation from your doctor, such as reports of any test including X-ray, MRI, CT scan, etc., that may be related to your condition. You may either bring these on your first visit or you may have them faxed to our office prior to your visit. These records are necessary in assessing your condition. If you are having your physician fax your records, please verify their receipt with our receptionist when she calls to confirm your appointment.

We'd like to thank you for the opportunity to serve you and look forward to seeing you soon.

Sincerely,

Brevard Pain Management, Inc.

Patient  
signature: \_\_\_\_\_

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## PATIENT RIGHTS AND RESPONSIBILITIES

OFFICE HOURS: Monday through Thursday from 7:30am – 5:30pm  
Closed Friday through Sunday

- My records will be held in strict confidence and will only be released upon written notification from me.
- I will keep my cell phone OFF while in an exam room with a provider.
- I will be treated with courtesy dignity and respect and in turn, I will treat the office staff with the same courtesy, dignity and respect that I am shown.
- I have a right to participate in make decisions about my plan of treatment, and have the right to request or refuse any treatment except as otherwise provided by law.
- I acknowledge that no guarantees have been made to me as to the results of this treatment.
- I will promptly notify your office of any changes in address/phone or insurance.
- I will give a 72-working hour advance notice when calling in my medication refills. I will call the pharmacy to check on my refills that may be called in, and if the medication can't be called in, I will check with the office no sooner the 48 hours after my original request for the refill. There will be a \$25.00 charge for rewriting your prescription due to it being lost, stolen or damaged.
- I will make every effort to understand the benefits of my insurance plan, even to the extent of calling the carrier or the benefits coordinator at my place of employment.
- I am responsible for obtaining all necessary referrals from my primary care physician. I am ultimately responsible for payment of services I receive, including services not covered by my insurance.
- I am responsible for keeping appointments with other physicians Dr. Jaffe has referred me to or for tests that the doctor has ordered for me. If I am unable to make the appointment, I will contact the office within 48 hours of the appointment.
- I agree to be on time for my appointments and will pay the no show fee of \$25.00 for any appointment missed if I fail to notify the office 24 working hours in advance.
- I agree to pay my co-payment at the time of my appointment.
- I agree to pay a \$25.00 charge for any check that is returned by my bank.
- If I fail to pay my bill in a satisfactory manner and if you assign the account to an attorney or collection agency, I will pay the costs of collection, including attorney's fees.
- I understand that the office can only bill for a diagnosis that is documented in my record and that to ask the doctor to change a diagnosis to secure insurance payment constitutes fraud.
- I agree to pay my insurance deductibles at the time of service unless it has been proven to Brevard Pain Management's satisfaction, through experience with your secondary insurance, that they will pay your deductible in a timely fashion. If my deductible amount is filed to my secondary insurance, I understand it will be filed only once and then the amount due will become my responsibility if my secondary insurance has not paid within 30 days.
- Once my deductibles have been met, Brevard Pain Management will file my secondary insurance for costs that I have incurred that were not covered by my primary insurance. Brevard Pain Management will file secondary insurance only once. If my secondary insurance does not pay within 30 days, I understand that the amount owed will be my responsibility.
- There will be a \$25.00 charge for any non emergent calls to the answering service for Dr. Jaffe after hours.
- Our office performs random drug screens and our patients are expected to comply with this policy.
- Consult our physician(s) concerning the availability of a less expensive generically equivalent drug and the requirements of Florida law.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Brevard Pain Management Assessment Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_

1. Name, address and phone number of physician or other person referring you to us: \_\_\_\_\_

2. Please finish the following statement "I believe my pain is due to" \_\_\_\_\_

3. On a scale of 1 to 10, with 10 being the worst, what is your pain intensity? \_\_\_\_\_

4. Has the intensity of your pain changed over time? same/ increase/ decrease \_\_\_\_\_

5. Please circle the words that describe the worst qualities of you pain.

Aching	disabling	gnawing	stabbing
Burning	dull	pins & needles	tender
Chronic	electric like	radiating	throbbing
Cramping	excruciating	sharp	worse in the AM
Deep	exhausting	shooting	worse in the PM

6. Please circle how often the pain occurs:

Constant	several times per week
1-2 times per day	less then 3-4 times per month
More then 3 times per day	has occurred previously

How long have you had this problem? \_\_\_\_\_

7. Where does your pain radiate?

Arm (left right both)	hand (left right both)	leg (left right both)
Buttock (left right both)	hip (left right both)	neck
Foot (left right both)	jaw (left right both)	shoulder (left right both)
Groin (left right both)	knee (left right both)	thigh (left right both)

8. Please circle the events that led to your pain

Bending over	fall	no obvious cause	twisting
Cancer	moving heavy object	surgery	work related
exercising	motor vehicle accident	throwing	Other: _____

9. What makes your pain worse?

Bending	exercise	massage	standing
Climbing	ice	medication	stretching
Direct pressure	immobilization	moist heat	walking
Environmental (temp/humidity)	lifting	rest	weight bearing
Everyday use	lying down	sitting	

10. What makes your pain better?

Bending	exercise	massage	standing
Climbing	ice	medication	stretching
Direct pressure	immobilization	moist heat	walking
Environmental (temp/humidity)	lifting	rest	weight bearing
Everyday use	lying down	sitting	

11. Please circle the therapy that you have tried for the pain.

Acupuncture	facet blocks	physical therapy	sympathetic plexus block
Biofeedback	Hyalagan Injection	psychotherapy	Tens Unit
Brace	Implanted pain pump	Rhyzotomy	trigger point injection
Chiropractic	Medication	spinal cord stimulation	
Epidural	Nerve block	surgery	

12. Please circle the activities or mental functions that are affected by your pain.

Bowel movements	household chores	sex
Concentrating	leisure	sleep
Eating	mood	work

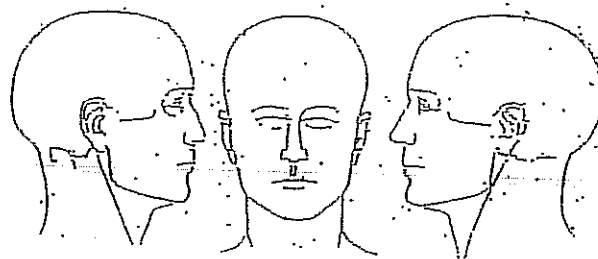
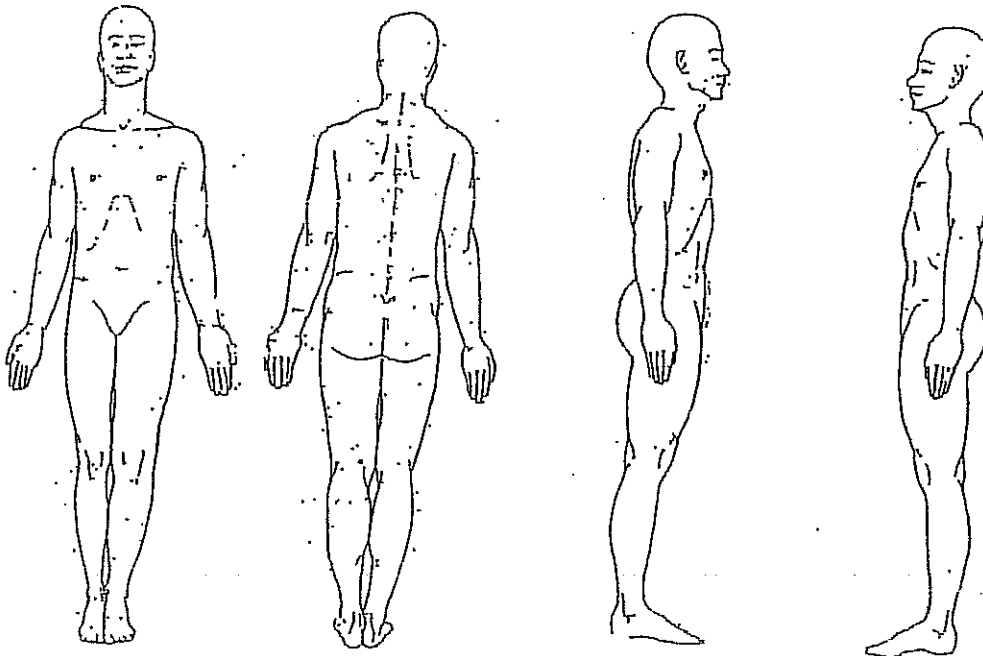
13. What medications have you tried in the past for pain? Please circle the ones that have helped.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

14. Please list the names of specialists that you have seen for your pain:

Orthopedic surgeon _____	Pain Specialist _____
Neurologist _____	Neurosurgeon _____
Psychiatrist _____	Psychologist _____
Other: _____	

Please shade in the areas where you feel the pain, mark the area that hurts the most with an "x", mark any areas of numbness with an "n", mark areas that have burning pain with a "b"



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32781-0129

Patient: \_\_\_\_\_

Date: \_\_\_\_\_ Office: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

### Current Medications/Dosages and the prescribing Physician

1. \_\_\_\_\_ 6. \_\_\_\_\_

2. \_\_\_\_\_ 7. \_\_\_\_\_

3. \_\_\_\_\_ 8. \_\_\_\_\_

4. \_\_\_\_\_ 9. \_\_\_\_\_

5. \_\_\_\_\_ 10. \_\_\_\_\_

Allergies: \_\_\_\_\_

Please you're your past surgeries/date of surgery and physician performing surgery:

Please circle if you have a **family history** of any of the following and indicate family member and if deceased or living:

Alcoholism

Anemia

Anxiety/Stress Disorder

Arthritis

Asthma

Cancer

Depression

Diabetes Insulin Dependant

Diabetes Non-Insulin Dependant

Drug Abuse

Headaches/migraines

Heart problems

Hyperlipidemia

Hypertension

Kidney Disease

Seizure Disorder

Stroke

Thyroid Disease

### Your past Medical History:

Yes No

\_\_\_\_ Arthritis

\_\_\_\_ Asthma

\_\_\_\_ Bleeding Problems

\_\_\_\_ Cancer

Yes No

\_\_\_\_ Diabetes

\_\_\_\_ Heart Disease

\_\_\_\_ Hepatitis

\_\_\_\_ HIV/AIDS

Yes No

\_\_\_\_ Hypertension

\_\_\_\_ Kidney Disease

\_\_\_\_ Lung Disease

\_\_\_\_ Ulcers

Additional notes about medical history \_\_\_\_\_

### Social History:

Alcohol: rarely, socially, daily      Exercise: 1-3x weekly   4 or more x weekly   none

Tobacco use: Never / Quit \_\_\_\_\_ years ago / Current smoking \_\_\_\_\_ packs per day for \_\_\_\_\_ years

Employment status and type of employment: \_\_\_\_\_

Marital status: Married Single Widowed Divorced      Children: 0 1 2 3 4 5 6 7

Abuse: any history of drug abuse? Yes No / If yes which drug(s)? \_\_\_\_\_

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Patient name: \_\_\_\_\_ today's date: \_\_\_\_\_

Please circle all of the following that apply to you today

- |                           |                      |                           |
|---------------------------|----------------------|---------------------------|
| Abuse or neglect          | painful urination    | Recent Seizure            |
| Addiction                 | High Blood Pressure  | Runny nose                |
| Anemia                    | Eye/Vision Problems  | Shortness of Breath       |
| Ankle swelling            | Fatigue              | Sleep Problems            |
| Asthma                    | Forgetfulness        | Stroke                    |
| Back pain                 | Headaches            | Passing out/fainting      |
| Blood clotting problem    | Heart Attack         | Thyroid Disease           |
| Bruise easily             | Heartburn            | Ringling in the ears      |
| Change in thirst/appetite | Heat Intolerance     | Tremors                   |
| Chest pain                | Hernia               | Vomiting                  |
| Cold intolerance          | Joint Pain           | Weight gain               |
| Constipation              | Kidney Stones        | Unintentional weight loss |
| Cough                     | Mood changes         | Wheezing                  |
| Dark urine                | Nausea               |                           |
| Depression                | Neck pain            |                           |
| Diabetes                  | Paralysis            |                           |
| Diarrhea                  | Peptic Ulcer Disease |                           |
| Difficulty concentrating  | Frequent Urination   |                           |
| Difficulty hearing        |                      |                           |

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## NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION (INCLUDING BUT NOT LIMITED TO HIV/PSYCHIATRIC/AND SUBSTANCE ABUSE) FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I, \_\_\_\_\_, understand that as part of my healthcare, Brevard Pain Management, Inc. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- ❖ A basis for planning my care and treatment
- ❖ A means of communication among the many health professionals who contribute to my care
- ❖ A source of information for applying my diagnosis and surgical information to my bill
- ❖ A means by which a third-party payer can verify that services billed were actually provided, and
- ❖ A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- ❖ The right to review the notice prior to signing this consent
- ❖ The right to object to the use of my health information for directory purposes, and
- ❖ The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that Brevard Pain Management, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Brevard Pain Management, Inc. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Brevard Pain Management, Inc. change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use or disclosure of my health information:

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I understand that as part of Brevard Pain Management's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, such as a primary care physician, or insurance carrier, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

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Patient's signature

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Date

Patient Name: \_\_\_\_\_

Medical Record # \_\_\_\_\_

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**FOR OFFICE USE ONLY**

- Consent received by \_\_\_\_\_ on \_\_\_\_\_
- Consent refused by patient, and treatment refused as permitted.
- Consent added to the patient's medical record on \_\_\_\_\_

BREVARD PAIN MANAGEMENT, INC.  
LIFETIME AUTHORIZATION STATEMENT  
ASSIGNMENT OF BENEFITS FOR DIRECT PAYMENT

PATIENT NAME: \_\_\_\_\_ MR#: \_\_\_\_\_

Brevard Pain Management, Inc. is pleased that you have selected this group to provide you for your medical needs.

Please review the following Lifetime Authorization Statement. Please do not hesitate to ask a staff member for clarification on any part of this document. Please sign where indicated and return it to the receptionist. If you disapprove, we certainly respect your right of refusal. However, please be aware that, without your legal signature, we cannot file with your insurance carrier for the services you are scheduled to receive. Therefore, we will have no alternative but to require that you be responsible for the cost of services rendered in full. (See reverse side for Refusal to Sign Lifetime Authorization Statement). Should you refuse this option, we have no other choice than to cancel your appointment.

**LIFETIME AUTHORIZATION STATEMENT/ASSIGNMENT FOR DIRECT PAYMENT**

I hereby instruct and direct my current insurance carriers to pay by check made payable to:

Brevard Pain Management, Inc.  
PO Box 129  
Titusville, FL 32781-0129

The medical, surgical and diagnostic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to Brevard Pain Management, Inc. and I have agreed to pay, in a current manner, any balance of said service charges over and above this insurance payment, including applicable co-payments, deductible, non-covered services and items, unauthorized services or any fees denied, except to the extent my liability for any such balance is limited by agreement or law applicable to Brevard Pain Management, Inc. A photocopy of this assignment shall be considered as effective and as valid as the original. Should my account be referred for collection procedures, I will also pay reasonable attorney's fees and collection expenses.

**CONSENT FOR TREATMENT**

I authorize Brevard Pain Management, Inc. to provide treatment as necessary for which I am, or my minor child is being seen. This includes, but is not necessarily limited to, injections, procedures, or any other treatment deemed proper care of my injury or illness.

**RELEASE OF MEDICAL RECORDS**

I hereby authorize Brevard Pain Management, Inc. to release any medical information in connection with these services to any person or corporation which is or may be liable for all or any portion of the charges, including insurance companies, health care services plans, workers' compensation carriers, adjusters or attorneys, to the extent necessary to obtain reimbursement; Also to the patient's personal physician, referring physicians, or primary care physician. **I am aware that any/all information contained within my medical records/chart is the property of Brevard Pain Management, Inc.**

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS ALL THE ABOVE, AND AS THE PATIENT GUARNTOR OR THE PATIENT'S RESPONSIBLE PARTY, AGREES TO AND ACCEPTS THE TERMS.

\_\_\_\_\_  
Signature of patient/responsible party

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date



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Date \_\_\_\_\_ Referred By \_\_\_\_\_  
Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell or Beeper Number \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip Code \_\_\_\_\_  
Marital Status \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address \_\_\_\_\_ Occupation \_\_\_\_\_  
Next of Kin not living with you \_\_\_\_\_ Phone \_\_\_\_\_  
If accident / injury, date of accident / injury \_\_\_\_\_

**PRIMARY INSURANCE**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Insured \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address \_\_\_\_\_  
Adjuster \_\_\_\_\_ Phone \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**SECONDARY INSURANCE**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Insured \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**ASSIGNMENT RELEASE**

I, the undersigned certify that I (or my dependent) have insurance coverage with the above named insurance company(ies) and assign directly to BREVARD PAIN MANAGEMENT, INC. all insurance benefits, if any, otherwise payable to me for services rendered.

\_\_\_\_\_  
Signature of Patient( or parent of minor) Date \_\_\_\_\_

2009