PAN AMERICAN PAIN INSTITUTE, P.L.
DARIO A. GRISALES, M.D.
Medical Director
16542 N Dale Mabry Hwy. Tampa, Florida 33618
Tel: 813-908-7868 Fax: 813-440-6925
www.mypaintreated.com

Dear Prospective Patient,

Please complete the attached packet before your appointment and bring it with you at the time of your appointment. You must complete the packet in full and sign the required forms. Please bring a valid driver's license and insurance card.

Remember to bring the latest MRIs, X-rays (both films and reports, if any) and medical records from your referring physician.

If you are an HMO patient, you must bring a referral with your Primary Care Provider or it may be faxed. All referrals need to be issued by your insurance company with a referral number and services requested. This is a requirement in order to be seen by a specialist.

All co pays, con insurances and payments will be collected at the time services and rendered.

If you do not complete the attached packet by the time of your appointment, we will reschedule your appointment for a later date.

Please keep in mind that if you must cancel your appointment for any reason you must call at least 48 hours in advance. If you fail to provide timely notice of your cancelation, it is our policy to charge a $25.00 no show fee. We advise all new patients to confirm their appointment when called by our office staff, failure to confirm will result in automatic cancellation of appointment.

We thank you in advance for your cooperation.

Attentively,

DARIO A. GRISALES, M.D.

OFFICE HOURS: Monday and Wednesday 7am-7pm, Thursday 8 am – 5 pm, Friday the office is closed for administrative purposes.

Dear patients,

This letter is to inform you of our new office policy in regards to cancellations and no-shows.

Due to multiple last minute cancellations and frequent no-shows we have unfortunately had to implement the following:

If you are unable to attend your scheduled appointment and need to cancel or reschedule, it must be done so 24 hours prior to your scheduled appointment. If for any reason our office is closed, a detailed message must be left to avoid a no-show fee.

The fees are as follow:

$25.00 for office visits

$100.00 for procedures

I understand if I fail to comply with this new office policy, I will incur a no-show fee that must be paid in full before or on the day of my next scheduled appointment.

Name (please print):____

Signature: ____

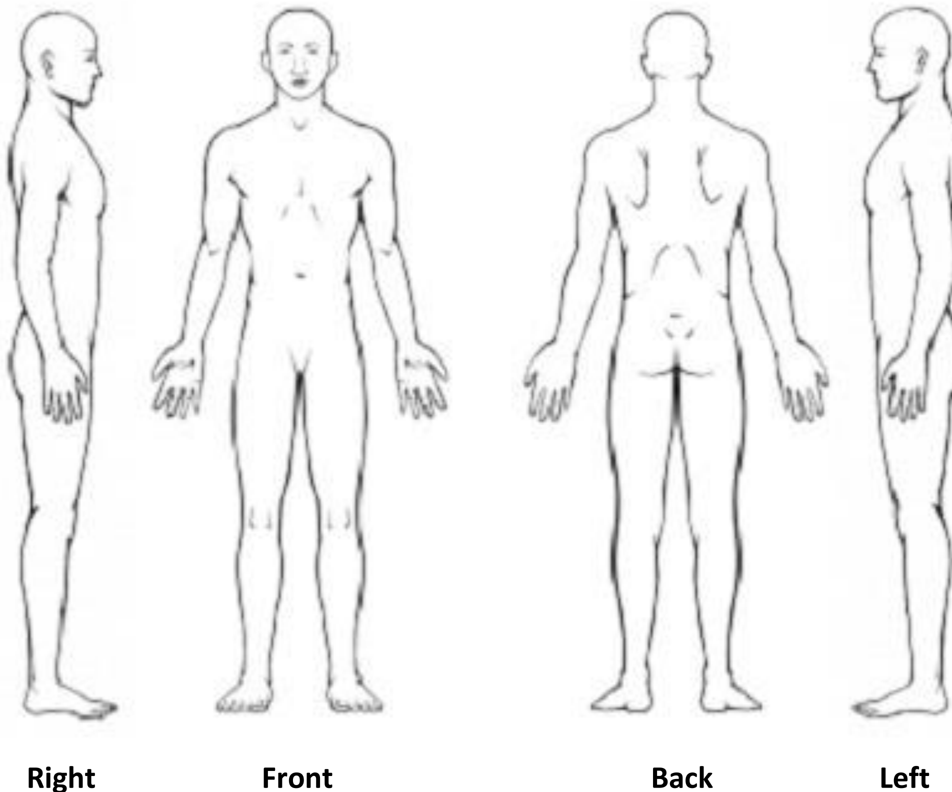
Date: ____________________

INITIAL EVALUATION PATIENT QUESTIONNAIRE

Name: _____________________________ Today's date: __/__/20____
Date of birth: __/__/____ Place of birth: _______________
Number of years lived in Florida: ______
Referring physician: ____
Primary Care physician: ____
Other important attending physicians: ____
____

PAIN HISTORY

Pain Diagram: Please shade the areas on the diagram that correlate with your current pain location(s).



Right Front Back Left

PLEASE CIRCLE ALL THE SYMPTOMS YOU HAVE

Headaches, neck pain, mid back pain, lower back pain, jaw pain L/R, elbow pain L/R, Wrist/hand pain L/R, Arm pain L/R, Leg pain L/R, hip pain L/R, shoulder pain L/R, ankle/foot pain L/R, Rib cage pain L/R, abdominal pain, facial pain.
OTHER: ____

LAST NAME: __________________ **DOB:** _________________

Please rate the following on a pain scale of 0-10 (0=no pain, 10=worst pain in your life)

What is your current pain level?
0 1 2 3 4 5 6 7 8 9 10

What does your pain generally decrease to with pain medication?
0 1 2 3 4 5 6 7 8 9 10

What is your pain on a bad day?
0 1 2 3 4 5 6 7 8 9 10

What is your pain on a good day?
0 1 2 3 4 5 6 7 8 9 10

For each pain please complete below, with #1 being your primary issue

#1 Location of Pain (primary complaint) ____________________________

How long ago did your symptoms begin? ___________________________
Are your symptoms: IMPROVING / WORSENING / SAME

Please circle any of the following symptoms that are associated: stabbing, throbbing, electrical shock-like, burning, cramping, tingling, numbness, aching, other______________________________

What makes this pain better or improve? ___________________________
____

What makes this pain worse? _____________________________________
____

****

#2 Location of Pain ____________________________

How long ago did your symptoms begin? ___________________________
Are your symptoms: IMPROVING / WORSENING / SAME

Please circle any of the following symptoms that are associated: stabbing, throbbing, electrical shock-like, burning, cramping, tingling, numbness, aching, other______________________________

What makes this pain better or improve? ___________________________
____

What makes this pain worse? _____________________________________
____

****

#3 Location of Pain ____________________________

How long ago did your symptoms begin? ___________________________
Are your symptoms: IMPROVING / WORSENING / SAME

Please circle any of the following symptoms that are associated: stabbing, throbbing, electrical shock-like, burning, cramping, tingling, numbness, aching, other______________________________

What makes this pain better or improve? ___________________________
____

What makes this pain worse? _____________________________________
____

LAST NAME: __________________ DOB: _________________

<u>**Present pain scoring evaluation:**</u>	**Strongly Agree**	**Somewhat Agree**	**Disagree**	**Strongly Disagree**
My pain is constant and incapacitating				
My pain has changed my whole life				
I would quit my job because of my pain (even if you are retired, would your current pain cause you to quit a job)				
My pain reduces my work capabilities				
My pain affects enjoying my life				
My pain has ruined my social life				
My pain is only episodic and short-lived				
My pain allows me to work				
My pain allows me to cook				
I can do my activities of daily living				
I can take a shower without help				
Although my pain is bad I can live with it				
I think pain must be endured				
I think pain can be treated to no pain at all				
I think pain can be decreased and tolerable				
My pain is affecting my sleep				
I am able to sleep all night long				
My goal is to have no pain at all				
My goal is to be able to function better				
My goal is to be able to work plentifully				

How does your pain affect your daily activities/job? Please describe:
How your pain has limited you: ____
____
____

Is your pain the result of an injury or accident? YES / NO
If yes, please list the date of the accident, specify current status, are you able to work (if yes, are there any restrictions and who was this determined by)? ___________________________
____
____

Have you been placed at Maximum Medical Improvement? YES/NO or N/A DATE:________

Have you ever been given a disability rating after an injury? YES / NO or N/A
DATE: ________________ %_________.

Have you ever been to the hospital because of your pain? YES / NO
If yes, when was this and which hospital? ____________________________

Have you ever been treated by another doctor for your pain? YES / NO If yes, please provide names, addresses, dates, and treatments: ___________________________________
____

LAST NAME: ________________ **DOB:** ________________

IMAGING/ DIAGNOSTIC TESTING

Have you had any imaging or diagnostic testing? YES / NO
If yes, please specify type: X-RAY, MRI, CT SCAN, NERVE CONDUCTION STUDY, ULTRASOUND, ELECTROMYOGRAM, OTHER: _______________
What was the imaging of, and approximate date of service: _________________________
____
Do you have any imaging or reports with you today? YES / NO

Have you received any of the following treatments? PAIN MEDICATIONS, PHYSICAL THERAPY, CHIROPRACTIC MINIPULATION, SPINE INJECTIONS, JOINT INJECTIONS, TRIGGER POINT INJECTIONS, TENS UNIT, SPINE TRACTION, VAX-D, MED-X, OTHER_______________________________________

MEDICATIONS

Do you have any medication allergies? YES /NO
If yes **please list**, and **specify reaction**: _______________________
____

Please list all medications you take with frequency and dose:

__________________________ __________________________
__________________________ __________________________
__________________________ __________________________
__________________________ __________________________

Are you currently taking any blood thinners? YES / NO
If yes, what are you taking? Coumadin, Lovenox, Aspirin, Plavix, Ticlid, Heparin, other__________________________

PAST MEDICAL HISTORY

Please circle if <u>you</u> suffer from or have any of the following: migraine/headaches, dizziness, seizures, sudden fainting, vertigo, vision loss, double vision, sleepiness, insomnia, chest pain, difficulty breathing, fever, cough, abdominal pain, nausea, vomiting, diarrhea, constipation, bloody stool, increased urinary frequency, bloody urine, burning with urination, incontinence, vaginal discharge/bleeding, tattoos, depression, anxiety, nightmares, weakness, constant fatigue, paralysis of any limb or muscles, wasting of any muscles, poor/excessive appetite.

FEMALE

Last PAP smear: ________ normal YES/ NO
Last mammogram: _______ normal YES / NO
Are you pregnant: YES / NO Last menstrual period ________

MALE

Last prostate exam: _________ normal YES / NO

LAST NAME: __________________ DOB: _________________

Please list any other medical problems that you may have not related to your pain:
____
____

List all surgeries you have had in the past including those related to present and past pain and injuries: ____
____

FAMILY HISTORY

Does any of the following run in <u>your</u> <u>family</u>? YES / NO / UNKNOWN

	Mother	**Father**	**Brother**	**Sister**	**Runs in family**
Cancer					
Diabetes					
Heart disease					
Hypertension					
Stroke					
Pulmonary emphysema					
Tuberculosis					
Thyroid disease					
Arthritis					
Incapacitating back pain					
Multiple sclerosis					
Leukemia					
Seizures					
Depression					
Suicide					
Alcoholism					
Drug addiction					

SOCIAL HISTORY

Marital status: SINGLE, MARRIED, WIDOWED, DIVORCED, SEPERATED.

Do you smoke: YES / NO. If yes, how many years? _____ Packs per day? ___

Do you drink: YES/ NO. If yes, how frequent and how much? __________

Do you or have you ever used illicit drugs? YES / NO.
If yes, which ones? _________________________

COMM

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1) In the past 30 days, how often have you had trouble thinking clearly or had memory problems?					
2) In the past 30 days, how often do people complain that you are not completing necessary tasks? (Like going to class, work, or appointments)					
3) In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient relief from medications? (Other doctors, the ER, friends, or street sources)					
4) In the past 30 days, how often have you taken your medications differently from how they are prescribed?					
5) In the past 30 days, how often have you seriously thought about hurting yourself?					
6) In the past 30 days, how much of your time was spent thinking about opiod medications (having enough, taking them, dosing schedule, etc.)					
7) In the past 30 days, how often have you been in an argument?					
8) In the past 30 days, how often have you had trouble controlling your anger? (Like road rage, screaming, etc.)					
9) In the past 30 days, how often have you needed to take pain medications that belong to someone else?					

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
10) In the past 30 days, how often have you been worried about how you are handling your medications?					
11) In the past 30 days, how often have others been worried about how you are handling your medications?					
12) In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?					
13) In the past 30 days, how often have you gotten angry with people?					
14) In the past 30 days, how often have how often have you had to take more of your medication than prescribed?					
15) In the past 30 days, how often have you borrowed pain medication from someone else?					
16) In the past 30 days, how often have you used your pain medicine for symptoms other than for pain? (Like to help you sleep, improve your mood, or relieve stress)					
17) In the past 30 days, how often have you had to visit the Emergency Room?					

Please include any additional information you wish to include about the answers above:

SOAPP-R

The following are some questions given to patients who are on or are being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1) How often do you have mood swings?					
2) How often have you felt a need for higher doses of medication to treat your pain?					
3) How often have you felt impatient with your doctors?					
4) How often have you felt that things are just so overwhelming that you cannot handle them?					
5) How often is there tension in the home?					
6) How often have you counted pain pills to see how many are remaining?					
7) How often have you been concerned that people will judge you for taking pain medication?					
8) How often do you feel bored?					
9) How often have you taken more pain medication than you were supposed to?					
10) How often have you worried about being left alone?					
11) How often have you felt a craving for medication?					

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
12) How often have you expressed concern over your use of medication?					
13) How often have any of your close friends had a problem with alcohol or drugs?					
14) How often have others told you that you had a bad temper?					
15) How often have you felt consumed by the need to get pain medication?					
16) How often have you run out of pain medication early?					
17) How often have others kept you from getting what you deserve?					
18) How often, in your lifetime, have you had legal problems or been arrested?					
19) How often have you attended an AA or NA meeting?					
20) How often have you been in an argument that was so out of control that someone got hurt?					
21) How often have you been sexually abused?					
22) How often have others suggested that you have a drug or alcohol problem?					
23) How often have you had to borrow pain medications from your family or friends?					
24) How often have you been treated for an alcohol or drug problem?					

Please include any additional information you wish to include about the answers above:

PAN AMERICAN PAIN INSTITUTE PL. 16542 North Dale Mabry Hwy. Tampa, FL 33618 Ph-813 908-7868

Patient's Name: Date:

DAST-10

There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

	These Questions Refer to the Past 12 Months	Yes	No
1	Have you used drugs other than those required for medical reasons?		
2	Do you abuse more than one drug at a time?		
3	Are you unable to stop using drugs when you want to?		
4	Have you ever had blackouts or flashbacks as a result of drug use?		
5	Do you ever feel badly about your drug use?		
6	Does your spouse (or parents) ever complain about your involvement with drugs?		
7	Have you neglected your family because of your use of drugs?		
8	Have you engaged in illegal activities in order to obtain drugs?		
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
10	Have you had medical problems as a result of your drug use (Like memory loss, hepatitis, convulsions, or bleeding)?		
	Totals:	0	0

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1/1/2018

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PATIENT PHYSICIAN NARCOTIC AGREEMENT 2018

The control of pain is a significant part of this practice's medical treatment. Many of the medications required to control your pain are known and designated as Controlled Substances. These medications have the potential for abuse by patients, their families, or co-habitants, whether intentionally or unintentionally. We require that each and every patient who is treated at this medical facility to agree and abide by the following agreement. We will not provide any prescriptions for Controlled Substances to any patient who fails to agree or abide by the following:

1. I ____ agree that I will obtain any and all Controlled Substances relating to the treatment of my pain ONLY from the office of Dr. Dario A. Grisales.
2. I will agree to abide by Dr. Dario A. Grisales's management of my medication treatment plan.
3. I will take my medication at the dose and frequency prescribed by this facility's physician.
4. I agree that I cannot increase the dose of these medications on my own and understand that doing so will lead to discontinuation of Controlled Substances based treatment.
5. I will attend all appointments, treatments, and consultations as requested by the physician in the treatment plan.
6. I will not receive Controlled Substances (pain medication), including opioids, from any other physician, except in the case of an emergency, which may include an in hospital admittance, or a natural disaster. I will inform the physician of any such emergency prescriptions as soon as possible.
7. I agree that **I** will not use my medication at a faster rate than prescribed.
8. I understand that I cannot make any requests for premature refills of pain control medications.
9. I agree and understand that I will obtain all pain control medications ONLY from the following pharmacy: Telephone #:______________________________. If I need to change pharmacies for any reason I will notify this medical practice immediately, and must **re-execute** this agreement with the new pharmacy's information.
10. I understand the need and importance of being discreet about the possession and use of Controlled Substances as part of my treatment plan. I must keep my medication in a safe place. I understand that stolen or lost medication or prescriptions will not be replaced.
11. I agree to submit to random and/or scheduled drug screening/testing in any form as requested by the physician.
12. I understand that common side effects of opioid therapy include nausea, constipation, sweating, and itchiness of the skin. Drowsiness may occur when commencing or switching an opioid therapy or when changing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.
13. I understand and have discussed with the physician the concepts of tolerance, dependence, and addiction. As such, I understand that the physician may change, taper, or discontinue my therapy at any point he considers it necessary.
14. I understand that the use of any mood-modifying substance, such as tranquilizers, sleeping pills, anti-anxiety pills, alcohol, or illicit drugs (cannabis, cocaine, heroin, hallucinogens, etc) can cause adverse effects and interfere with opioid therapy. I agree that I shall refrain from the use of all of these substances, and like-substances, without first discussing them with the physician.

15. I agree that I will attend the scheduled appointment before I run out of my prescribed medications, and that it is vitally important to adhere to the scheduled treatment plan.

16. I agree that I will not call for refills of any medications on Fridays or during week-ends.

17. **I AGREE THAT THIS FACILITY, AS A LICENSED PAIN MANAGEMENT CLINIC, HAS ADOPTED THE STATE'S ZERO TOLERANCE POLICY. ANY ABUSE/DIVERSION/NON-COMPLIANCE WITH THIS AGREEMENT WILL RESULT IN IMMEDIATE DISMISSAL AS A PATIENT.**

    a. The doctor may, at his discretion, provide up to a 2-week supply of medication upon my dismissal for Controlled Substances and up to a 2 month supply of non-controlled substances upon my dismissal.

    b. In the event that I am dismissed for "Doctor Shopping" or for having acquired prescriptions for controlled substances by multiple physicians I will not be provided with a prescription for Controlled Substances.

18. **I AGREE TO REVIEW, UPDATE, AND RE-EXECUTE THIS AGREEMENT AT LEAST EVERY FOUR MONTHS.**

THIS OFFICE WILL REPORT ANY PATIENT CRIMINAL ACTIVITY DISCOVERED IN RELATION TO CONTROLLED SUBSTANCES OR TO DOMESTIC VIOLENCE TO THE APPROPRIATE AUTHORITIES.

Patient: ____________________________________ Date: ________________

Physician: __________________________________ Date: ________________

Witness: ___________________________________ Date: ________________

01/01/2018

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OPIOID/NARCOTIC TREATMENT CONSENT

Patient: ____ Date:_______________

1. I hereby authorize Dr. Dario A. Grisales and his or her chosen associate to prescribe me medications in the category of controlled substances like opioids, narcotics, sedatives or barbiturates.

2. I affirm that the nature, purpose, material risks, complications and consequences of the medications implicated during the course of treatment, as well as alternatives have been explained to me by my physician, and that my questions regarding the medications have been answered and that with this knowledge. I have given my consent to the treatment.

3. I understand that the explanations and answers that I have received are not necessarily exhaustive and that other, more remote risks, complications or consequences may arise. I understand that a more detailed and complete explanation of any of the foregoing matters will be given to me by the physician if I do so desire but acknowledge that I do not desire any further explanation or answers.

4. I affirm that I am aware that the practice of medicine is not an exact science, and I acknowledge that I have been given no guarantee or assurance as to any results that may be obtained.

5. I am aware that inherent to the intake of these medications, there may be risks such as (but not limited to), respiratory arrest with possible death, overdosing, mental impairment, excessive sleepiness, medications dependency, addiction, harm to myself or others, and significant side effects like nausea, vomiting, poor appetite and impairment to operate heavy machinery, including but not limited to driving automobiles or any motorized/man propelled vehicle. I understand that 1 may inquire my physician, for additional information.

6. I am aware that any improper use or unauthorized dose increase of the medications prescribed, may increase the risks named in the paragraph above, and that any such act will exonerate Dr. Grisales from any liability or consequences.

I certify that I have read and fully understood all paragraphs of the foregoing form; that the explanations and answers referred to herein were given and that I understood them; that any questions that I had have been answered; and that all blanks requiring completion were filled in, before I signed.

___________________________________ AND/OR_______________________________

Patient's Signature Parent/Legal Guardian/Legally Designated Representative

Date: ___________________________________ Witness: ______________________________________

If applicable:
Relationship of legally designated Representative to patient: ____________________________________

I do affirm and certify that on this date I have informed the patient, and/or parent, legal Guardian, or legally designated Representative of the above named patient of the condition requiring control substance medications, referred above, and that I have, consistent with my best medical judgment fully explained the nature and purpose of such treatment, consented to by the patient or the responsible person in the above consent form. Possible alternative methods of treatment and procedures, the risks involved, and the possibility of complications described in the above consent form after the foregoing factors have been explained.

_____________________________ ___/___/_____.

Physician Signature Date 01/01/2018

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ADVANCED BENEFICIARY NOTICE OF NON-COVERAGE

NAME: ____ DATE: ____________________

INSURANCE NAME: ______________________________ ID#_______________________

Service Description

- Pain management treatment
- Office Visits and Procedures

I hereby affirm that I have been informed and I understand that there are services that are excluded or excludable through my insurance listed above. Therefore all cost associated with these services are not allowable expenses under my insurance program. By signing the ABN non-covered services waiver, I am hereby agreeing in advance, in writing, to accept full responsibility for all cost associated with the non-coverage medical services, described in this document under “service Description” and performed by the named Network Provider Pan American Pain Institute.

Patients signature: ____________________________________ Date: __________________

Witness Signature: ____________________________________ Date: __________________

Physician Signature: ___________________________________ Date: __________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of HIPAA Notice of Privacy Practices.

Name: ____

Signature: ____ Date: _______________

FOR OFFICE USE ONLY
Date acknowledgement received: ___________________________
Or
Reason acknowledgment was not obtained:

____

____

____

____

Name: ____

Signature: ____ Date: _______________

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MEDICAL RECORDS RELEASE

Date: ________________

Patient's Name: ____ DOB: ___________________

Authorization to release medical records from the office of DR/Hospital/Other

____

Address: ____

Fax #: ________________________________ Phone #: ________________________________

Medical report: ____

____

X-rays report: ____

MRI/CT Scan: ____

Others: ____

To the office of Dr: Dario A Grisales, M.D.
Please send records by mail to the address above or fax to 813-440-6925

Patient Signature: ____

The material in this transmission contains confidential information that is legally privileged. This information is intended only for the use of the individual or entity named above.
You are hereby notified that any disclosure, copying, distribution, or action taken based on the contents of this transmission is strictly prohibited.

____

Dario A Grisales, M.D.

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PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, ____DOB: _______________
Patient's Name
____ SS#: ________________________
Patient's Address
Authorize Pan American Pain Institute, Dario Grisales MD, 16542 N Dale Mabry Hwy. Tampa, Florida 33618 to provide (Where you want the medical records sent. Name of Physician, Practice, Person, Hospital, Other) ____
Address: ________________________________ Office phone #:_______________________
The information to be released (state specific documents, time, period, etc.):
____
Purpose or need for the information requested:
Continued Care: ______ Insurance______ Legal______ Transfer______ Personal______

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated and signed communication. This consent will remain in effect no more than ninety (90) days from date I signed this consent. I also understand that medical records may include mental health information, drug/alcohol information and/or HIV information.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule.

I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected. If there is a charge for the requested information, ________________________ will be responsible for payment.

_________________________________ ________________ ____________
Patient/Parent/legal Guardian Signature Relationship Date

_________________________________ ________________
Witness Signature Date

If signed by other than patient, state relationship and reason for patient's inability to sign.
____

A copy of this authorization has been ____ Accepted ____ Rejected by the patient/representative.
A photocopy or facsimile of this authorization will be considered valid unless otherwise specified.
THIS MEDICAL RECORD RELEASE IS VALID FOR UP TO ONE YEAR (1Y) AFTER SIGNING.

Office Use Only: