REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name: **First:** **Middle:**		**Marital status:** Single ☐ Mar ☐ Div ☐ Sep ☐ Widow ☐
Do You Have Insurance Coverage? ☐ Yes ☐ No	**Social Security Number:**	**Birth date:** **Age:** **Sex:** ☐ M ☐ F
Mailing address:	**Primary/Preferred Phone:** ( )	**Secondary Phone:** ( )
City: **State:**		**ZIP Code:**
What Pharmacy do you use?		**City:**
Email Address:		**Employer:**

INSURANCE INFORMATION (PLEASE BE SURE TO GIVE YOUR CARD(S) TO THE RECEPTIONIST)

What is your Primary Insurance?				**Co pay Amount:**
Policy Holder name:	**Policy Holder SS #:**	**Birth date:**	**Group no.:**	**Policy no.:**
Policy Holder Relationship to Patient:	☐ Self	☐ Spouse	☐ Parent/Guardian	☐ Other:

What is your Secondary Ins? ☐ **None**

Policy Holder name:	**Policy Holder SS #:**	**Birth date:**	**Group no.:**	**Policy no.:**
Policy Holder Relationship to Patient:	☐ Self	☐ Spouse	☐ Parent/Guardian	☐ Other:

IN CASE OF EMERGENCY

Name of local friend or relative :	**Relationship to patient:**	**Primary Phone:** ( )	**Secondary Phone:** ( )

PROTECTED HEALTH INFORMATION RELEASE

Concerning matters of my health, lab results, and appointments, I, the patient/legal representative give permission for Dr. Hashim and members of the staff to speak to and share my information with:

☐ **I do NOT want to share my information with anyone**

Name **Relationship**

Name **Relationship**

I ☐ ALLOW ☐ DO NOT ALLOW test results and other specific information regarding my care to be left on my answering machine or voicemail.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Hashim and the insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date***

Financial Policy and Signature on File

I authorize the release of any medical pertinent information to my consulting provider, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of claim benefits to Dr. Hashim.

Claims are filed to insurance as a courtesy. However, I understand that I am financially responsible for all services rendered including for the following reasons: 1) I do not have the proper referral at the time of service 2) My referral is invalid/expired 3) I have given incorrect/invalid insurance information 4) Expenses are not covered by my insurance company 5) I have not met my deductible 6) The services rendered are deemed medically unnecessary by my insurance company. ***Failure of insurance company to pay your claim does not excuse the patient's financial responsibility. It is patient's responsibility to know what is/is not covered and to make sure insurance pays your claims in a timely fashion.***

NSF CHARGES: Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. In the event a check is returned for Non Sufficient Funds we will assess a $25.00 charge in addition to your current balance to cover the bank charges incurred by our office due to Non Sufficient Funds.

Collections Fee: If an account remains unpaid, the account will be transferred to a collections agency and a 20% fee of the overdue balance will be added to the account. This is not negotiable. The fee is the collection agency fee imposed by the agency for their cost of business.

Medicare: We will file claims for you. Please note that Medicare will not pay for a variety of procedures that they do not consider medically necessary due to their regulations. Payment is expected at time of service for those procedures although they may be balance billed after insurance is filed.

Medicaid: We do **not** participate with Florida or any other state Medicaid program.

Your signature below signifies your understanding and willingness to comply with Dr. Hashim's office policies.

Patient/Responsible Party Signature for Financial Policy

X_____ **Date**_____

HIPAA COMPLIANCE STATEMENT - *THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*

Dr. Hashim and his staff are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION - Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care to you.

YOUR RIGHTS - Although your medical chart belongs to our practice, the information contained in the chart is yours. You have the right to inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information to certain parties.

OUR RESPONSIBILITIES - We are required to maintain the privacy of your health information, send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED - Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Claims will be sent to your insurance company. The information in the claims will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

OTHER NOTICES - We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

FOR MORE INFORMATION, QUESTIONS OR TO REPORT A PROBLEM - If you have concerns or would like additional information, you may contact the Billing Department at 855-586-8160.

Patient/Responsible Party Signature (HIPAA Policy)

X Date

Mark N. Hashim, M.D.
Interventional Pain Institute of West Florida
Patient Evaluation Form

Please complete this form and **return completed form** to the office via fax, mail, email or hand delivery.

Fax: (352) 513-4865 Beverly Hills, (727) 861-1010 Hudson
Email: Info@markhashimmd.com
Mail: 7412 Community Court
Hudson, Fl. 34667
Phone: (352) 513-4862 Beverly Hills, (727) 861-1000 Hudson

PLEASE PRINT CLEARLY. Fill out this form as completely as possible.

DATE: _____ Email address _____

NAME: _____ AGE: _____

HEIGHT: _____ WEIGHT: _____ Mobile Phone Number _____

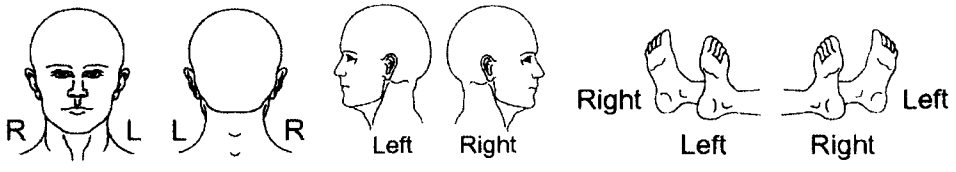
PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

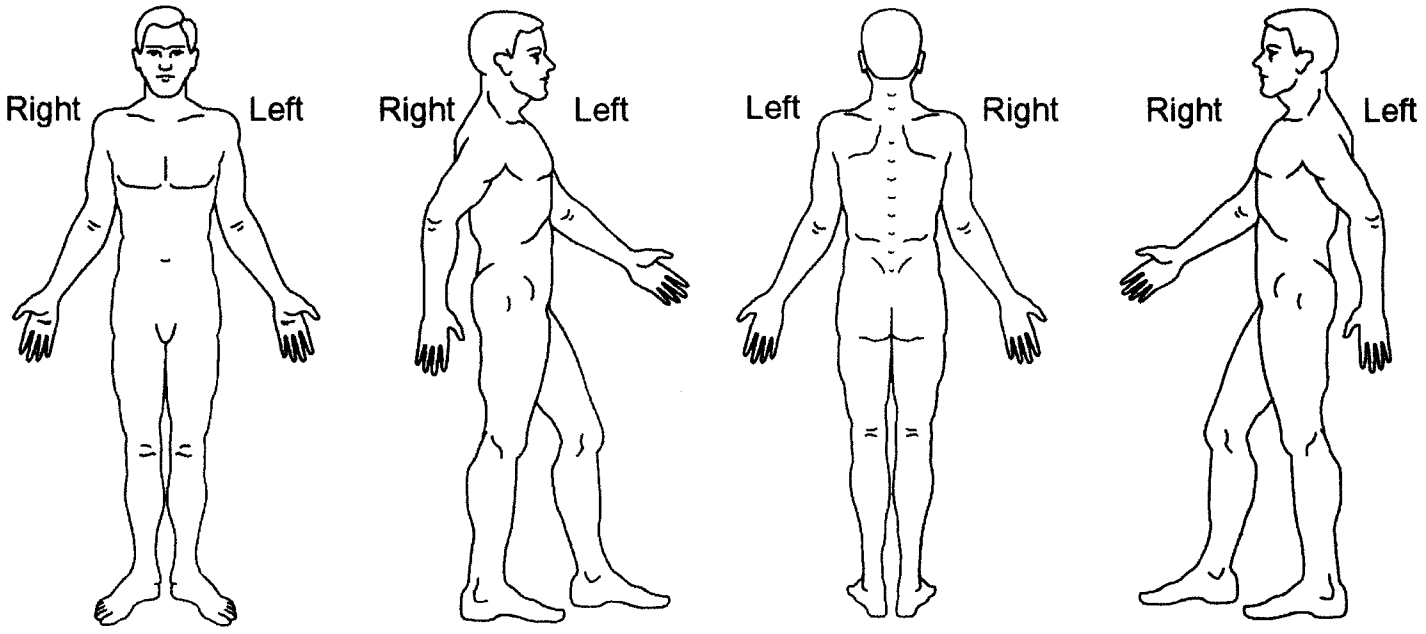
PLEASE LIST ALL PHYSICIANS (or mental health professionals) that you have consulted:

NAME	DATE LAST SEEN	OFFICE PHONE NUMBER

Use the following diagrams to label where the pain is located. This will be what problem area to be discussed with the physician. Please label the area with the following letters.

B = BURNING
S = SHARP
D = DULL ACHE
N = NUMBNESS / TINGLING





HOW did your pain start?

☐ auto accident ☐ fall (not at work) ☐ after surgery

☐ work related ☐ just started ☐ other; describe below:

_____

_____

_____

WHEN did your pain start? _____

CHECK the number that indicates the degree of pain you are in **NOW** (0=no pain):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

CHECK the number that indicates the AVERAGE pain you felt in the PAST WEEK:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

In the last 2-3 weeks, WHEN does your pain occur:

☐ constant ☐ intermittent (on & off) ☐ less then 8 hours/day ☐ 8-16 hours/day

What **INCREASES** your pain:

☐ sitting ☐ walking ☐ standing ☐ work ☐ other; describe below:

_____

What **DECREASES** your pain:

☐ rest ☐ physical therapy ☐ lying down ☐ relaxation ☐ injections

☐ drugs ☐ heat ☐ cold ☐ not working

☐ treatment in emergency room ☐ other; describe below:

_____

CHECK any of the following treatments that you have tried for your pain:

Pain Clinic / Anesthesiologist	☐ Better	☐ Same	☐ Worse
Anti-depressant medications	☐ Better	☐ Same	☐ Worse
Trigger point injections	☐ Better	☐ Same	☐ Worse
Epidural steroid injections	☐ Better	☐ Same	☐ Worse
Biofeedback or relaxation	☐ Better	☐ Same	☐ Worse
TNS unit (transcutaneous nerve stim)	☐ Better	☐ Same	☐ Worse
Physical therapy	☐ Better	☐ Same	☐ Worse
Home exercises	☐ Better	☐ Same	☐ Worse
Hypnosis / psychotherapy	☐ Better	☐ Same	☐ Worse
Acupuncture	☐ Better	☐ Same	☐ Worse
Chiropractic	☐ Better	☐ Same	☐ Worse
Massage therapy	☐ Better	☐ Same	☐ Worse
Pain killers	☐ Better	☐ Same	☐ Worse

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:

☐ stroke ☐ angina ☐ hepatitis ☐ epilepsy ☐ heart disease ☐ arthritis

☐ cancer ☐ asthma ☐ diabetes ☐ migraines ☐ easy bleeding ☐ HIV

☐ lung disease ☐ recent weight loss ☐ other; describe below:

List any surgeries:

SURGERY:	DATE:

Do you take aspirin? ☐ Yes ☐ No If yes, last dose & date:

Do you use any anticoagulants (like heparin, aspirin or coumadin): ☐ Yes ☐ No

Do you use recreational drugs or medications prescribed to someone else?
☐ Yes ☐ No If YES, describe below:

List **ALL** medications, nutritional supplements and over the counter medications:

NAME:	STRENGTH:	HOW OFTEN:

List the medications you are ALLERGIC to or have had problems with:

MEDICATION: REACTION:

Please check any items that apply to **YOU** currently or in the past:

- ☐ heart trouble
- ☐ breathing problems
- ☐ frequent diarrhea
- ☐ diabetes
- ☐ seizures
- ☐ high blood pressure
- ☐ frequent pneumonia
- ☐ loss of urinary control
- ☐ thyroid problems
- ☐ numbness arms or legs
- ☐ heart or chest pain
- ☐ frequent nausea/vomiting
- ☐ frequent constipation
- ☐ joint stiffness/swelling
- ☐ severe headaches
- ☐ shortness of breath at rest
- ☐ stomach ulcers
- ☐ urinary tract infections
- ☐ use of stool softeners
- ☐ weakness of arms or legs
- ☐ bleeding problems
- ☐ loss of bowel control
- ☐ pain on urination
- ☐ frequent infections
- ☐ strokes or TIA's
- ☐ swollen ankles
- ☐ frequent laxatives
- ☐ joint pain
- ☐ skin problems
- ☐ fainting spells
- ☐ OTHER:

Have any of your relatives had: ☐ cancer ☐ heart disease ☐ neurologic disease ☐ muscular disease

Have you gained or lost more than 10 pounds in the last year? ☐ Yes ☐ No

FOR **WOMEN** ONLY:

Are you pregnant? ☐ Yes ☐ No

Are you trying to get pregnant? ☐ Yes ☐ No

FOR **MEN** ONLY:

Do you have problems with erections? ☐ Yes ☐ No

Do you smoke? How much? ☐ Yes ☐ No

Do you drink alcohol? How much? ☐ Yes ☐ No

Has anyone ever complained about your drinking? ☐ Yes ☐ No

If yes, who?

Do you drink caffeine? How much? ☐ Yes ☐ No

Are you married? ☐ Yes ☐ No

Current Employer:

Occupation:

Job description: _____

How long with this employer? _____

Are you currently working? ☐ Yes ☐ No Date last worked: _____

If not working, who took you off work? _____

When will your off work slip expire? _____

Are you on Worker's Comp? ☐ Yes ☐ No

Date started: _____

Are you on disability? ☐ Yes ☐ No

Date started: _____

Type: ☐ social security disability ☐ long term disability ☐ short term disability
☐ other: _____

What do you get disability for: _____

Are you in a lawsuit with Workers Comp? ☐ Yes ☐ No

Are you involved in a lawsuit regarding an auto accident? ☐ Yes ☐ No

Are you involved in a lawsuit regarding a disability claim? ☐ Yes ☐ No

If you are involved in a lawsuit, who is the lawsuit against? _____

How has pain affected your personality? (check all that apply)

☐ no effect	☐ alert	☐ cheerful	☐ get along well
☐ slightly upset	☐ irritable	☐ disagreeable	☐ complaining
☐ moderately upset	☐ unhappy	☐ anxious	☐ uncooperative
☐ severely upset	☐ quite depressed	☐ bitter	☐ withdrawn
☐ totally incapacitated	☐ panicked	☐ severe withdrawal	☐ avoid everyone
☐ moody	☐ dull	☐ desperate	

Since the pain, what are you concerned about? (check all that apply **now**)

☐ loss of recreational activities	☐ ability to earn income
☐ memory/concentration difficulties	☐ poor sleep and daytime fatigue
☐ sexual desire, interest or ability	☐ unidentified medical problems
☐ the pain lasting forever	☐ other; describe below:

_____

Have you ever seen a counselor, psychologist or psychiatrist? ☐ Yes ☐ No
(if yes, please include on list page 1)

What treatments have you had for emotional problems? (check all that apply)
☐ ECT ☐ counseling ☐ medication ☐ group therapy ☐ other:

_____

Do you want to see a pain psychologist to help you deal with the pain?
☐ Yes ☐ No

What diagnostic studies have been done in the **last 5 years**? Please give area of body studied and date of study. Please have the REPORTS of these studies available for your first visit.

MRI DATE:	**PART OF BODY:**	**DO YOU HAVE REPORT?**	**NAME OF FACILITY:**
_____	_____	☐ No ☐ Yes	_____
_____	_____	☐ No ☐ Yes	_____

MYELOGRAM DATE:

_____	_____	☐ No ☐ Yes	_____

CT SCAN DATE:

		☐ No	☐ Yes	
		☐ No	☐ Yes	

XRAY DATE:

		☐ No	☐ Yes	
		☐ No	☐ Yes	

EMG DATE:

		☐ No	☐ Yes	

BONE SCAN DATE:

		☐ No	☐ Yes	