Center for Neuro-Interventional and Functional Pain Medicine

Dr. Allen A. Baidey, M.D.
2450 Bee Ridge Rd., Suite A
Sarasota, FL. 34239

Ph:941-552-3487 Fax:941-552-3486

Last Name____________________First Name______________________Middle______
Address____ Phone(___)-____-______
City________________________ State________________________ Zip____________
Date of Birth___/___/___ Age_________________ SS#________-_____-________
Martial Status ___S___M___D___W Male/Female

Insurance Information

Primary Insurance____
ID# _________________________________ Policy/Group________________________
Address____________________________ City_____________________ State________
Zip____________ Phone(___)-____-_____ Policy Holder_________________________

Secondary Insurance____
ID# _________________________________ Policy/Group________________________
Address____________________________ City_____________________ State________
Zip____________ Phone(___)-____-_____ Policy Holder_________________________

Policy Holder Information

Last Name_____________________First Name______________________Middle_____
Address____ Phone(___)-____-______
City________________________ State________________________ Zip____________
Date of Birth___/___/___ Age__________________ SS#________-_____-________

Workers Comp

Were you hurt on the job?_______ Date of Injury__________
Worker Comp Ins.____

I herby assign and direct to pay all benefits for medical services under this claim directly to Center for Interventional Pain Management. I herby authorize the release of any medical information request by the insurance companies with the assignment. I understand that the Center for Interventional Pain Management will bill my Primary Insurance as a courtesy to me. I will be responsible for secondary payment (if applicable) at the time of service. If payment is not received within 30 days from the date of billing, <u>I will be financially responsible for payment in full</u> for all services rendered to myself and/or dependents by Center for Interventional Pain Management. I also agree to pay any and all collection costs, attorney costs, and court costs (if applicable). A 24 hour notice is required for all cancellations or a $25.00 fee will be applied to your following visit.

Patient/Responsible Party ___________________________________ Date__________

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Please fill out to the best of your ability. Some questions may not apply to your circumstance and you may opt to leave them blank. Thank You

Date _____________

Name:______________________________________ Age:_____________
Referring Doctor:____
Primary Doctor (Family Physician):________________________________
Height:________________Weight:______________

Problem:
Describe your issue (Please be specific)
____
Date of onset :__________________________
If you are here for implant pre-certification please answer questions about your chronic pain. If this is not your issue please ignore questions about pain.
Describe your pain:

Burning	Stabbing	Constant	Intermittent	Dull
Aching	Throbbing	Tingling	Cramping	

Rate your pain (1 is least, 10 is worst) 1 2 3 4 5 6 7 8 9 10
What makes your pain worse:

Coughing	Sitting
Bending forward	Bending backwards
Concentrating or Reading	Moving from sitting to standing
Lifting	Driving
Walking	Lying
Twisting	

Other:____
If you have pain, what makes your pain better?
____
Do you have Depression? Yes No
Do you have any pain at night? Yes No
Do you have trouble sleeping? Yes No
Do you feel like is worth living? Yes No
Is your problem interfering with your ability to work or function ? Yes No

List all medications which have been prescribed for your pain problem, circle the ones you are currently
taking.____
____
____
____
____
____

Please list the Doctor or Doctor's prescribing you medications.
____
____

Past medical history

List all your past surgeries and dates:____
____
____
____

List your current medical problems:
____
____

List all your medications (pain/non pain):
____
____
____
____

List your drug allergies:
____
____

Do you take blood thinners?____
Do you use tobacco? Yes No how many packs/day:___________________________
If you are a former smoker when did you quite?_________________________
Do you drink alcohol? Yes No how many drinks/week?_________________
Do you drink coffee/tea? How many cups/day?__________________________

Do you have any children? Yes No
If applicable how many children live at home:_________________________________
Work status: Full-Time Part-Time Unemployment Disability Leave Permanently Disabled
Describe your occupation:____
Are you happy with your employment? Yes No
Education: high school graduate college graduate postgraduate degree
Do you exercise? Yes No Type of exercise____________________________________
Is there anything causing you severe stress or anxiety in your life? Yes No
If yes please describe:
____
____

Review of Systems (circle problems that you have of have had in the past)

Head:	Sinus problems	Headache	Migraines	Jaw problems
	Tooth problems	Cataracts	Glaucoma	
Respiratory:	Cough	Shortness of Breath	Emphysema	
	Asthma	Pneumonia		
Cardiac:	Myocardial Infarction(Heart Attack)		Chest Pain/Angina	
	High Blood Pressure		Heart Valve Disease	
	Rapid Heart Rate		Atrial Eibrillation	
Gastrointestinal:	Diarrhea	Constipation	Hiatal Hernia/Reflux	
	Ulcers	Gastritis	Pancreatitis	
	Hepatitis	Crohn’s	Ulcerative Colitis	
	Diverticulitis			
Genitourinary:	Kidney Disease	Kidney Stones	Dialysis	
	Difficulty Voiding	Prostate Disease	Incontinence	
Cancer:	Breast Cancer	Lung Cancer	Skin Cancer	
	Lymphoma	Leukemia	Prostate Cancer	
	Other Cancers			
Neurological:	Seizures	Stroke	Paralysis	Spasticity
	Multiple Sclerosis	Cerebral Palsy	Difficulty Swallowing	
	Zoster	Neuropathy		
Psychiatric:	Depression	Schizophrenia	Manic-depression	Drug Abuse
Hematologic:	Anemia	Sickle Cell	HIV/AIDS	
	Coagulation Disorder			
Endocrine:	Diabetes	Hyperthyroid	Hypothyroid	
Skeletal:	Osteoporosis	Arthritis	Rheumatoid	
	Scoliosis	Lupus	Broken Bones	
	Compression Fracture			
Toxins:	Asbestos	Lead	Industrial Chemicals	

Authorization To Release Medical Information
(If under 18 years of age, parent or guardian must sign)

Name of Patient:________________________________ Date of Birth:___________________
Patient Address:____Phone:(___)-___________

I authorize and request the release of medical records from Center for Neuro-Cognitive Health, Dr. Allen A. Baidey, M.D. and wish to disclose same to:

Name__________________________________Address________________________________
_
City/State____Zip__________________

For the purpose of:
__ Continuation of medical treatment __ Payment of bill __ Worker's Comp
__ Personal Use __ Legal or Insurance purposes __

The information to be disclosed is:
__ Discharge summary __ Operative reports __ History & Physical
__ X-Ray reports __ Laboratory reports __ Pathology reports
__ Consultations __ Other (specify)

______(Initial) I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) of Hepatitis. It may also include information about behavior or mental health services, and treatment for alcohol and drug use.

_______ (Initial) I have carefully read and understand the above statements, and do hereby expressly and voluntarily consent to disclose the above information about, or medical records of my medical condition to those persons of agencies named above. Disclosure by the recipient will no longer be protected by the federal regulations governing the Privacy of Individually Identifiable Health Information (45 C.F.R. Part 164). A photocopy of this authorization shall have the same effect as the original.

______ (Initial) The staff at Center for Interventional Pain Management may leave discrete telephone messages on my personal answering machine or at another number that I provide.

If the patient is a minor, this authorization must be signed by a parent of legal guardian. If the patient is physically unable to sign this authorization, he/she should put an "X" on the signature line and have his/her consent witnessed. If the patient has been declared mentally incompetent, this authorization may be signed by a legally appointed guardian. If the patient is deceased, this authorization may only be signed by the next-of-kin or personal representative of the estate.

This authorization for release of information will not expire unless revoked by patient.

____ Date____________________
Signature of Patient

______________________________ __________________ Date____________________
Consenting party signing in lieu of patient Relationship

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HIPAA COMPLIANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of protected health information has been identified as a national problem causing some patients inconvenience, aggravation and money. We want you to know that all of our employees/managers periodically receive training to assist them in understanding and complying with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with a particular emphasis on the "Privacy Rule". We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. Other entities may have indirect treatment relationships with you (such as the physician reading your x-ray) and we may have to disclose personal health information for purposes of treatment or payment. These entities are most often not required to obtain patient consent.

You may refuse, in writing, the consent to the use of disclosure of your personal health information. Under this law, we then have the right to refuse to treat you, should you refuse to disclose your personal health information. At any time in the future you may request to refuse all or part of disclosure to your personal health information. However you may not revoke actions that have already been taken which relied on this or a previously signed consent.

It is our policy to determine appropriate uses of personal health information in accordance with the government ruled, laws and regulations. We want to ensure that our Center never contributes in any way to the growing problem of improper disclosure of personal health information. We have implemented a program we believe will help us prevent any inappropriate use of personal health information.

We also know that we are not perfect! Because of this fact, our policy is to listen to our patients and employees without any thought of penalty if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

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Thank you for being one of our highly valued patients.

____ ________________

Signature of Patient Date