Dear Patient,

Thank you for choosing Invasive Pain Management Clinics, the offices of Dr. Edwin Colon, M.D., P.A. for your healthcare needs. The following are the addresses to our offices. We look forward to meeting your healthcare needs.

<table>
<thead>
<tr>
<th>New Port Richey:</th>
<th>Dade City</th>
<th>Wesley Chapel</th>
</tr>
</thead>
<tbody>
<tr>
<td>8819 River Crossing Blvd.</td>
<td>36739 S.R. 52</td>
<td>2407 Cypress Ridge Blvd.</td>
</tr>
<tr>
<td>New Port Richey, FL 34655</td>
<td>Suite 102</td>
<td>Wesley Chapel, FL 33543</td>
</tr>
<tr>
<td>(727) 834-8833 Office</td>
<td>(352) 567-4117 Office</td>
<td>(813) 907-3300 Office</td>
</tr>
<tr>
<td>(727) 834-8842 Fax</td>
<td>(352) 567-4122 Fax</td>
<td>(813) 907-3311 Fax</td>
</tr>
</tbody>
</table>

- **Our New Port Richey** office is located on the North East corner of Little Road and River Crossing Blvd’s. We are behind the Hess gas station and the Auto Spa car wash.

- **Our Dade City** office is located in the old HRS building, right across the street from the Pasco County Fairgrounds and the Dade City MotoCross.

- **Our Wesley Chapel** office is located off State Road 56, behind the Synovus Bank and right next door to Tower Radiology. We’re just 1.5 miles west of Wiregrass Mall.

Should you need additional information or directions, please don’t hesitate to call us!

Sincerely,

Edwin Colon, M.D.,P.A.
I____________________________ Social Security # _________ - _________ - _________
(Print Patient’s Name)
Date of Birth _________ / _________ / _________ Phone (_______) _________ - _________
Address _____________________________________________________________________________
Authorize ____________________________________________________________________________
(Name of Doctor or person who is to release information)

To release information from my Medical Records, requested medical information, including:
___ Office Notes, Lab Work, Testing & X-rays
___ HIV Antibody test results / AIDS records
___ Communicable Diseases (Hepatitis, etc.)
___ Psychotherapy Notes / Drug and Alcohol
___ Other __________________________

The information will be used for the following purpose(s):
Continued Medical Care ______ Insurance ______ Legal Follow-up ______
Personal Information ______ Disability ______ Other ________________

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by Federal privacy regulations.

I understand that this consent shall be valid for a period of 1 year from the date of authorization and may be revoked at any time upon written notice, except to the extent that the information has already been released in reliance upon this authorization.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on any actions they took before they received the revocation.

I further understand that the confidentiality of this information may be protected by Federal regulations (42CFR, Part II), Prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated.

________________________________________
(Patient’s signature)
________________________________________
(Patient representative signature)

________________________________________
(Date signed) (Relationship to patient)

________________________________________
(Witness)

Invasive Pain Management
A Center of Excellence
Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

New Port Richey:  Dade City  Wesley Chapel
8819 River Crossing Blvd.  36739 S.R. 52  2407 Cypress Ridge Blvd.
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(727) 834-8842 Fax  (352) 567-4122 Fax  (813) 907-3311 Fax

RELEASE OF CONFIDENTIAL INFORMATION
Attention All Patients

We are a specialist office that REQUIRES a referral BEFORE you can be seen by the physician. If you are on a HMO (health maintenance organization) or an insurance plan that requires a referral, you MUST obtain the referral from your PCP (primary care physician) before you can see our physicians. It is YOUR responsibility to obtain this referral and you WILL NOT be seen without it per your insurance company guidelines.

Your Insurance Company / HMO WILL NOT pay for your visit without the proper referral.
Invasive Pain Management
A Center of Excellence

Patient Last Name ___________________________ First ______________________ Middle Initial _____

Address __________________________________ City, State, Zip___________________________

Hm: (_____) _______ - _______ Wk (_____) _______ - _______ Cell (_____) _______ - _______

D.O.B. __/__/____ SSN________ - ______ - _______ Marital Status ____________________________

Employer ___________________________ Occupation ___________________________

Employer Address ________________________________________________________________

Employer Phone (_____ ) _______ - _______ ext. _________

Spouse Last name ___________________________ First ___________________________ Middle Initial _____

D.O.B.- __/__/____ SSN________ - ______ - _______ Cell Phone# (_____ ) _______ - _______

Spouse Employed By ___________________________ Business # (_____ ) _______ - ______ ext

Address __________________________________ Occupation __________________________

Who is responsible for account? ______________________ Relationship to patient ______________

Primary Insurance Co. ___________________________ Phone (_____ ) _______ - _______

Address __________________________________ City, State, Zip___________________________

Policy# ___________________________ Group# __________________________

Name of Policy Holder _______________ D.O.B. __/__/____ SSN________ - ______ - _______

Secondary Ins. Co. ___________________________ Phone (_____ ) _______ - _______

Address __________________________________ City, State, Zip___________________________

Policy# ___________________________ Group# __________________________

Name of Policy Holder _______________ D.O.B. __/__/____ SSN________ - ______ - _______

How did you hear about us? Who referred you?
_____________________________________________________________________________

Please remember that insurance is considered a method of reimbursing the patient for fees paid/owed to the physician, but is usually not designed to pay the entire fee. Insurance companies vary in the amount they will pay for various services. It is ultimately your responsibility to pay the portion of the bill not paid by your insurance company restricted by law or agreement we might have made with the insurer.
Patient Privacy Rights
You Have the Right To:

- Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy of your record. We must respond within 30 days if the record is readily available and within 60 days if it is not readily available.

- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days.

- Receive an accounting of any disclosures made from your record over the last six years starting April 14th, 2003. You can get this with a written request directed to our office. We must respond within 60 days.

- Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supersede the typical disclosures noted above. You may revoke or restrict consent.

- Request confidential communications. All communications in our office are confidential. You may specifically request that all communications be confidential with a written request directed to our office.

- Receive a copy of this notice by printing it or with a written request directed to this office and a copy of this notice will be given with all new patient packets.

We may contact you for appointment reminders and we may provide you with information about health related or product benefits and services. Each patient is given a copy of the privacy notice & an opportunity to review and understand it.

Our responsibilities under HIPAA:

We are required by law to maintain the privacy of your personal health information and to provide you notice of our legal duties and privacy practices and adhere to this notice. We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change. Copies will be made available.

You can submit a complaint about our privacy policy or its execution either verbally or in writing to our PRIVACY OFFICER at:

Edwin Colon MD, PA
P.O. Box 99
Dade City, FL 33525

(727) 834-8833 Office
(727) 834-8842 Fax

If you get no resolution to your complaint, you can send a written statement to this officer or the Secretary of Health and Human Services.
Dear Patient,

It is in everyone’s best interest to take the time to read this notice.

As a pain management practice, we have the responsibility of prescribing pain medications for our patients.

**NARCOTICS** in particular. As specialists in the field of pain management, we reserve the right to evaluate, assess and prescribe the appropriate medication for our patients. If you are placed on any narcotics, you **MUST** take the medications as prescribed. **NARCOTICS MUST NOT BE CHEWED, CRUSHED, CUT IN HALF, DISSOLVED, OR INJECTED.** Doing so will lead to very serious consequences resulting in death.

As a patient, you must fully understand the consequences mentioned above. By signing this notice, you acknowledge that you have read and understand this notice.

____________________________  _____________________  ____________________
Edwin Colon, M.D., P.A.        Rosemary Clanton, A.R.N.P.

____________________________  ________________________  ____________________
Patient Signature              Please Print                   Date
Narcotic Agreement

The purpose of this agreement is to maintain a safe controlled treatment plan. I am asking for narcotic pain medication because other treatment and medications I have received have not given enough pain relief. It is unlikely that any medication will completely take away my pain. But humane reasons, narcotic pain medication will be given to me as long as my pain continues, provided I follow the terms of this agreement.

I understand that the possible complication of chronic narcotic therapy include but are not limited to Chemical Dependence (Addiction), Constipation, which could be severe enough to require medical treatment, difficulty with urination, drowsiness, nausea, itching, slowed respiration, and reduced sexual function. If I take more medication than what is prescribed, a dangerous situation could result, such as coma, organ damage or even death. I understand that if I run out of my medication too soon, or if my medication is stopped suddenly, I could have withdrawal symptoms, which can be very uncomfortable and dangerous. If I become pregnant, there are known and unknown risks to the unborn child, which include narcotic addiction and the possibility of the baby experiencing narcotic withdrawal at birth. I am obligated to let my doctor know if I am pregnant and they will help me find ways of controlling my pain without narcotics.

The terms of the agreement are as follows:

- Only ONE pharmacy will be used for filling narcotic prescriptions. That pharmacy’s name address and phone number is:
  
  Name: ____________________________________________
  Address: __________________________________________
  Phone#: ____________________________________________

- If it is discovered that I received a prescription for narcotic medications from a source other than Edwin Colon MD, PA (Invasive Pain Management Clinic), I may be discharged from their care and any prescriptions of narcotics may be immediately discontinued.

- If it is necessary to call the office of Edwin Colon MD, PA (Invasive Pain Management), I will call on Monday through Friday (9:00 am – 4:30 pm) to refill medications. It is important to make sure that I have enough medications to get me through the weekend or after hours. I understand and agree that refills will only be given as I follow up in the office and keep my appointment maintenance.

- The physicians on call after hours and on weekends will NOT refill my medications. They do not have medical records available for review to make decisions regarding my medications.

- I agree ad will sign a release to allow Edwin Colon MD, PA (Invasive Pain Management) to contract and communicate with Edwin Colon MD, PA (Invasive Pain Management) about narcotics and other pain related medications and side effects. I will NOT contract other physicians who do not work for Edwin Colon MD, PA (Invasive Pain Management), regarding the above concerns, if I have a significant side effect that occurs after hours or during the weekend, it is appropriate to go to the emergency room or the nearest hospital.

- I agree to take the narcotic medication EXACTLY as instructed by Edwin Colon MD, PA (Invasive Pain Management) physicians. I am NOT allowed to change dosage amounts or alter the time schedule of

- taking the medication without talking to a staff member of Edwin Colon MD, PA (Invasive Pain Management)
Invasive Pain Management
A Center of Excellence
Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

- I agree that Edwin Colon MD, PA (Invasive Pain Management) will NOT replace lost, stolen or inaccessible narcotic medications or narcotic prescriptions for any reason.
- I MUST keep all regular follow up appointments as recommended by the physicians of Edwin Colon MD, PA (Invasive Pain Management). Failure to comply may cause discontinuation of narcotic prescriptions and possible discharge from the care of Edwin Colon MD, PA (Invasive Pain Management).
- Edwin Colon MD, PA (Invasive Pain Management) will NOT accept telephone requests for refills from anyone other than me.
- All narcotic prescriptions must be picked up by me. If I am too disabled or sick, an exception may be allowed, at the discretion of Edwin Colon MD, PA (Invasive Pain Management).
- I understand that the benefits of narcotic medications will be evaluated regularly using the following criteria of pain relief: increase function and increase in life activities, improvement in pain intensity level, absence of unacceptable or intolerance adverse side effect, if appropriate progress in a rehabilitation program, and if appropriate possible return to work and maintenance of a job.
- I agree to periodic urine screens for other medications and drugs if the physicians of Edwin Colon MD, PA (Invasive Pain Management) deem appropriate.
- I have been given information about the use of narcotic medications and possible risks of side effects including development of tolerance, dependency, addiction and withdrawal problems due to the medications and I agree to undergo narcotic administration.
- I agree to NOT hoard medications or alter the narcotic prescription. These behaviors and other unacceptable behaviors will result in the discontinuation of narcotic prescriptions and possible discharge from the practice of Edwin Colon MD, PA (Invasive Pain Management).
- I agree to the following:
  - That I am NOT currently abusing illegal or prescription drugs and I am NOT undergoing treatment for substance dependence or abuse.
  - That I have NEVER been involved in sale, illegal possession or transport of any drugs.
  - FOR WOMEN ONLY: That I am not pregnant and that I will inform the physicians of Edwin Colon MD, PA (Invasive Pain Management) if I become pregnant.

This form has been fully explained to me. I have read it or have had it read to me, and I understand and agree to the terms of this agreement. If any part of this agreement as outlined above is broken, I understand that it may result in the immediate discharge from the care of Edwin Colon MD, PA (Invasive Pain Management) and discontinuation of narcotic prescriptions.

Print Patient Name: __________________________________________________________

Patient Signature: ___________________________ Date: ___________________________

Witness Signature: ___________________________ Date: _________________________
## Invasive Pain Management
A Center of Excellence
Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Age:</th>
<th>Date:</th>
<th><em><strong><strong><strong>/</strong>____/20</strong></strong></em>___</th>
</tr>
</thead>
</table>

Primary Physician:  
Referring Physician:  

Please list all Physicians (or Mental Health Professionals) you have consulted:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date last seen</th>
<th>Office phone number</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

How did your pain start?  When did your pain start?  ________________

- [ ] Auto accident  - [ ] Fall (not at work)  - [ ] Just started
- [ ] After surgery  - [ ] Work related  - [ ] Other (Describe what happened)

**WHERE is your pain?**  Using the following color code on the drawing, color the areas where you feel pain as it has been for the last 2-3 weeks:

- **RED** Excruciating Pain
- **Blue** Severe Pain
- **Green** Moderate Pain
- **Black** Mild Pain
# Invasive Pain Management

**A Center of Excellence**

Edwin Colon MD, PA  
Rosemary Clanton A.R.N.P.

| In the last 2-3 weeks, **WHEN** does your pain occur? | __ Constant  
| __ Intermittent (on and off)  
| __ Less than 8 hours / day  
| __ 8 - 16 Hours / day |

| What does your pain feel like? (check all that apply) | __ Mild  
| __ Severe  
| __ Burning  
| __ Aching  
| __ Sharp  
| __ Other, Please describe: |

| What **INCREASES** your pain? (check all that apply) | __ Work  
| __ Sitting  
| __ Walking  
| __ Standing  
| __ Other, Please describe: |

| What **DECREASES** your pain? (check all that apply) | __ Not working  
| __ Drugs  
| __ Rest  
| __ Physical therapy  
| __ Lying down  
| __ Heat  
| __ Cold  
| __ Relaxation  
| __ Injections  
| __ Treatments in the Emergency Room  
| __ Others, Please Describe: |

| What has been used to **TREAT** you pain? (check all that apply) | __ Drugs  
| __ Rest  
| __ Physical therapy  
| __ Surgery  
| __ Counseling  
| __ Chiropractic / Manual therapy  
| __ Other. Please describe: |

| Does your pain keep you from falling asleep at night? | __ Yes  
| __ No |

| Does your pain wake you up at night? | __ Yes  
| __ No |

| What are your past or current medical problems? (check all that apply) | __ Stroke  
| __ Angina  
| __ Hepatitis  
| __ High blood pressure  
| __ Epilepsy  
| __ Heart Disease  
| __ Arthritis  
| __ Recent weight loss  
| __ Migraines  
| __ Asthma  
| __ Cancer  
| __ Lung disease  
| __ Diabetes  
| __ Easy bleeding  
| __ Heartburn / peptic ulcers  
| __ Other, Please describe: |

| Please list any surgeries and dates: |  
|  
|  
|  |

Name:  

---
Do you use anticoagulants (such as Heparin or Coumadin)?  ____ Yes  ____ No

Do you use over the counter medications, recreational drugs or medications which were prescribed for someone else?  ____ Yes  ____ No  If yes, Please describe:

_______________________________________________________________________
_______________________________________________________________________

Please list your current Medications:  Dose:  Frequency:

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Please list the medications you are allergic to or have had problems with in the past. Describe what happened when you used the medication.

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Name:
# Invasive Pain Management

## A Center of Excellence

Edwin Colon MD, PA  
Rosemary Clanton A.R.N.P.

This column for office staff use only.

<table>
<thead>
<tr>
<th>ROS</th>
<th>CV</th>
<th>Pulm</th>
<th>GI/GU</th>
<th>Endo</th>
<th>Imm</th>
<th>Skel</th>
<th>Neuro</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart trouble</td>
<td>Yes No</td>
<td>Shortness of breath at rest</td>
<td>Yes No</td>
<td>Frequent pneumonias</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
</tr>
<tr>
<td>Heart or chest pain</td>
<td>Yes No</td>
<td>Swollen ankles</td>
<td>Yes No</td>
<td>Frequent pneumonias</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
</tr>
<tr>
<td>Bleeding problems</td>
<td>Yes No</td>
<td>Frequent pneumonias</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
</tr>
<tr>
<td>Breathing problems</td>
<td>Yes No</td>
<td>Frequent pneumonias</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
</tr>
<tr>
<td>Frequent nausea/vomiting</td>
<td>Yes No</td>
<td>Frequent pneumonias</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
</tr>
<tr>
<td>Frequent diarrhea</td>
<td>Yes No</td>
<td>Frequent pneumonias</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
</tr>
<tr>
<td>Loss of bowel control</td>
<td>Yes No</td>
<td>Frequent pneumonias</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
</tr>
<tr>
<td>Pain on urination</td>
<td>Yes No</td>
<td>Frequent pneumonias</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Yes No</td>
<td>Frequent pneumonias</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
</tr>
<tr>
<td>Joint stiffness or swelling</td>
<td>Yes No</td>
<td>Frequent pneumonias</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
</tr>
<tr>
<td>Frequent infections</td>
<td>Yes No</td>
<td>Frequent pneumonias</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
</tr>
<tr>
<td>Seizures</td>
<td>Yes No</td>
<td>Frequent pneumonias</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
</tr>
<tr>
<td>Severe headaches</td>
<td>Yes No</td>
<td>Frequent pneumonias</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
</tr>
<tr>
<td>Strokes or TIA’s</td>
<td>Yes No</td>
<td>Frequent pneumonias</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
<td>Stomach ulcers</td>
<td>Yes No</td>
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<tr>
<td>Have you gained or lost more than 10 pounds in the last year?</td>
<td>Yes No</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

For men only:

Do you have any problems with erections? | Yes No

For women only:

Are you pregnant? | Yes No

Are you trying to get pregnant? | Yes No

If you smoke, how much do you smoke?

If you drink alcoholic beverages, how much do you drink?

Has anyone complained about your drinking? | Yes No

If yes, who has complained?

If you drink beverages containing caffeine, how much do you consume?

Are you married? | Yes No

Do you have dependants at home? | Yes No

If yes, please list children’s ages or describe other dependants:

________________________________________________________________________

________________________________________________________________________

Current employer: ________________________________________________________

Occupation: _____________________________________________________________

How long with this employer? ____ Years.

If not working, date last worked? ____ / ____ / ________

If not working, who took you off work? _______________________________________

When will your off work slip expire? ____ / ____ / ________

Name: ____________________________
Invasive Pain Management
A Center of Excellence
Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

<table>
<thead>
<tr>
<th>Are you on Worker’s Comp?</th>
<th>__ Yes __ No</th>
<th>Date W.C. started <strong>/</strong>/____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you on Disability?</td>
<td>__ Yes __ No</td>
<td>Date disability started <strong>/</strong>/____</td>
</tr>
<tr>
<td>If yes, which type of disability do you have? (check all that apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short Term Disability</td>
<td>Long Term Disability</td>
<td>Social Security Disability</td>
</tr>
<tr>
<td>Other: ____________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you in a lawsuit with Worker’s Comp?</td>
<td>__ Yes __ No</td>
<td></td>
</tr>
<tr>
<td>Are you involved in a lawsuit regarding an auto accident?</td>
<td>__ Yes __ No</td>
<td></td>
</tr>
<tr>
<td>Are you involved in a lawsuit regarding a disability claim?</td>
<td>__ Yes __ No</td>
<td></td>
</tr>
<tr>
<td>If you are involved in a lawsuit, who is the lawsuit against?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How has pain affected your personality? (circle all that apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No effect</td>
<td>Alert</td>
<td>Cheerful</td>
</tr>
<tr>
<td>Slightly upset</td>
<td>Irritable</td>
<td>Disagreeable</td>
</tr>
<tr>
<td>Moderately Upset</td>
<td>Unhappy</td>
<td>Anxious</td>
</tr>
<tr>
<td>Severely Upset</td>
<td>Quite depressed</td>
<td>Bitter</td>
</tr>
<tr>
<td>Totally incapacitated</td>
<td>Severely withdrawn</td>
<td>Panicked</td>
</tr>
<tr>
<td>Moody</td>
<td>Dull</td>
<td>Desperate</td>
</tr>
<tr>
<td>Since the pain, what are you concerned about? (check all that apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of recreational activities</td>
<td>Ability to earn income</td>
<td></td>
</tr>
<tr>
<td>Memory / Concentration difficulties</td>
<td>Poor sleep and daytime fatigue</td>
<td></td>
</tr>
<tr>
<td>Sexual desire, interest</td>
<td>Unidentified medical problems</td>
<td></td>
</tr>
<tr>
<td>The pain lasting forever</td>
<td>Other, please describe: ____________________________</td>
<td></td>
</tr>
<tr>
<td>What stress has the pain caused you at home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What stress has the pain caused you at work?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What stress has the pain caused you emotionally?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What stress has the pain caused you with relationships?</td>
<td></td>
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<tr>
<td>What stresses were you under before the pain?</td>
<td></td>
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<tr>
<td>Are you depressed now?</td>
<td>__ Yes __ No</td>
<td></td>
</tr>
<tr>
<td>Have you ever seen a counselor, psychologist or psychiatrist?</td>
<td>__ Yes __ No</td>
<td></td>
</tr>
<tr>
<td>If yes, please include their name, date last seen and office phone number on page 8.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Which treatments have you had for emotional problems? (check all that apply)</td>
<td>ECT</td>
<td>Counseling</td>
</tr>
</tbody>
</table>

Name: ________________________________
Describe the stressful experience in your *ENTIRE LIFE* up to now:
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

In addition to decreased pain, what do you hope to get from treatment at our pain clinic?
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

What diagnostic studies, such as X-rays, CT scans, MRI’s, Myelograms, EMG (electromyelogram and/or nerve conduction study), or bone scans have been done within the last 5 years? Please give studied area and date. Please have the reports of these studies available when you are first seen.

<table>
<thead>
<tr>
<th>Type of study? (circle one)</th>
<th>Date?</th>
<th>Do you have the report? (circle one)</th>
<th>Part of your body studied?</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray MRI EMG CT Myelo Bone scan</td>
<td></td>
<td>Yes No</td>
<td></td>
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<td>X-ray MRI EMG CT Myelo Bone scan</td>
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<td></td>
<td>Yes No</td>
<td></td>
</tr>
</tbody>
</table>

Height: _____ Feet _____ Inches Weight: _____________ lbs

Name:
Dear Patient;

The completion of information / insurance forms represents an administrative service to our patients above and beyond the provision of medical care. Recent changes in health care have resulted in the tremendous increase in the volume of information requests to our practice. The time and effort involved in providing this detailed information results in significant costs, especially when multiplied over the large number of patients our practice services. The refusal of insurance companies and requesting agencies to cover the cost requires us to institute a policy of charges for the completion of forms as follows:

**NO CHARGE INVOLVED:**
- Mailing of records to a new physician or practice.
- Records or reports mailed to a primary physician.

**$25.00 and up for completion of the following:**
- Any dictated letter describing medical care and limitations
- Workers Compensation requested disability and work status forms
- Auto insurance carrier requests for work status and treatment plan
- Disabled parking applications
- Private disability insurance form
- School educational disability limitation form

**$50.00 for the following:**
- No Show / No Cancellation fee for OFFICE APPOINTMENT that is not cancelled within 24 hours of your appointment time

**$100.00 for the following:**
- No Show / No Cancellation fee for SURGERIES that are not cancelled within 48 hours of your surgery time. ALL SURGERIES must be cancelled at the OFFICE in which you are seen. NOT THE SURGERY CENTER OR HOSPITAL.

**$100.00 and up for the following:**
- Any narrative report detailing diagnosis, treatment and future medical care including work capacity statement. (Functional capacity evaluation testing necessary prior to or in addition to the narrative report).

In closing, thank you in advance for your cooperation and understanding.

____________________________________  __________________________________
Patient signature                        Date

Name:
Invasive Pain Management
A Center of Excellence
Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care / diagnostic treatment and or minor surgical treatment by the physicians of Invasive Pain Management Clinics (offices of Edwin Colon, M.D., P.A.) deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment in the office. I authorize the release of any of my past/current medical records that are needed for my treatment from prior healthcare providers.

Signature: ____________________________________________  Date: _____ / _____ / __________

AUTHORIZATION & ASSIGNMENT

Thank you for choosing us as your health care provider! We are committed to the excellent treatment of all our Patients and we will always do our best to provide excellent care both in the office and in the hospital. As in most practices, medical fee reimbursements continue to increase. We have implemented this Patient Financial Policy to help control costs so that we can always provide high-quality medical care. If you have any questions about this policy, please discuss them with the Office Manager. We are dedicated to providing care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

PRIVATE INSURANCE & SELF PAY

FULL PAYMENT is due at time of service, unless other arrangements have been made in advance by yourself or your health coverage. For your convenience, we accept Visa, MasterCard and Discover. We are happy to assist you by billing your insurance company for all office and surgical procedures and requesting the insurance companies to remit the payment to our office. YOU are responsible for the annual deductible and any co-insurance requirements at the time of treatment, as well as any differences between the amount of our fee and the amount received from your insurance company.

HMO, PPO, or WORKER’S COMPENSATION

If you are covered by an HMO, PPO or Worker’s Compensation, please bring the referral/authorization form provided by the referring physician. Without this form, your insurance company may not pay for the treatment and you WILL be rescheduled for another appointment. We will bill the insurance company for all treatments except for any deductibles or co-pay.

Medicare & Medicaid

We participate with Medicare and Medicaid and fully cooperate with all the rules and regulations. However, you are responsible for the deductible and co-pay requirements at time of service.

I request that the payment of Authorized Medicare/Insurance Benefits be made either to me or on my behalf for any service furnished by INVASIVE PAIN MANAGEMENT (the offices of EDWIN COLON, M.D., P.A.) I authorize any holder of medical information about me to release to CMS/Insurance Carriers and its agents any information needed to determine these benefits.

Name: ____________________________
I hereby authorize **Edwin Colon M.D., P.A. (Invasive Pain Management)** to furnish information to Medicare/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my Insurance Carrier (s)/Medicare to make payments directly to **Edwin Colon MD, PA (Invasive Pain Management)** for medical, diagnostic or surgical benefits payable for services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status) that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or any other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician’s office for services.

I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you need to reschedule. There will be a **NO SHOW CHARGE OF $50.00** for all appointments not cancelled within a 24 hour notice. This charge will be your responsibility and not your insurance company’s.

**PLEASE NOTE YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. THE DOCTOR IS NOT INVOLVED.**

I have read and understand the financial policy of Edwin Colon MD, PA (Invasive Pain Management) and I agree to be bound by its terms. I also understand that such terms may be amended from time-to-time by the practice as deemed necessary.

<table>
<thead>
<tr>
<th>Signature</th>
<th>______ / ______ / 20______</th>
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<tbody>
<tr>
<td>Date</td>
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</tbody>
</table>

**DESIGNATED RELATIVE**

I authorize discussion of my general medical condition and diagnosis (including treatment, payment and health care operations) with ( ) Spouse ( ) Children ( ) Other ________________________________________________

Please list the family members or significant others, if any, whom we may inform about your medical conditions and/or in case of emergency.

<table>
<thead>
<tr>
<th>Name: ____________________</th>
<th>Relationship: ____________________</th>
<th>Phone: ____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: ____________________</td>
<td>Relationship: ____________________</td>
<td>Phone: ____________________</td>
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<tr>
<td>Date</td>
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**PRIVACY NOTICE**

I received a copy of **Edwin Colon MD, PA (Invasive Pain Management’s)** privacy notice.

<table>
<thead>
<tr>
<th>Signature</th>
<th>______ / ______ / 20______</th>
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<tbody>
<tr>
<td>Date</td>
<td>__________________________</td>
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<table>
<thead>
<tr>
<th>Print Name</th>
<th>Social Security Number</th>
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<tbody>
<tr>
<td>Print Name</td>
<td>____________________</td>
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</table>

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<tr>
<th>Witness</th>
<th>Relationship</th>
</tr>
</thead>
</table>
NOTICE of PRIVACY PRACTICES for PROTECTED HEALTH INFORMATION (HIPPA)

This notice describes how medical information about you may be used and disclosed and how you may get access to this information. Please review it carefully!

We safeguard information about your health and person:
We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and are available only to designated staff and only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer but for service of computer operations.

Typical uses and disclosures of medical information:
We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities and agencies for whom you authorize disclosure such as other healthcare providers (doctors, nurses, extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:
- When required by law
- Public health activities (deaths, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors
- Organ and tissue donation
- Research, provided authorization is IRB-approved or privacy board-approved
- Emergencies to avert serious threat to health or safety
- Specialized government functions (military, inmates)
- Worker’s Compensation
- Disaster relief

We will not use or disclose your medical information for any purpose not listed without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.