CENTRAL FLORIDA
SPINE & PAIN

COVID – 19 SCREENING QUESTIONNAIRE

Patient Name:_____ DOB:_____ Date:_____

Have you had a fever within the past 14 days? ☐ Yes ☐ No

Have you had a cough or any difficulty breathing within the past 14 days? ☐ Yes ☐ No

Have you or a household member had any contact with a known COVID-19 patient within the past 14 days? ☐ Yes ☐ No

Have you or a household member traveled outside of Florida within the past 14 days? ☐ Yes ☐ No

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Patient Demographics

Patient Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____-_____-_____

Gender: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female ☐ Other: _____

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other: _____

Race: _____ Ethnicity: _____

Preferred Language: _____

Home Address: _____

Home Phone Number: _____ Cell Phone Number: _____

How would you prefer to be contacted for reminders? ☐ Call ☐ Text ☐ Email

Email Address: _____

Primary Care Provider: _____ Phone Number: _(_____)_____-_____

Who referred you to our practice? _____

Prior pain management provider: _____ Phone Number: _(_____)_____-_____

Cardiologist : _____ Phone Number: _(_____)_____-_____

Neurologist: _____ Phone Number: _(_____)_____-_____

Orthopedic Surgeon: _____ Phone Number: _(_____)_____-_____

Endocrinologist: _____ Phone Number: _(_____)_____-_____

Emergency Contact Name: _____Phone Number: _____

Relation to Emergency Contact:_____

Insurance Information

Insurance Company Name: _____ Member ID#: _____

Relationship to Insured: _____

Policy Holder: _____ Policy Holder DOB: _____

Employer: _____

Secondary Insurance Information

Insurance Company Name: _____ Member ID#: _____

Relationship to Insured: _____

Policy Holder: _____ Policy Holder DOB: _____

Employer: _____

*I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, examination, testing, injection or procedure ordered on my behalf. I understand that confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

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Describe your main problem _____

Where is your pain located? _____

On a scale of 1-10 how bad is your pain? 1 2 3 4 5 6 7 8 9 10

How long have you had this pain? _____

Was there any event that caused this pain? _____

When does this pain occur? _____

Does your pain radiate anywhere? _____

Is your pain associated with any other symptoms?_____

_____

List previous Hospitalizations/Surgeries/Serious Injuries	When
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any known allergies to medications: _____

Please list allergies to contrast or shellfish: _____

Have you ever had any of the following?:

Heart Disease:	Yes	No
Hypertension:	Yes	No
Diabetes:	Yes	No
Cancer:	Yes	No
Pace/Defib:	Yes	No
Thyroid Disease:	Yes	No
Kidney Disease:	Yes	No

Patient Social History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Consumption of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Previously ☐ Current # of Packs a Day: _____

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Patient Name: _____ DOB: _____ Date: _____

Date Last Updated: _____ , _____ , _____ , _____

Medication List

Please list ALL medications you are currently taking.

NAME OF MEDICATION	DOSE	FREQUENCY	NOTES
1.			
2.			
3.			
4.			
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CENTRAL FLORIDA

A SPINE & PAIN

INFORMED CONSENT FOR TREATMENT AND
CONSENT FOR LONG-TERM OPIOID THERAPY AGREEMENT FOR CHRONIC NON-CANCER PAIN

PATIENT NAME: _____ DATE OF BIRTH: _____

The purpose of this agreement is to assure that you and your provider(s) at Central Florida Spine and Pain LLC comply with all state and federal regulations concerning the prescribing of controlled substances.

CONSENT FOR TREATMENT:

- I voluntarily request Dr. Nicholas Giordano and other providers at Central Florida Spine and Pain LLC treat my chronic painful condition.
- I understand that my chronic painful condition represents a complex problem which may benefit from a combination of physical therapy, psychotherapy, behavioral medicine strategies, and/or surgery. I understand that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program as recommended by my provider(s) to achieve the possibility of improved function and coping with my condition.

CONSENT FOR MEDICATION TREATMENT:

- I hereby authorize and give my voluntary consent for Dr. Nicholas Giordano and other providers at Central Florida Spine and Pain LLC to administer or write prescription(s) for dangerous and/or controlled medication(s) as an element in the treatment of my chronic pain.
- I understand that these medication(s) may include opioid/narcotic medication(s) which can be harmful if taken without medical supervision.
- I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other medication(s) used in the practice of medicine, produce adverse effects or results.
- I understand the alternative methods of treatment, the possible risks involved, and the possibilities of complications as listed below in this agreement.
- I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medications.
- I understand that the specific medication(s) that Dr. Nicholas Giordano and other providers at Central Florida Spine and Pain LLC prescribe will be described and documented separately from this agreement. This may include the use of medication(s) for purposes different than what has been approved by the drug company and the government. This is sometimes referred to as “Off-Label” prescribing. My provider will explain his/her treatment plan(s) for me and document it in my medical chart.
- I understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random, unannounced checks for drugs and psychological evaluations if and when it is deemed necessary. I hereby give my permission to perform the tests or my refusal to these tests may lead to terminations of treatment. I understand that the presence of unauthorized substances may result in being discharged from Central Florida Spine and Pain LLC.

FOR FEMALE PATIENTS ONLY:

- To the best of my knowledge:
  - ☐ I’m **NOT PREGNANT.** I understand that:
    - It is my responsibility to use appropriate contraception/birth control during my course of treatment at this practice.

- It is MY RESPONSIBILITY to inform Dr. Nicholas Giordano and other providers at Central Florida Spine and Pain LLC immediately if I become pregnant during my course of treatment at this practice.

☐ I AM PREGNANT.
☐ I'm NOT CERTAIN if I am pregnant. I will notify Dr. Nicholas Giordano and other provider(s) at this practice IMMEDIATELY if I become so.

- I understand that the treatment provided for my painful condition may have unfavorable effects on a pregnant woman and their unborn child(ren).
- I understand that the controlled medication(s) and possibly other medication(s) prescribed or administered during the course of my treatment by Dr. Nicholas Giordano and other provider(s) at this practice are transmitted to the fetus and will cause physical dependence. So, I will notify Dr. Nicholas Giordano and my provider(s) at Central Florida Spine and Pain LLC IMMEDIATELY if I become pregnant.
- I understand that it is my responsibility to inform my other treating provider(s) who see me during my present or any future pregnancies or who see my children, after birth, about my past, current, or any future treatments for my chronic painful conditions.
- I understand that I should not be nursing my child after birth because Opioids and other controlled medication(s) are transmitted through the milk to the child and this may cause physical dependence for the child.
- I understand that the child may show signs of temporary irritability or other ill effects after birth if I continue to take Opioids and/or other controlled medication(s) during the pregnancy.
- I understand and have full knowledge of the information on the ill effects of the medication(s), used for treatment of my painful condition, on me during my pregnancies, and also on the embryo/fetus/child. I hereby consent to my treatment by Dr. Nicholas Giordano and other provider(s) at Central Florida Spine and Pain LLC and I DO NOT hold Dr. Nicholas Giordano and other provider(s) at Central Florida Spine and Pain LLC responsible for the injuries caused to me during my pregnancies and to the embryo/fetus/child.

COMMON SIDE EFFECTS:

- I understand that the most common side effects that could occur in the use of the drug(s) used in my treatment include but are not limited to the following:

  - Impairment of reasoning and judgment
  - Urinary retention (inability to urinate)
  - Arrhythmia (irregular heartbeat)
  - Respiratory depression (slow or no breathing)
  - Physical + emotional dependence or even addition
  - Orthostatic hypotension (low blood pressure)
  - Excessive drowsiness
  - Itching
  - Vomiting
  - Death
  - Tolerance to med(s)
  - Constipation
  - Impotence
  - Nausea
  - Insomnia
  - Depression

- I understand that it may be dangerous for me to operate an automobile or other machinery while using these medication(s) and I may be impaired during all activities including work.
- I'm aware of alternative methods of treatment, the possible risks involved, and the possibilities of complications, and I still desire to receive medication(s) for the treatment of my chronic painful condition.

GOALS OF THE TREATMENT:

- The goal of this treatment is to help me gain control of my chronic painful condition in order to live a more productive and active life.
- I realize that I may have a chronic illness and there is a limited chance for a complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life.
- I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal. From the use of some of all medication(s).
- I understand that my treatment plan will be tailored specifically for me.
- I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and I will notify Dr. Nicholas Giordano and my other provider(s) at Central Florida Spine and Pain LLC of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.
- I understand that no warranty or guarantee has been made to be as to the result of any drug therapy or cure of any condition. The long-term use of medication(s) to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefits. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment, or diagnostic procedure(s) to be used to treat my condition, and the hazards of such drug therapy, treatment, and procedure(s), and I believe that I have sufficient information to give this informed consent.

KEY TERMINOLOGY TO BE AWARE OF IN PAIN MANAGEMENT:

- ADDICTION: Addiction is defined as the use of medication(s) even if it causes harm, having cravings for the medication, feeling the need to use the medication, and a decreased quality of life. I'm aware that the chance of becoming addicted to my pain medication is very low if I follow the instructions provided to me by Dr. Nicholas Giordano and other provider(s) at Central Florida Spine and Pain LLC. The risk of addiction may be higher in a patient with a family or personal history of addiction.
- DEPENDENCE: Dependance is a normal and expected result of long-term usage of medication. I understand that physical dependence is not the same as addiction. Abrupt discontinuation of these medication(s) may result in "Withdrawal Syndrome." Withdrawal syndrome may present with any of the following signs/symptoms: running nose, yawning, goosebumps, abdominal pain, cramping, diarrhea, irritability, aches throughout the body, and the feeling of the worst kind of flu. I understand that the withdrawal is uncomfortable but not life-threatening.
- TOLERANCE: Tolerance is defined as a situation where my body requires a higher amount of medication to achieve the same amount of pain relief. I understand that there is a chance that tolerance may occur to me during the course of my treatment. I understand that increasing the doses may not help my pain but it may result in increased risk of unacceptable side effects. I understand that Dr. Nicholas Giordano and my other provider(s) at Central Florida Spine and Pain LLC may alter my treatment when tolerance is suspected.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

This pain management agreement relates to my use of any and all medication(s) (i.e., Opioids, also called. 'narcotics, painkiller,' and other prescription medications, etc.) for chronic pain prescribed b Dr. Nicholas Giordano and other provider(s) at Central Florida Spine and Pain LLC. I understand that there are federal and state laws, regulations, and policies regarding the use and prescribing controlled substances. THEREFORE, MEDICATION(S) WILL ONLY BE PROVIDED. SO LONG AS I FOLLOW THE RULES SPECIFIED IN THIS AGREEMENT.

Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or discharge from care and treatment:

- I will bring all my medication(s) in their original bottles to every appointment and understand that refills will not be considered otherwise. The medication will be counted by authorized medical staff at Central Florida Spine and Pain LLC in a sterile manner to ensure that I'm following the recommendations of my prescribing provider(s) and that I'm in compliance of my treatment recommendations.
- Dr. Nicholas Giordano and other provider(s) at Central Florida Spine and Pain LLC may choose to discontinue the medication(s) at any time.
- My progress will be periodically reviewed and if the medication(s) are not improving my quality of life, the medication(s) may be discontinued.
- I will disclose to my provider(s) at Central Florida Spine and Pain LLC all medication(s) that I take at any time, prescribed by any physician.
- I will use the medication(s) exactly as directed by my physician.
- If my provider(s) discontinue my medication(s) and start me on another medication(s), I agree to **turn in the leftover medication that was discontinued at the local police department** and obtain a copy of the receipt to be provided to my provider(s) for documentation.
- I agree not to share, sell, or otherwise permit others, including my family and friends, to have access to these medication(s).
- I will not allow or assist in the misuse/diversion of my medication(s) nor will I give or sell them to anyone else.
- I will safeguard my medication(s) from loss or theft. I will keep the medication in a safe box at home that can only be opened with a key or some other security measure to which only I have access to.
- I understand that the medication(s) written for my painful condition are exactly like money. **If these medication(s) are lost or stolen, they will not be replaced.** The refill will only be provided at the time it is due.
- I understand that the medication(s) written for my painful condition will need to last at least for the duration they were written for if not more. **If these medication(s) run out early, a refill will not be provided early.** The refill will only be provided at the time it is due.
- If it appears to my physician that there are no demonstratable benefits to my daily function or quality of life from the medication(s), then my physician may try alternative medication(s) or may taper me off all medication(s). I will not hold Dr. Nicholas Giordano or my other provider(s) at Central Florida Spine and Pain LLC liable for problems caused by my discontinuation of medication(s).
- I agree to submit urine and/or blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without warning. If I test positive for illegal substance(s) such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated.
- If I decide to use medical marijuana for my painful condition under the supervision of my medical marijuana prescribing provider as allowed by the state of Florida, I understand that Dr. Nicholas Giordano and other provider(s) at this practice will not be continuing my treatment with controlled medication(s) and that I will be weaned off slowly.
- I must take the medication(s) as instructed by my provider(s). Any unauthorized increase in the dose of medication(s) may be viewed as a cause to discontinue treatment.
- I must keep all follow-up appointments recommended by Dr. Nicholas Giordano and other provider(s) at Central Florida Spine and Pain LLC or my treatment may be discontinued.
- I will obtain permission from my provider(s) at Central Florida Spine and Pain LLC before I begin any anti-anxiety medication(s) from other provider(s). I will not begin an anti-anxiety medication regimen if Dr. Nicholas Giordano and my provider(s) at Central Florida Spine and Pain LLC recommend against it due to my treatment.

- I will acquire permission from my provider(s) at Central Florida Spine and Pain LLC before I obtain any stimulant medication from other provider(s). I will not begin a stimulant medication regimen if Dr. Nicholas Giordano and my provider(s) at Central Florida Spine and Pain LLC recommend against it due to my treatment.
- I will not attempt to obtain Opioid pain medication(s) and any other controlled medications from any provider(s). I agree to the terms laid out above specifically for anti-anxiety and stimulant medications.
- I agree that I shall inform any provider who may treat me for any other medication problems that I'm enrolled in a pain management program since the use of other medication(s) in conjunction with the treatment provided by providers at this practice may cause harm.
- I will receive all my medication(s) prescribed for my painful chronic condition from only ONE provider unless it is for an emergency or Dr. Nicholas Giordano or my other provider(s) at Central Florida Spine and Pain LLC approves the medication(s) that is being prescribed by another physician. Information that I have been receiving medication(s) for my painful chronic condition prescribed by other providers that has not been approved by my provider at Central Florida Spine and Pain LLC may lead to discontinuation of medication(s) and treatment.
- I hereby give my physician permission to discuss all diagnostic and treatment details with my other provider(s) including pharmacist(s) regarding my use of medication(s) prescribed by my other physician(s).
- Refill(s) will not be ordered before the scheduled fill date.
- I agree to notify my provider(s) at Central Florida Spine and Pain LLC well in advance if I'm on medication(s) that require refills when I'm traveling. **I understand that I need to notify Dr. Nicholas Giordano and my provider(s) at Central Florida Spine and Pain LLC of any travel plans within the next 30 days so scripts could be written accordingly.** I understand that I will not receive early refills if I make travel plans without informing this practice.
- I agree that refills of my prescription(s) for pain medicine will be made only at the time of an office visit or during regular business hours and understand I must allow at least 24 hours for my refill request to be considered and/or authorized.
- I agree that any evidence of hoarding of controlled medication(s), increasing the dosage without communication with my provider(s), refilling my medication(s) too frequently, getting controlled medication(s) from multiple outside provider(s) unless approved by Dr. Nicholas Giordano or my other provider(s) at Central Florida Spine and Pain LLC, increasing the dosage of medication(s) despite significant side effects, altering prescriptions, selling/trading/giving away medication, un-approved use of other drugs I've been warned against taking (alcohol, sedatives, or using non-prescription medications inconsistent with drug labeling) during my treatment at this practice, or any other unacceptable behavior will result in tapering and discontinuation of the controlled medication treatment at this practice. I understand that this may also result in me being discharged from Central Florida Spine and Pain LLC.
- I agree that I may be discharged **IMMEDIATELY FOR ANY ALLEGED CRIMINAL BEHAVIOR.**
- All medication(s) must be received through one pharmacy when possible. Should the need arise to change pharmacies, I will inform my provider(s) at Central Florida Spine and Pain LLC.

I agree to use the following pharmacy for filling all of my prescriptions for pain medication(s) and other controlled medication(s) even if they are prescribed by my other provider(s) outside Central Florida Spine and Pain LLC.

Pharmacy Name:_____ Pharmacy Phone: (_____) _____-_____

Pharmacy Address:_____

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I certify and agree to this entire agreement and to the following:

- I'm not currently using illegal drugs or abusing prescription medication(s) and I'm not undergoing treatment for substance dependence (addiction) or abuse. I'm reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.
- No guarantee or assurance has been made as to the results that may be obtained from chronic pain treatment. Will full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.
- I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain and I fully understand the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.

I _____, AGREE TO THIS CONTRACT IN ITS ENTIRETY; HOWEVER, I WOULD LIKE TO NOTIFY MY PROVIDER(S) AT CENTRAL FLORIDA SPINE AND PAIN OF THE FOLLOWING:

- ☐ I **DO NOT** wish to receive any controlled medications such as Opioids from Dr. Nicholas Giordano and my provider(s) at Central Florida Spine and Pain LLC.
- ☐ I wish to receive all other forms of treatment(s) from Dr. Nicholas Giordano and my provider(s) at Central Florida Spine and Pain LLC; this may include, but not limited to, non-controlled medication(s) as well as other treatment recommendations including interventional pain procedures.

_____	_____	_____
PATIENT SIGNATURE	PATIENT NAME	DATE

_____	_____	_____
PROVIDER SIGNATURE	PROVIDER NAME	DATE

CENTRAL FLORIDA

SPINE & PAIN

ASSIGNMENT OF BENEFITS

For the treatment provided and other goods and valuable consideration.

I, _____, (hereinafter referred to as Patient) hereby assign all rights and benefits that Patient had under any health group, HMO plan, individual health, PIP, disability or any other health or medical insurance policy or reimbursement plan that may pay benefits for services and treatment that Patient has received or will receive to Central Florida Spine and Pain.

This assignment includes but is not limited to, all rights to collect benefits directly from Patient's insurance company or HMO for services and treatment that Patient has received and all rights to proceed against Patient's insurance company or HMO in any action including legal suit if for any reason Patient's insurance company or HMO fails to make payments of benefits to which Patient is due. This assignment also includes the right to recover attorney's fees and cost for such action brought by the provider as Patient's assignee.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

PATIENT NAME	PATIENT DOB	SIGNATURE	DATE

WITNESS NAME	WITNESS SIGNATURE

If policy holder is different than the patient, then please fill out the following information:

POLICY HOLDER NAME	POLICY HOLDER SIGNATURE

WITNESS NAME	WITNESS SIGNATURE

CENTRAL FLORIDA

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AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

This form is for our clinic to release your medical information to those listed below.

PATIENT NAME:_____ DATE OF BIRTH:_____

By signing this form, I authorize Central Floria Spine and Pain LLC to release confidential information about my treatment by providing a copy of my medical record or a summary or narrative of my protected health information to the person(s) listed below. I understand that the information in my health record may include information relating to communicable disease, acquired immunodeficiency syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health conditions, alcohol/drug abuse, or any such related information.

THIS AGREEMENT, ONCE EXECUTED, IS EFFECTIVE INDEFINITELY UNLESS REVOKED OR TERMINATED, IN WRITING, BY THE PATIENT OR HIS/HER LEGAL REPRESENTATIVES. IT IS THE PATIENT'S RESPONSIBILITY TO UPDATE Central Floria Spine and Pain LLC IF THE PERSON(S) IN THE LIST BELOW CHANGES/ALTERS AT ANY TIME.

INFORMATION TO BE DISCLOSED: This agreement permits Central Floria Spine and Pain LLC and any of its representatives to share any and all medical information, including information listed in the paragraph above, with person(s) listed below unless patient requests limitations documented below:

Limitations to this agreement:_____

_____

Release my protected health information to the following person(s):

- ☐ DO NOT share my protected health information.
- ☐ I authorize Central Floria Spine and Pain LLC to share my protected health information with the following:

Name:_____ Relationship:_____ Phone Number: (_____)_____-_____

Name:_____ Relationship:_____ Phone Number: (_____)_____-_____

Name:_____ Relationship:_____ Phone Number: (_____)_____-_____

_____	_____	_____
PATIENT SIGNATURE	PATIENT NAME	DATE
_____	_____	_____
WITNESS SIGNATURE	WITNESS NAME	DATE

CENTRAL FLORIDA

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ADVANCE DIRECTIVES

PATIENT NAME:_____ DATE OF BIRTH:_____

The Patient Self- Determination Act (PSDA) is a federal law passed to ensure that a patient's right to self-determination in health care decisions be communicated and protected. State law requires health care entities to educate the patient on their position's advance directives.

Advance directives are available in many forms but LIVING WILLS and DURABLE POWER OF ATTORNEY FOR HEALTH CARE are two common types.

These examples of advance directives include the documented wishes conveyed by the patient when competent.

These wishes may include the types of medical treatment desired or not by the patient in the situation where the patient is unable to make decisions.

Central Florida Spine and Pain LLC Position on Advance Directives:

- Our staff, in the event of a medical emergency or other life-threatening situation, will provide resuscitation measures in every instance and the patient will be transferred to a higher level of care.
- Any previously formulated advance directive WILL NOT be honored at our facility. If, for any reason, you disagree with this policy, then please discuss your concerns with your physician before arriving to the facility for your scheduled procedure.

_____	_____	_____
PATIENT SIGNATURE	PATIENT NAME	DATE
_____	_____	_____
WITNESS SIGNATURE	WITNESS NAME	DATE

CENTRAL FLORIDA

SPINE & PAIN

Medical Records Release

PATIENT NAME:_____ DATE:_____
Date of Birth:_____

To:_____
From: Nicholas Giordano, M.D._____

Records to Release:_____
_____
_____
_____

Please Release the Following:

- ☐ Imaging Reports
- ☐ EMG / NCS
- ☐ Office Notes
- ☐ Procedure Notes
- ☐ Lab Results/ Utox Screen
- ☐ Discharge Summary
- ☐ All Medical Records

Patient Signature:_____

Thank You!
Central Florida Spine and Pain LLC.
395 South Wickham Road Melbourne, FL 32904
O: (321) 802 – 5021 F: (321) 802 – 4999

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ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICE

PATIENT NAME:_____ DATE OF BIRTH:_____

I have reviewed or have had the opportunity to review the "Notice of Privacy Practices" document provided to me by Central Florida Spine and Pain LLC. This document explains how my medical information will be used and disclosed.

_____	_____	_____
PATIENT SIGNATURE	PATIENT NAME	DATE
_____	_____	_____
WITNESS SIGNATURE	WITNESS NAME	DATE

CENTRAL FLORIDA
SPINE & PAIN

No Show / Cancellation Policy

Thank you for trusting your medical care to Central Florida Spine and Pain LLC. When you schedule an appointment with Central Florida Spine and Pain, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24-hours prior to your scheduled appointment. This gives us time to schedule other patients who might be waiting for an appointment. Please review our appointment cancellation/ no-show policy below:

- Effective March 29, 2021, any established patient who fails to show or cancels/ reschedules an appointment and has not contacted our office with at least 24-hours notice will be considered a '**No-Show**' and charged a **$25.00 fee**.
- Any established patient who fails to show or cancels/ reschedules an appointment without a 24-hour notice a *second* time will be charged a **$50.00 fee.**
- If a *third* no-show/cancellation without proper notice takes place the patient may be dismissed from Central Florida Spine and Pain.
- Any new patient who fails to show for their initial visit *twice* will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is due at the patients next office visit.
- As a courtesy, we send out reminder calls and/or text messages for appointments. If you do not receive a reminder call or text message, the above policy will remain in effect.

We there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the associated fee. You may contact Central Florida Spine and Pain LLC Monday through Friday, 9 A.M. to 5 P.M, or leave a message after business hours. Your call will be returned during business hours.

Central Florida Spine and Pain (321) 802 – 5021

I have read and understand the Medical Appointment Cancellation/No-Show Policy and agree to all terms.

Patient Signature:_____ Printed Name:_____
Date:_____ Relationship to Patient (if applicable): _____