FLORIDA WELLNESS & REGENERATIVE MEDICINE LLC

Date	DOB:	Age:	SSN:
Last name:	First Name:		MI:
Home address:		City/ State/Zip code:	
Home phone:	Mobile:		Work:
Email:	Marital Status:	Spouse Name:	
Occupation:	Employer		

Referring Physician:	Phone:
Family Physician:	Phone:
Pharmacy name:	Phone:

Emergency Contact:	Phone:
Relationship:	Alternate phone:

Primary Insurance:	Phone:
Policy Number:	Group Number:
Claims: Address/ City/ Zip:	
Policy Holders name:	Relationship
SSN of policy holder:	DOB:

Secondary Insurance:	Phone:
Policy Number:	Group Number:
Claims: address/ City/ Zip	
Policy holders name:	Relationship:
SSN of policy holder	DOB:

Work Related injury: [] yes [] no	Date of the accident: / /	Claim #:	WC Company Name:
W/C Case manager name:			
Auto accident/ Slip and fall: [] yes [] no	Date of the accident: / /	Claim #:	Insurance Name:
Adjuster's name:		Phone number:	
Attorney's name:		Phone number:	

I authorize the release of any medical information necessary to process the claims rendered to me. I also authorized payment of medical benefits directly to FL Wellness & Regenerative Medicine LLC for services rendered to me. I understand that I will be responsible for all copays, deductible, and non-covered services as determined by my insurance Carrier. I accept full responsibility for any outstanding balance with Florida Wellness & Regenerative Medicine LLC.

_____ _____

SIGNATURE DATE

Diana Hussain, M.D. FAAPMR, DABPM
7345 W. Sand Lake Rd. Ste 301
Orlando, FL 32819
Phone (321) 204 8237 Fax (407) 250-6117

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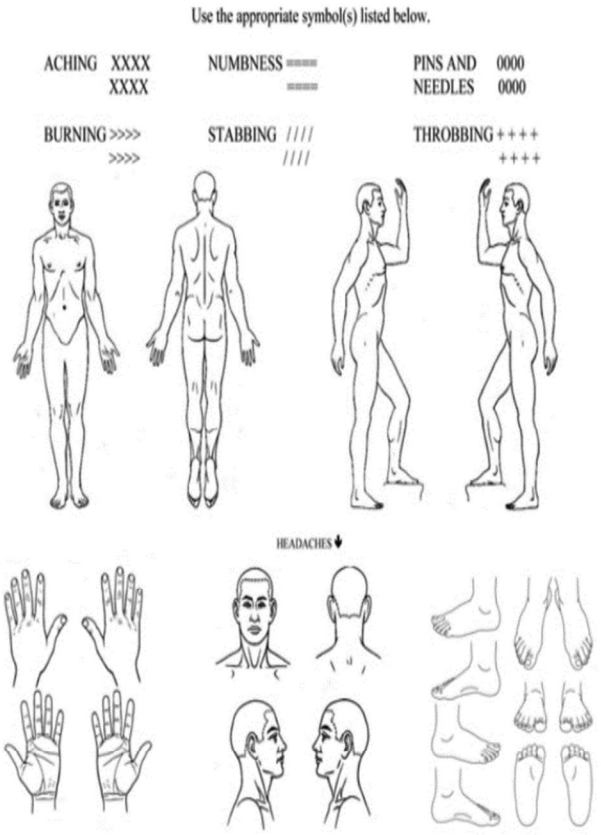
Name: _____ DOB: _____ Account#: _____

What is the reason for your referral? _____

Right _____ or left _____ handed

Pain Diagram and rating

Please number and mark the severity of your symptoms [] Current pain ____/10 0 1 2 3 4 5 6 7 8 9 10 [] Average pain ___/10 0 1 2 3 4 5 6 7 8 9 10
When did the symptoms begin?
What were you doing when your symptoms started?
What is the primary area affected?
How are your symptoms changed since it started? [] Improving [] No change [] Worsening
What activities worsen your condition? [] Rest [] sitting [] Standing [] Walking [] Sneezing [] Coughing
What relieves your symptoms? [] Lying down [] Sitting [] Standing [] Walking [] Massage [] Heat [] Ice [] Physical therapy [] Injection ` []TENS unit [] Nothing [] Medication



Past treatments

Physical Therapy	Chiropractor
Injections	
Medication	
Surgery	

Previous Testing

MRI	X Rays	EMG/Nerve study	Bone scan
Myelogram	Blood tests	Other:	

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Past Medical History

Diabetes	High blood pressure	Heart disease	Osteoporosis	Cancer	Bladder problems
Liver disease	Gastritis/ peptic ulcer	Anemia	Hepatitis	HIV	Bowel problems
Kidney disease	Asthma	Stroke	Epilepsy	Glaucoma	Mitral valve Prolapse
Alcoholism	Seasonal Allergies	Thyroid disease	Alcoholism	Drug addiction	Autoimmune disease
Other					

Current Medications

Name	Dose	Frequency	Last time taken

Social History

Occupation:
Highest level of education:
Marital status:
Home situation:
Quantity of tobacco, alcohol or another drug use:
Do you feel safe at home?
Do you have advanced directives?
Do you need help with activities of daily living?

Surgical History [] yes []no

Type of surgery, year, surgeon's name, and hospital name.

Allergies_____

_____

Family history

Parents:
Siblings:

Patient's name_____ patient signature_____ Date _____

Patient representative_____ Relationship/Authority to the patient _____

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Form Completion Policy

FWRM charge $____ for form completion. The charge will be payable by the patient requesting the completion and will not be billed to insurance companies, attorneys, etc. Requests will be completed in 7-10 business days and payment is due prior completion of the forms.

Medication Refill Policy

There is a 48 to 72-hours (2-3 business days) for medication refills. I you call for refill on a Friday afternoon, then your request will begin on the next business day. Worker's Compensation cases may need to come into the office to pick up medication refills. Do not wait until you are out of medication before your is called in. Your doctor may not be in the office or available to approve your refill on an emergency basis.

FWRM is **NOT** a Pain Clinic. Per Florida Legislature (HB 21), a prescription for a Schedule II opioid for the treatment of acute pain may not exceed a three-day supply. If you need more that a 3-day supply of pain medication, please let the doctor know so you can be referral to a registered Pain Clinic for Prescription and monitoring of such medication.

Medical Records Release Policy

You will need to sign a release form to allow our office to release any records to the doctors (s) of your choice. If your attorney (s) are requesting records, they must submit a written request and released to our office with your signature. Please allow 1 to 2 weeks for request to be processed. If you, as the patient, I requested a copy of your records, the cost is $1 per page. Please follow-up 1 week for request to be processed.

No-show/ Cancellation Policy.

If it is necessary to cancel or reschedule your appointment, please do so prior to 24 hours of their appointment to avoid the $___charge order and to allow someone else to use that appointment time. The fee of $____is to be paid by the patient and is not billable to any insurance, attorney etc.

If it becomes necessary to cancel or reschedule your appointment for an injection or nerve study, please do so prior to 24 hours of the scheduled appointment time to avoid a $100 charge and to allow someone else to use that appointment time. Injections and nerve studies are scheduled over several “normal” appointment slots due to the nature of the procedure. Therefore, it is very important that notification is given if you are unable to your scheduled appointment. This fee of $100 is to be paid the patient and it is not billable to any insurance companies.

Billing of co-pays/Balances

Co-pays are due at the time of your visit and **must** be collected per our contracts with your insurance company. We reserve the right to reschedule your appointment if you are unable to pay at the time of the visit. You will be charge $5.00statement fee for each statement that is mailed to you for collection of those fee if we do agree to see you at the time of the visit without payment of your required co-pay.

Collection Fees

A fee totaling 30% of the balance due will be added to your account if we have to send your account to an outside collection agency.

_____ _____ _____

Signature Print Date

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Controlled Substance Contract

_____Controlled substance medications are very useful, but they can be harmful if taken without medical supervision. I understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results.

_____The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained including but not limited to constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. 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 medication(s).

_____FWRM is **NOT** a register Pain Clinic. Per Florida Legislature (HB 21), a prescription for a Schedule II opioid for the treatment of acute pain may not exceed a three-day supply. If you need more that a **3-day supply** of pain medication, please let the physician know so you can be referred to a registered Pain Clinic for prescription and monitoring of such medication.

_____ I will not be involved in any activity that maybe dangerous to myself or someone else while I am under the effect of controlled medications, such as driving vehicles or operating heavy machinery.

_____ I will disclose to my physician 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.

_____ I agree not to share, sell or otherwise permit others, including my family and friends, to have access to these medications.

_____ I will not allow or assist in the misuse/diversion of my medication; nor will I give or sell them to anyone else.

_____ All medication(s) must be obtained at one pharmacy, where possible

_____ I understand that if my medication is lost or stolen, they may NOT BE REPLACED.

_____ I will receive controlled substance medication(s) only from ONE physician unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my physician.

_____ I will not use illegal substances.

_____ I agree to submit to a blood or urine test and/or pill counts at any time if necessary.

For female patients only:

_____To the best of my knowledge I am NOT pregnant.

_____If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is MY responsibility to inform my physician immediately if I become pregnant.

_____ I have read this agreement and agree to follow it. I am aware that if I violate this agreement, my physician will discontinue this treatment and my physician will discharge me from the Practice

_____	_____	_____
Signature	Print	Date

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