Fabian A. Ramos, MD · Abraham J. Fura, DO · John J. D'Auria, MD
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Ramos Center for Interventional & Functional Pain Medicine
New Patient Paperwork

Thank you in advance for taking the time to complete our paperwork. We are aware that it is extensive and time consuming. We hope you understand that this is our first introduction to you and your medical history and the best way for us to begin to understand your pain. Below is a checklist to help guide you through this process. We welcome you to the Ramos Center family and we look forward to helping you find relief from your pain and getting you back to your normal daily activities.

Print and Complete the Following Forms:

□ Personal/Contact Information

□ Privacy Authorization & Verification

□ Controlled Substances Agreement

□ Medical & Pain History

□ Advanced Beneficiary Notice for Office Anesthesia Services of Non-Coverage (ABN)

□ Behavioral Health Screening Questionnaire

Please bring the following items with you to your first appointment:

□ Current Insurance Card

□ Photo ID

□ Most Recent MRI Reports (If applicable)

□ Current Medications (Bring in their original bottle to your first appointment)

100 3rd Ave W Suite 110 Bradenton, FL 34205
2540 S. Tamiami Trail Sarasota, FL 34239
1370 East Venice Ave. Suite 104 Venice, FL 34285
Phone: (941) 708-9555 • Fax: (941) 708-5465

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<table>
<tr><td colspan="3">First Name</td><td colspan="2">Middle Initial</td><td>Last Name</td></tr>
<tr><td colspan="3">Local Address</td><td colspan="3">City, State, & Zip Code</td></tr>
<tr><td>Date of Birth</td><td>Age</td><td colspan="2">Sex:
Male Female</td><td colspan="2">Marital Status:
Single Married Divorced Widowed</td></tr>
<tr><td colspan="2">Preferred Language</td><td colspan="2">Race</td><td colspan="2">Ethnicity</td></tr>
<tr><td colspan="2">Home Phone</td><td colspan="2">Work Phone</td><td colspan="2">Cell Phone</td></tr>
<tr><td colspan="2">E-mail Address</td><td colspan="4">Social Security No (For insurance & record keeping only)</td></tr>
<tr><td colspan="2">Employer</td><td colspan="4">Occupation</td></tr>
<tr><td colspan="3">Guarantor Full Name/Person Responsible for Payment</td><td colspan="3">Relation to Patient:
Self Spouse Legal Guardian</td></tr>
<tr><td colspan="6">Whom may we thank for referring you to us:
Insurance Advertisement Yellow pages Doctor, friend or family:</td></tr>
<tr><td colspan="2">Medical Insurance Co. Name</td><td colspan="4">Medical Insurance ID/Contract Number</td></tr>
<tr><td colspan="3">Policy Holder/Insured's Full Name</td><td colspan="3">Patient's relation to insured:
Self Spouse Legal Guardian</td></tr>
<tr><td colspan="3">Policy Holder/Insured's Date of Birth</td><td colspan="3">Insured's Employer Name</td></tr>
</table>

Today's Date: ___________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
By signing below, I acknowledge that I have viewed or have been given a copy of Notice of Privacy Practices. A copy of our Notice of Privacy Practices is posted in the reception/waiting area of our office.
NO SHOW FEE: Please give us 24 hours advance notice if you cannot make your appointment. A No-Show fee will be charged if you do not make your appointment and fail to give us advanced notice.

Patient or Patient representative____ Date: _______________________

SIGN BELOW IF WE ARE BILLING INSURANCE ON YOUR BEHALF
I hereby authorize the physician to release any information required to process this claim. If the physician is accepting insurance, I also authorize my insurance benefits be paid directly to the physician, and I understand I am financially responsible for non-covered services. I authorize the use of this signature on all my insurance submissions.

Patient or Patient representative:____ Date:________________________

SIGN BELOW IF YOU HAVE MEDICARE PART B FOR YOUR HEALTH INSURANCE
I request that payment of authorized Medicare benefits be made to Fabian Ramos, M.D. for services rendered to my by him. I authorize any holder of medical information about me to be released to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits. I understand my signature request that payment be made and authorizes release of medical information necessary to pay this claim. If other health insurance is listed in Item 9 of the CMS 1500 or elsewhere, my signature authorizes release of medical information to the insurer or agency shown. In Medicare assigned cases, Fabian Ramos, M.D. agrees to accept the charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient or Patient representative: ____ Date:_________________________

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Ramos Center
for Interventional &
Functional Pain Medicine

PRIVACY AUTHORIZATION & VERIFICATION

Please answer the following questions to help us protect your privacy.

1. Is it okay to leave a detailed message on your answering machine? **YES OR NO**
   Is it okay to leave a detailed message for you at Work? **YES OR NO**

   If the answer is **NO,** please let us know how you wish to be notified by our office:
   ____

2. Is it okay to release information to anyone **other than** you or a physician? **YES OR NO**

   If the answer is **YES,** please list each person, relationship to you, and contact phone number:

   Name _________________________ Relationship _______________ Phone __________________

   Name _________________________ Relationship _______________ Phone __________________

REMINDER! WE WILL NOT RELEASE INFORMATION TO ANYONE NOT LISTED ABOVE.

This is to verify that I have read and understand the above information. By signing this statement, I Authorize the Ramos Center and its' staff consent to release my medical information as described above.

I acknowledge that I have read a copy of the Ramos Center's Privacy Policy and have been given an opportunity to ask questions.

Signature __________________________________ Date _______________

Print Name ________________________________

Or person legally authorized to sign for the above-mentioned patient:

Signature _________________________________ Relationship ____________________

Print Name _______________________________ Date _______________

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Ramos Center
for Interventional &
Functional Pain Medicine

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION

I hereby request and authorize the Ramos Center to obtain the health records of:
Name ____ DOB _________________

( ) All general medical records, including HIV/AIDS, substance abuse, and psychiatric records.

( ) Limited records (i.e. lab results, EKG, MRI, X-rays, CT, etc.)

To: **Ramos Center for Interventional & Functional Pain Medicine**
2540 S. Tamiami Trail Sarasota, FL 34239

Phone Number: (941) 708-9555 **Fax Number: (941) 554-4780**

PROHIBITION ON RE-DISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosures of such information without the express written consent of the person to who such information pertains, or as otherwise permitted by state law. With regard to HIV/AIDS, substance abuse, or psychiatric records; a specific written consent is required – a general authorization for the release of medical or other information is NOT sufficient for this purpose.

In the event these records are being requested other than for the personal use of the patient or an attending physician, a charge of $1.00 per page will be assessed in accordance with Florida State Statute 395.3025.

________________ ______________________________________
Date signed Signature or patient or authorized representative

Authorized Representative: ( ) Parent ( ) Surviving Spouse
( ) Legal Guardian/Administrator/Executor*

*If Legal Guardian, Administrator, or Executor, legal proof of this status must accompany this authorization.

The patient or authorized representative may revoke this authorization at any time after it is signed by submitting a written request to the facility.

Information and Agreement Regarding Controlled Substances

This agreement is a tool to protect both you and your physician by establishing guidelines, within the laws, for proper controlled substance use. The words "we" and "our" refer to the facility, and the words "I", "you", "your", "me", or "my" refer to you, the patient.

We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of chronic pain and related anxiety and depression, which is strictly regulated by both state and federal agencies. The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the **risk of addictive disorder** developing or risk of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason, you, the patient, as consideration for and a condition of the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain agree to the following policies:

1. I understand that chronic opioid therapy has been associated with not only addiction and abuse, but also multiple medical problems including the suppression of endocrine function resulting in low hormonal levels in men and women which may affect mood, stamina, sexual desire, and physical and sexual performance.

2. **For female patients:** If I plan to become pregnant or believe that I have become pregnant while taking this medication, I am aware that, should I carry the baby to delivery while taking these medications unless my obstetrician recommends otherwise; the baby will be physically dependent upon opioids. I will immediately call my obstetrician and this office to inform them of my pregnancy. I am also aware that opioids may cause a birth defect, even though it is extremely rare.

3. I have been informed that long-term and/or high doses of pain medications may also cause increased levels of pain known as opioid induced hyperalgesia (pain medicine causing more pain) where simple touch will be perceived as pain and pain gradually increases in intensity and also the location with hurting all over the body. I understand that opioid-induced hyperalgesia is a normal, expected result of using these medicines for a long period of time. This may be helped with addition of non-steroidal anti-inflammatory drugs such as Advil, Ibuprofen, etc., or by reducing or stopping opioids.

4. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped, or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome.

5. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable, and could even result in heart attack, stroke, or death.

6. I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment, reduce the dose, or stop it. The best way to prevent or slow down tolerance is not to take opioids every day or at most once, targeted to specific activities during the day. A twice a day schedule should be indicated only in a few selected patients during a limited amount of time. For long term treatment, the use of extended release medication is indicated.

7. All controlled substances for pain must come from the physician whose signature appears below or during his/her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to risky drug interactions or poor coordination of treatment).

8. I understand that I must tell the physician whose signature appears below or during his/her absence, the covering physician, all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death.

9. I will not seek prescriptions for controlled substances for chronic pain from any other physician, health care provider, or dentist. I understand it is unlawful to be prescribed the same type of controlled medication (opioids) by more than one physician at a time without each physician's knowledge. Prescriptions for pain from a surgical procedure given by the surgeon, are exceptions if all doctors are informed in advance and authorized. Your chronic pain doctor should not treat your acute post-operative pain.

10. I also understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician or his/her staff or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed or illegal street drugs).

11. You are expected to inform our office of any new medications or medical conditions and of any adverse effects you experience from any of the medications that you take.

12. You may not share, sell, or otherwise permit others to have access to these medications.

13. These drugs should not be stopped abruptly, as abstinence or withdrawal syndrome will likely develop.

14. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below or during his/her absence, by the covering physician, as set forth in Section 1 above. I will not use, purchase, or otherwise obtain any Schedule I drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance or any combination of substances (e.g., alcohol and prescription drugs), may impair my driving ability and may result in DUI charges. I acknowledge that opioids may impair my ability to drive. I acknowledge that driving or operating machinery while impaired is my responsibility & that I have been advised to avoid.

15. **Unannounced urine or serum toxicology screens may be requested and your cooperation is required.** Presence of unauthorized substances may prompt referral for assessment for addictive disorder and/or dismissal from this practice. I understand that the facility may call me for a pill count at any time. I will go the same day that I am called with the original vials and all remaining pills. If I don't go the same day, I might not be eligible to continue receiving these medications.

16. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescriptions. They should not be left where others might see or otherwise have access to them.

17. Original containers of my opioid medications with full amount of remaining pills should be brought in to each office visit.

18. Since the drugs may be hazardous and/or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

19. **Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc.** If the medication has been stolen I understand that more medications will not be supplemented. It is my responsibility to keep my opioid medications safe.

20. Medication changes will not be made between appointments unless medically necessary, which will be determined by the physician. Early refills will not be given.

21. Unscheduled "drop in" visits for prescription refills are not allowed, as the physicians are busy seeing scheduled patients.

22. Prescription refill requests may be phoned into the Ramos Center (941-708-9555) at least 48 hours prior to needing the refill.

23. Prescriptions cannot be mailed to you.

24. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends. Since this would be considered a next day call and 48 hours will apply from next day.

25. It should be understood that any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit.

26. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).

27. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.

28. I also understand that the prescribing physician has permission to discuss all diagnostic and treatment details, including medications, with dispensing pharmacists, other professionals who provide your health care or appropriate drug and law enforcement agencies for the purpose of maintaining accountability.

29. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

30. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at the facility and that law enforcement officials may be contacted. I affirm that I have full right and power to sign and to be bound by this agreement, that I have read it, and understand and accept all of its terms. A copy of this document has been given to me. A copy of this document is uploaded to RamosCenter.com for my review at any time.

31. Addendum to this agreement will be generated every time that a new medication is prescribed or dose changed. This addendum will bind the patient to the prescribed opioid frequency of the prescribed medication.

32. All controlled substances must be obtained at the same pharmacy, where possible, our office must be informed. Complete with your selected pharmacy:

    Pharmacy: ____ Phone:____________________________

________________________________	___________________________________	____________
Patient Signature	Patient Name (Printed)	DOB
________________________________	____________	
Physician Signature	Date	

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Ramos Center
for Interventional & Functional Pain Medicine

History & Physical

Date __________________

Patient Name: ____

Date of Birth: _____________________ Sex: ________ Age: ________ Height: ________ Weight: ________

R or L Handed (please circle) Occupation ___________________________________

Are you taking aspirin or any other blood thinner? Y N

Name of blood thinner (if yes) ____

Consultation: Requested by Dr. ____

Referral: Patient comes referred by ____

Primary Care Physician's Name ____

Worker's Compensation Case? Y N

Auto Accident? Y N

Represented by Attorney? Y N Attorney's Name ________________________________

Lawsuit Pending? Y N

Chief Complaint: **(You may X more than one if applicable)**

- ☐ Leg pain ☐ Left ☐ Right ☐ Both
- ☐ Low back pain
- ☐ Neck pain
- ☐ Shoulder pain ☐ Left ☐ Right ☐ Both
- ☐ Thoracic pain
- ☐ Headache
- ☐ Other __________________________________

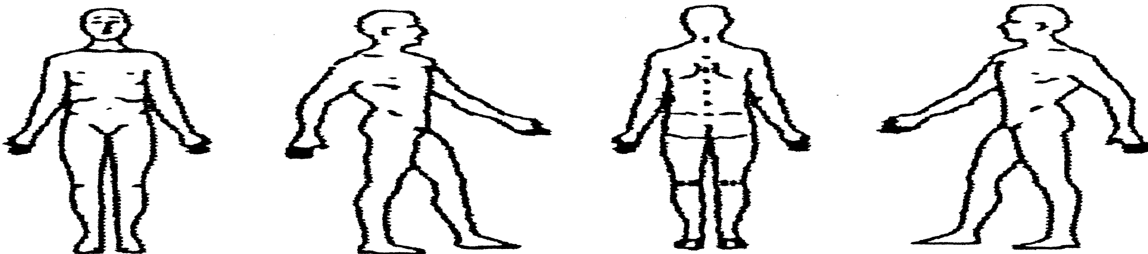
Physician use only: Reviewed: _______

History of Present Illness:

Location of Pain:

Physician use only: Reviewed: _______

On the diagram below **"SHADE"** all areas where you feel pain and **"X"** the areas that hurt the most.



Events associated with the onset of pain:

☐ Car accident ☐ Lifting ☐ Fall ☐ Work Related ☐ Unknown

☐ Other ____

When did the first sign/symptom occur? Year ____________ Month ____________________

<u>Quality of Pain:</u> **Use one box per body site where you experience pain <u>TODAY</u>.**

(Example: one box for back, one for leg and another for neck)

Circle the words that **<u>best</u>** describe the pain at that site. Also indicate the intensity of the pain.

Body Site________________________ Circle the words that <u>best</u> describe the pain

Sharp	**Numb**	**Burning**	**Intermittent**	**Exhausting**
Shooting	**Throbbing**	**Cramping**	**Continuous**	**Miserable**
Stabbing	**Aching**	**Gnawing**	**Penetrating**	**Unbearable**

Intensity Scale 0 1 2 3 4 5 6 7 8 9 10

No pain Worst Pain

Body Site ________________________ Circle the words that <u>best</u> describe the pain

Sharp	**Numb**	**Burning**	**Intermittent**	**Exhausting**
Shooting	**Throbbing**	**Cramping**	**Continuous**	**Miserable**
Stabbing	**Aching**	**Gnawing**	**Penetrating**	**Unbearable**

Intensity Scale 0 1 2 3 4 5 6 7 8 9 10

No pain Worst Pain

Body Site ________________________ Circle the words that <u>best</u> describe the pain

Sharp	**Numb**	**Burning**	**Intermittent**	**Exhausting**
Shooting	**Throbbing**	**Cramping**	**Continuous**	**Miserable**
Stabbing	**Aching**	**Gnawing**	**Penetrating**	**Unbearable**

Intensity Scale 0 1 2 3 4 5 6 7 8 9 10

No pain Worst Pain

Modifying Factors: **Circle the number below that best describes the amount of pain relief that treatment is providing or has provided in the past.**

	Never Tried	No Relief ... Complete Relief	✓ If Receiving Now
Physical Therapy	□	0 1 2 3 4 5 6 7 8 9 10	□
Surgery	□	0 1 2 3 4 5 6 7 8 9 10	□
Injection/Nerve Block	□	0 1 2 3 4 5 6 7 8 9 10	□
Drug/Medication Therapy	□	0 1 2 3 4 5 6 7 8 9 10	□
Chiropractic Adjustment	□	0 1 2 3 4 5 6 7 8 9 10	□
TENS	□	0 1 2 3 4 5 6 7 8 9 10	□
Acupuncture	□	0 1 2 3 4 5 6 7 8 9 10	□
Biofeedback	□	0 1 2 3 4 5 6 7 8 9 10	□

Physician use only: ____

____

____

____

____

Does any of the following make your pain worse?

Y N Coughing or sneezing
Y N Sitting If yes, after how many minutes? ____________________
Y N Standing If yes, after how many minutes? _______________________
Y N Walking If yes, after how many minutes? _______________________
Y N Physical activity If yes, what types?_________________________
Y N Do you use either a cane or walker because of your pain?
Y N Do you lean on a shopping cart or a counter to help decrease your pain?

Do you have any of the following symptoms where your pain is?

Y N Numbness or Tingling ("pins and needles")
Y N Bladder or Bowel problems (incontinence or leakage without your control)
Y N Muscle spasms or cramps ("Charley horses")
If yes, are these at night or during the day? ______________________
Y N Muscle Weakness

Specific Studies Done: (circle)

MRI X-Rays CT/Myelogram Bone Scan

Previous Pain Treatment Procedure:

Date	Procedure	Physician	Phone#	Facility where performed	Any help/relief?

ALCOHOL G9622 G9621 G9623 **BMI** G8420 G8417 G8418 **PAIN** G8730 G8731 **BP** G8783 G8950

Review of Systems: **Signs & Symptoms that you have TODAY** (circle all that apply)

Cardiovascular: chest pain palpitations poor circulation
Constitutional: fever chills nausea vomiting
Pulmonary: cough
Hepatic: yellow eye bleeding jaundice
Renal: kidney stones blood in urine pain upon urination
Endocrine: high blood sugar low blood sugar unexplained weight loss
Gastrointestinal: stomach upset diarrhea heartburn
Neurological: tremor foot drop paralysis
Cancer: abnormal mass or lump
Musculoskeletal: arthritis joint stiffness pain
Visual problems: wear glasses or contacts
Hearing problems: hearing aids hearing loss
Psychiatric: hallucinations suicide attempts nervous breakdown

Past Medical History: Please check Medical problems you have had in the past or still have

Yes	No	**Cardiovascular Disease**
□	□	Heart Attack
□	□	High Blood Pressure
□	□	Low Blood Pressure
□	□	Chest Pain/Angina
□	□	Arrhythmias or Palpitations
□	□	Heart Failure
□	□	Valvular Disease
□	□	Pacemaker
□	□	Shortness of breath when climbing stairs
□	□	Angioplasty

Other ______________________________

Yes	No	**Pulmonary Disease**
□	□	Asthma
□	□	Emphysema/COPD
□	□	Lung Surgery
□	□	Bronchitis
□	□	Sleep Apnea

Other ____________________

Yes	No	**Neurologic Disease**
□	□	Seizures/Epilepsy
□	□	Stroke
□	□	Mini-Stroke/TIA
□	□	Alzheimer's
□	□	Parkinson's
□	□	Multiple Sclerosis

Other ____________________

Yes	No	**Gastrointestinal Disease**
□	□	Acid Reflux/GERD
□	□	Hiatal Hernia
□	□	Gastric Ulcer

Other ____________________

Yes	No	**Cancer**
□	□	Location________________

Yes	No	**Skin Disease**
□	□	Psoriasis

Yes	No	**Blood Disease**
□	□	Sickle Cell Anemia
□	□	Clotting/Bleeding Problems

Other______________________

Yes	No	**Kidney Disease**
□	□	Kidney Failure

Last Dialysis ____________________

Other _________________________

Yes	No	**Endocrine Disease**
□	□	Diabetes (High Blood Sugar)
□	□	Thyroid Problems

Yes	No	**Musculoskeletal Disease**
□	□	Fibromyalgia/Chronic Fatigue Syndrome
□	□	Arthritis
□	□	Raynaud's Disease
□	□	Scoliosis
□	□	Lupus
□	□	Osteoporosis

Other_______________________

Yes	No	**Psychiatric Disease**
□	□	Depression
□	□	Anxiety
□	□	Drug Addiction
□	□	Suicidal Ideas/Attempts
□	□	Child Abuse
□	□	Eating Disorders

Yes	No	**Immunologic Disease**
□	□	HIV

Yes	No	**Liver Disease**
□	□	Hepatitis/Jaundice

Other ______________________

Other Significant Medical Conditions/Diseases

____

____

Family History: Describe any relevant medical history in you family that relates to your chronic pain

____

____

____

Previous Surgeries: (Year and surgery performed)

____
____
____
____

Medications: (currently used)

____
____
____
____

Herbs: (over-the-counter): ____

Medications that you have tried in the past for your chronic pain and you no longer take:

Medication	Reason you are no longer taking it
_________________________	________________________________
_________________________	________________________________
_________________________	________________________________
_________________________	________________________________

Allergies:

Allergic to Latex?	Y	N
Allergic to Iodine or Shellfish?	Y	N
Allergic to IV Dye or Contrast Dye?	Y	N
Allergic to Medication?	Y	N

List ALL Medications to which you are allergic to: _____________________________________
____

Social History: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Children How Many? ____

Domestic Situation:

Do you live alone?	Y	N
Are there any substance abuse issues in the household?	Y	N

If yes, please explain____

Are you able to take care of yourself?	Y	N

If no, please enter name of caregiver __________________________________

Employment:

Employed?	Y	N

If yes, please describe job performed __________________________________

Years worked? _____________ Why did you leave? ___________________________

Substance Abuse: **Next to each drug or substance that you circle, indicate if you use or have used:**

Never (N) Infrequently (I) Frequently (F) Regularly (R)

Which of the following drugs or substances, if any, have you used in the **past**? (circle all that apply)

Alcohol_____Barbiturates_____Cocaine_____Heroin_____Amphetamines_____Marijuana_____

Are you **presently** using any of the following drugs or substances? (circle all that apply)

Alcohol_____Barbiturates_____Cocaine_____Heroin_____Amphetamines_____Marijuana_____

Smoke?: ☐ Y ☐ N _____Packs/Per day _____Years ☐ Quit When? _____

Are you or could you be pregnant?: ☐ Y ☐ N ☐ Not Applicable

Patient's signature ____ **Date** _______________

Physical Examination: B/P __________ P __________ R __________

GENERAL

____ A & O X 3
____ Affect proportionate
____ Attention span good
Ambulatory Status: □ Normal
□ Limited
□ Cane □ Walker □ Wheelchair
____ Well Nourished
____ No Acute Distress
____ Distress □ mild
□ moderate
□ severe
Due to ________________
____

SKIN

____Normal turgor
____No rashes
____No sign of infection
____No significant lesions
____ Trophic changes

HEENT

____Normocephalic
____PERRLA
____EOMI
____Conversational Hearing WNL
____Throat unremarkable

NECK

____Supple
____FROM
____Adenopathy
____Thyromegaly
____Bruits R L
____JVD
____Pain: □ w/flexion
□ w/extension
□ w/lat flexion
□ w/rotation
□ against resistance
Trigger Points: _____________
____

CARDIO

_____Normal Rate _____Reg rhythm
____S1, S2 WNL
____S3 ____S4
____Murmur
____Peripheral pulses palpable
□ upper □ lower

RESPIRATORY

____CTA, BBS
____Rales
____Rhonchi
____ Wheezing
____Thorax NL

NEURO

____Motor intact
□ upper □ lower
____Sensory intact
□ upper □ lower
____CN II-XI WNL
____Cerebellar WNL
____Speech WNL
____Gait WNL
____Leg extension test:
L_______ R______
____DTR's:

	B	BR	T	P	A
L					
R					

VASCULAR

____Varicose veins
____Venous insufficiency
____Stasis Ulcer R L
____Cap refill seconds ______
____Color WNL
____ Temperature to touch WNL
____Acrocyanosis
____Extremity Edema

ABDOMEN

____Soft ___NTND
____Rebound
____Bowel Sounds
____Organomegaly
____Scars ____Hernia

MUSCULOSKELETAL

ROM:
____upper ____active ____passive
____upper ____active ____passive
____Symmetrical strength
____Symmetrical tone
____DJD changes
____Muscle spasm

TRIGGER POINTS

____
____
____
____

BACK

____Spine straight
____Kyphosis
____Scoliosis
____Levo
____Dextro Levels ________
____Spinous processes:
□ tender
□ nontender
____Paraspinal muscle tenderness
Facet maneuvers: C T L
SIJ maneuvers:
Deep palpation _________
Patrick's Test __________
____Piriformis recess tenderness
____Trochanteric bursa tenderness
____Gluteal tenderness

Impression – Differential Diagnosis: ____

Last UDS Date: ____

Plan: ____

PATIENT RECEIVED THESE MEDICATIONS TODAY

Medication	Quantity	Patient's Signature
______________________	________	______________________
______________________	________	______________________
______________________	________	______________________
______________________	________	______________________
______________________	________	______________________

______________________________ ______________________________
Physician Signature Date Provider Signature Date

Fabian A. Ramos, MD · Abraham J. Fura, DO · John J. D'Auria, MD
Robert F. Benson, MD · Samuel Amen, MD
Janine Zaccagnino, APRN-BC · Danny Delgado, PA-C · Chad Henderson, APRN-BC
Deborah Vogel-Howard, APRN-BC · Jessica Radcliffe, DNP, APRN-BC
Justin Kotlarczyk, MSPT · Marly Ayala-Ycaza, M/S, PSY. LMHC · Katiuska Ramos, CCH, NLP-P

CONSENT FOR URINARY DRUG SCREEN TEST

PATIENT NAME: ____ DOB: ___________________

DATE OF SERVICE: ________________________ MRN # : _____________________________________

I CERTIFY THAT I VOLUNTARILY CONSENT TO THE COLLECTION AND TESTING OF MY SPECIMEN, THAT THE SPECIMEN IDENTIFIED ON THIS FORM IS MY OWN; IT IS FRESH AND HAS NOT BEEN ADULTERATED IN ANY MANNER.

I CERTIFY THAT THE INFORMATION PROVIDED ON THIS FORM AND ON THE LABEL AFFIXED TO THE SPECIMEN IS CORRECT.

I FURTHER AUTHORIZE THE RAMOS CENTER TO RELEASE THE RESULTS OF THIS TEST AND MY SPECIMEN TO A CERTIFIED TESTING LABORATORY SHOULD IT BECOME NECESSARY TO QUANTIFY OR CONFIRM THE RESULTS OF THIS TEST OR TO PERFORM ADDITIONAL TESTS. IF OUR OFFICE FINDS IT NECESSARY TO SEND THIS SPECIMEN, IT WILL GO TO OUR PREFERRED CONFIRMATION LAB – PRECISION. PLEASE UNDERSTAND THAT YOU MAY RECEIVE A SEPARATE BILL FOR THIS SERVICE FROM PRECISION LABS.

I AUTHORIZE THE RAMOS CENTER TO BILL MY INSURANCE PROVIDER AND TO RECEIVE PAYMENT OF BENEFITS FOR THIS TEST. THIS AUTHORIZATION INCLUDES THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

I AUTHORIZE THE RAMOS CENTER TO COPY AND SEND THE RESULTS OF THIS TEST TO ANY PHYSICIANS INVOLVED IN MY CARE.

IF THE SAMPLE PROVIDED DOES NOT FALL WITHIN THE ACCEPTABLE RANGE FOR FRESH URINE SAMPLE, I WILL PROVIDE A NEW SAMPLE.

________________________________ ________________ __________________
Signature of Patient or Guardian Witness Date

The patient is unable to sign due to______________________________ and the undersigned, who is the

_______________________________ hereby consents for the patient.

UDS Collected by: ___________________________________

FOR OFFICE USE ONLY! FOR OFFICE USE ONLY! FOR OFFICE USE ONLY! FOR OFFICE USE ONLY!

Patient Denies use of THC __________ Patient Admits use of THC ___________ Patient Admits use of: _____________

Medications Patient is Prescribed			
Oxycodone	Oxycontin	Clonazepam	Xanax
Morphine	Opana	Amitriptyline	Lorazepam
Hydrocodone	Fentanyl	Soma	Diazepam
Methadone	Butrans	Lyrica	Other:
Nucynta	Hydromorphone	Fioricet	Other:

☐ HCL Confirmation ☐ Send out for confirmation ☐ URGENT(Need results within 45 days)

A. Notifier: Ramos Center
B. Patient Name:
C. Medical Record Number:

Advance Beneficiary Notice for Office Anesthesia Services of Non-Coverage (ABN)

This notice only applies to anesthesia and procedures performed in office
(excludes anesthesia services in ASC or hospital cases)

This notice is to inform you that ***anesthesia*** *may not be covered by your insurance for a procedure for pain. In order to protect you, if your insurance does not pay for these anesthesia services, the Ramos Center will cap the amount billed to you for the anesthesia at $150 instead of transferring the entire billed amount. This is to protect you in case of this very rare eventuality. The $150 covers the anesthetist fee, anesthetics, recovery nurse and IV Supplies.*

I authorize the Ramos Center to bill my insurance for the anesthesia. If the anesthesia claim is denied by my insurance (even though they pay for the procedure claim), I understand I will be responsible for payment but the amount will be reduced to max $150.

____ ________________________
Signature Date

____
Printed Name

Last Edited 3/27/2017

Ramos Center
for Interventional &
Functional Pain Medicine

Behavioral Health Screening Questionnaire

Name: ______________________________ **Age:** ______ **Date:** ______________ **Physician:** ______________________

Instructions: The following questionnaire should take less than 5 minutes to complete. This information is vital in your pain management care to better assist you in improving your ability to manage and cope with your pain. The questions address issues regarding how your pain may affect your emotional coping, stress, memory, and alcohol and other substance use. Please do your best to answer **every** question by circling either **YES** or **NO**. The questions relate to how you have been functioning over the past year unless otherwise indicated. ***All information obtained on this questionnaire is confidential and will not be shared with anyone without your consent.***

YES NO I sometimes think that I or my family would be better off without me around.

YES NO I have thought seriously in the past year of harming myself.

YES NO My pain is significantly affecting my relationships with my family.

YES NO I cry more than I used too.

YES NO I find myself irritable, anxious, or nervous a great deal of the time.

YES NO My mood has been down for most of the past month.

YES NO My mood and my pain are directly related (My mood improves when my pain is less; my mood is worse as my pain gets worse).

YES NO Almost the only thing I think about is whether my pain will get better.

YES NO I am certain that my situation will never get any better.

YES NO I expect my pain to always be what it is now.

YES NO I feel I need more support from my family in terms of helping me deal with my pain.

YES NO I feel like a burden to my family.

YES NO I feel like a failure.

YES NO I sleep poorly not just due to pain but also due to what’s going through my mind.

YES NO I feel like I have no control over my life.

YES NO I have difficulty dealing with all the problems in my life.

YES NO I have difficulty coping with stress.

YES NO There are times now that I feel that I am or about to panic.

YES NO When I feel panicky, my heart races, my hands tremble, or my hands get sweaty.

YES	NO	I sometimes drink too much.
YES	NO	I have a history of alcohol or drug problems.
YES	NO	I frequently have had more to drink or have taken more medication than I intended.
YES	NO	I have been treated for anxiety or depression sometime in the past 2 years with medication or mental health treatment.

YES NO In the past year, I have had to deal with alcohol or drug problems brought on by family (children, spouse, parents, siblings) or close friends.

YES NO I sometimes use marijuana, alcohol or another non-prescribed drug to help my pain.

YES NO I sometimes use marijuana, alcohol or another non-prescribed drug to help my nerves.

YES NO I would like to stop smoking cigarettes but feel that I need some help to do this.

YES NO I need to drink in order to express my feelings.

YES NO I become more depressed after I have sobered.

YES NO I typically have 3 or more drinks at least twice per week.

YES NO Do you currently have a psychologist? If yes, name: ________________________________

YES NO Do you currently have a psychiatrist? If yes, name: _________________________________