

**FLORIDA PAIN MANAGEMENT ASSOCIATES  
INTERVENTIONAL PAIN MANAGEMENT**

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SEBASTIAN, FLORIDA 32958**

**787 37<sup>TH</sup> STREET SUITE E-140  
VERO BEACH, FLORIDA 32960**

**HAROLD J. CORDNER, M.D.  
BOARD CERTIFIED  
PAIN MANAGEMENT AND ANESTHESIA**

**NEW PATIENT INFORMATION  
WELCOME TO FLORIDA PAIN MANAGEMENT**

**The purpose of your first visit is for consultation. During your first visit, you will have the opportunity to discuss your pain and its treatment alternatives. This may include information about procedures, alternative therapies, and the advantages and disadvantages of each. This will allow you to choose, with your doctor, the treatment plan that is best for you.**

**Please take the time to fill out the patient information and the pain assessment form included with this letter. It is important to fill out all forms in their entirety as it will allow us to more thoroughly address your concerns and allow more 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, and reports of any test that may be related to your condition. These include the physical x-rays, MRI, CT scans, and other such tests. It is very important that you bring these films with you to your initial appointment. It is your responsibility as the patient to make sure you obtain these records it is not the doctor's office responsibility. These records and films are necessary in assessing your condition. If you are having your physician fax your records, please verify their receipt before your scheduled appointment.**

**We would like to thank you for the opportunity to serve you and we look forward to seeing you soon.**

**Your appointment is scheduled for \_\_\_\_\_ at \_\_\_\_\_ in our \_\_\_\_\_ office.**

**FLORIDA PAIN MANAGEMENT ASSOCIATES**

To help us meet all of your healthcare needs, please answer the following questions as completely as possible. Thank you.

PATIENT INFORMATION: DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ SEX: M F AGE: \_\_\_\_\_

SSN: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME #: \_\_\_\_\_ CELL #: \_\_\_\_\_ WORK #: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

PRIMARY CARE: \_\_\_\_\_ SOURCE OF REFERRAL: \_\_\_\_\_

ARE YOU PRESENTLY: EMPLOYED / RETIRED / DISABLED / UNEMPLOYED

WHAT WAS OR IS YOUR OCCUPATION? \_\_\_\_\_

IS THERE A LAWYER INVOLVED WITH YOUR INJURY? \_\_\_\_\_

NAME OF LAWYER: \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY: \_\_\_\_\_

PHONE #: \_\_\_\_\_

RELATION: \_\_\_\_\_

PHARMACY NAME: \_\_\_\_\_ LOCATION: \_\_\_\_\_

PHARMACY PHONE#: \_\_\_\_\_

CIRCLE ONE: MEDICARE AUTO WORK COMP SELF-PAY OTHER

\*Please bring your insurance cards and a photo ID with you to your appointment\*

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

\*IF AUTO OR WORK COMP. PLEASE FILL OUT INFORMATION BELOW:

Auto/ Work Comp Insurance: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Claim #: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

I AUTHORIZE THE RELEASE OF NEEDED INFORMATION TO MY INSURANCE CARRIER, AND I AUTHORIZE PAYMENT OF MY INSURANCE BENEFITS TO FLORIDA PAIN MANAGEMENT ASSOCIATES.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

**FLORIDA PAIN MANAGEMENT**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_

\_\_\_ **Yes** \_\_\_ **No**      **Problems with Anesthesia?**

\_\_\_ **Yes** \_\_\_ **No**      **Diabetes? Controlled with (circle): Insulin   Pills   Diet**

\_\_\_ **Yes** \_\_\_ **No**      **Heart Problems? Circle the one that applies:**  
**Heart attack (year)\_\_\_\_\_; Coronary heart disease;**  
**Pacemaker/Defibrillator; Irregular heart beat; Palpitations;**  
**Other\_\_\_\_\_**

\_\_\_ **Yes** \_\_\_ **No**      **High Blood Pressure?**

\_\_\_ **Yes** \_\_\_ **No**      **Breathing Problems? (circle) On oxygen; Asthma; COPD;**  
**Emphysema; Chronic Cough; Sleep Apnea; Bronchitis;**  
**Other\_\_\_\_\_**

\_\_\_ **Yes** \_\_\_ **No**      **Smoker? \_\_\_\_\_ packs per day**

\_\_\_ **Yes** \_\_\_ **No**      **Stomach or Digestion problems? GERD/ Reflux**

\_\_\_ **Yes** \_\_\_ **No**      **Stroke: year of stroke\_\_\_\_\_ Weakness-where\_\_\_\_\_**

\_\_\_ **Yes** \_\_\_ **No**      **Seizures?      How often?\_\_\_\_\_**

\_\_\_ **Yes** \_\_\_ **No**      **Kidney/ Urinary Problems? Describe: \_\_\_\_\_**

\_\_\_ **Yes** \_\_\_ **No**      **Liver/ Thyroid Problems? Describe:\_\_\_\_\_**

\_\_\_ **Yes** \_\_\_ **No**      **Blood Thinners?(circle) Coumadin Warfrin Plavix Aspirin**  
**81mg   325mg Other\_\_\_\_\_**

\_\_\_ **Yes** \_\_\_ **No**      **Do you have Cancer? Where?\_\_\_\_\_ When?\_\_\_\_\_**  
**Undergoing treatment now?\_\_\_\_\_**

\_\_\_ **Yes** \_\_\_ **No**      **Arthritis? \_\_\_\_\_**

\_\_\_ **Yes** \_\_\_ **No**      **Psychiatric Problems?\_\_\_\_\_**

\_\_\_ **Yes** \_\_\_ **No**      **Substance Abuse?\_\_\_\_\_**

\_\_\_ **Yes** \_\_\_ **No**      **Drink Alcohol? \_\_\_\_\_ drinks per day      \_\_\_\_\_ per week**

**Is there any other medical problem we should know about?**

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**List Surgeries:**

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**ALLERGIES to drugs, foods, dyes, preservatives:** \_\_\_\_\_

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**List Prescription Medications Strength and Frequency:**

_____	<b>x day</b>	_____	<b>x day</b>
_____	<b>x day</b>	_____	<b>x day</b>
_____	<b>x day</b>	_____	<b>x day</b>
_____	<b>x day</b>	_____	<b>x day</b>
_____	<b>x day</b>	_____	<b>x day</b>
_____	<b>x day</b>	_____	<b>x day</b>

**List over the counter medicines (non-prescription, Vitamins-Aspirin etc)**

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\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

**FLORIDA PAIN MANAGEMENT ASSOCIATES**

**PLEASE CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR ANSWERS  
TO THE FOLLOWING STATEMENTS**

**WHEN YOUR PAIN IS AT ITS WORST**

**0      1      2      3      4      5      6      7      8      9      10**  
**NO PAIN    MILD                    DISCOMFORTING                    DISTRESSING                    HORRIBLE                    EXCRUCIATING**

**WHEN YOUR PAIN IS AT ITS LEAST**

**0      1      2      3      4      5      6      7      8      9      10**  
**NO PAIN    MILD                    DISCOMFORTING                    DISTRESSING                    HORRIBLE                    EXCRUCIATING**

**WHEN YOUR PAIN IS AT ITS AVERAGE**

**0      1      2      3      4      5      6      7      8      9      10**  
**NO PAIN    MILD                    DISCOMFORTING                    DISTRESSING                    HORRIBLE                    EXCRUCIATING**

**WHAT MAKES YOUR PAIN WORSE-(i.e. walking, standing, lifting)\_\_\_\_\_**

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**WHAT MAKES YOUR PAIN BETTER-(i.e. heat, medicine, rest)?\_\_\_\_\_**

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**WHAT TREATMENTS, MEDICATIONS, ETC. HAVE YOU TRIED TO  
RELIEVE YOUR PAIN? HAVE ANY OF THEM WORKED? \_\_\_\_\_**

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**REASON FOR YOUR CONSULTATION TODAY \_\_\_\_\_**

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## FLORIDA PAIN MANAGEMENT

### **PAYMENT AGREEMENT & CANCELLATION POLICY**

Please read the following agreement. It explains your financial obligations while under our care and our policies regarding cancellations.

- **Co-pays are always due at the time of service**
- We do accept self-pay patients, however:
  - An initial consultation is \$250 that is due at the time of service
  - Follow up visits are either \$50 or \$75 based of the level of service and is also collected at the time of service.
  - If a procedure is scheduled- a fee schedule will be discussed with you prior to the appointment day. The amount discussed will be due at the time of service.
- **Regretfully, we have been forced to institute this policy due to a large volume of last-minute cancellations, scheduling changes, and “no-shows.”**
- We have a very busy practice. Assuring that all our established patients have access to their doctor when necessary is a constant challenge. When you cancel or reschedule at the last minute, or fail to show for your appointment, you are depriving another patient the care they need.
- New patient visits require our doctor to block out large time slots, making last-minute cancellations and rescheduling of visits even more problematic. We provide a large amount of time and attention with each and every one of our new patients because we are committed to providing the highest quality care. Again, please be aware that when you cancel or reschedule at the last-minute you are depriving care to another patient in need.
- All new patients are required to verbally confirm their appointment 24 to 48 hours’ prior. If you fail to verbally confirm your appointment during our normal office hours your appointment will be cancelled.
  - ◆ **New Patient Appointments:**
    - If you cancel your appointment with less than 24 hours’ notice you will be charged \$35.
    - If you fail to show for your appointment without notification you will be charged \$50.
    - If you verbally confirm that you will be at your appointment and fail to show up for your scheduled appointment time you will be charged \$100.

◆ **Follow- Up Visits:**

- If you cancel you appointment within less that 24 hours 3 times, on the third time you will be charged \$35.
- If you fail to show for your appointment without notification you will be charged \$35.
- If you continue to cancel, reschedule, or fail to show up for your scheduled appointments you may be discharged from our practice.

● **Phone Consultations:**

- We bill for phone consultations. They require the same time and expertise as office visits.
- Billing for phone consultations is, however, at the doctor's discretion. The doctor may choose not to bill you if the nature of the phone consultation is uncomplicated, such as taking a minute to answer a question about your treatment protocol or reviewing a diagnostic test that the Doctor has ordered. If any type of extended discussion ensues or if a number of questions need to be addressed, it is likely your doctor will bill for the phone consultation.

By signing this payment agreement & cancellation policy, you are indicating that you understand and agree to the terms of service explained above.

Name of Patient or Legal Guardian: \_\_\_\_\_

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

Witness: \_\_\_\_\_ Copy Given to Patient: \_\_\_\_\_

FLORIDA PAIN MANAGEMENT

**CONFIDENTIALITY STATEMENT-HIPAA**

Your privacy is important to us. All medical records and interactions between doctor and patient are entirely confidential.

Outlined below is a brief summary of your rights and protections under the Health Insurance Portability and Accountability Act (HIPAA). You can learn more about your right from the website at <http://www.hhs.gov/ocr/hipaa/> or by calling 1-866-627-7748.

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used or shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Request where you would like to be contacted
- Ask that your information not be shared. For example, you could ask your doctor not to share your medical record with other doctors in the office.

If you believe your rights are being denied or your health information isn't being protected, you can:

- File a complaint with your doctor.
- File a complaint with the U.S. Government.

If it is necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public, your doctor has the obligation to disclose and relevant information.

Patient Name/ Legal Guardian: \_\_\_\_\_

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

FLORIDA PAIN MANAGEMENT

**REQUEST FOR RELAEASE OF MEDICAL RECORDS**

**DR:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**PHONE #:** \_\_\_\_\_ **FAX #:** \_\_\_\_\_

**I hereby request the release of all medical, laboratory, radiology, operative and hospital records and reports to:**

**Dr. Harold J. Cordner, M.D.  
Florida Pain Management  
13825 US Hwy 1  
Sebastian, FL 32958  
(772) 388-9998 Fax (772) 388-9742**

**PATIENT NAME (PLEASE PRINT):** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**PATIENT SIGNATURE:** \_\_\_\_\_

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