FLORIDA PAIN MANAGEMENT INSTITUTE

Patient Information

First Name:	Middle Name:	Last Name:	Gender: ☐ Male ☐ Female
Street Address:	City, State, Zip:	E-mail Address: *(Required)*	
Date of Birth: / /	Soc Sec #:	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Partnered ☐ Widowed	
Home Phone:	Cell Phone:	Work Phone: (please include ext.)	
What is your *preferred* method of contact? ☐ Home Phone ☐ Cell ☐ Work ☐ E-Mail ☐ Mail			
Employer: ☐ Check here if Retired	Occupation:	Referred by or how did you hear about us:	
Emergency Contact:	Contact Phone:	Relationship to Patient: ☐ Spouse/Partner ☐ Child ☐ Sibling ☐ Parent ☐ Friend	

Race: ☐ White ☐ Black or African American ☐ Hispanic ☐ Asian ☐ Pacific Islander ☐ American Indian ☐ Other Race:_____ ☐ Unreported/Refused to Report

Preferred Language:	Ethnicity: ☐ Hispanic ☐ Non- Hispanic ☐ Unreported/Refused to Report

Pharmacy: Address: Telephone #

Financially Responsible Party

First Name:	MI:	Last Name:	Soc Sec #:	Date of Birth: / /

Relationship of Financial Party to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other _____

Address (if different from Patient): Phone:

Employed by: Occupation:

Business Address: Business Phone:

Insurance Company: Group # Subscriber/Member #

Additional Insurance

☐ **Check here if No additional Insurance and skip this section** Name Financially Responsible Party:	Soc Sec #:	Date of Birth: / /

Relationship of Financial Party to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other _____

Address: (if different from Patient): Phone:

Employed by: Occupation:

Business Address: Business Phone:

Insurance Company: Contract # Group # Subscriber #

If Patient is a Minor: By signing below, as parent, legal guardian or authorized party, I consent and authorize on behalf of the Patient, to the rendering of care and treatment, in including but not limited to medical, surgical, diagnostic, administration of anesthesia or other treatments/procedures considered necessary or advisable by employees and authorized Agents of FLPMI.

By signing below you acknowledge and agree to the terms above.

Signature of Patient or Legal Guardian:	Date:
Patient Name:	

Patient Service and Fee Acknowledgement / Consent to Contact

I understand that I am financially responsible for my bill for services rendered in this office. Should this bill be sent to my insurance company for my convenience, I understand that I still remain obligated to pay the entire balance, no matter what my insurance company pays. I understand that the insurance company may not cover certain services and may also not cover a deductible, copayments and other charges. I also understand that the insurance company may also determine that certain charges were "unnecessary." This does not mean that they were medically unnecessary, but that it was unnecessary for the insurance company to pay for them. I also understand the doctor is unable to determine the amount of time it may take my insurance company to pay for services rendered. I understand, however, that in general, most insurance companies will pay for services rendered within 30 days. If my insurance company has not paid for the charges in full within 90 (ninety) days of a specific visit, I understand that the doctor will immediately automatically roll over any balance for that visit onto my credit card. To the extent any sums due and owing cannot be obtained through the authorized credit card, I understand that I will be responsible for any and all costs, fees and attorney's fees associated with collection thereof.

I hereby consent to FLPMI using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that I have had the right to review the Practice's Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice reserves the right to revise its Privacy Policy at any time. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request for same to the Practice.

By signing below, I consent to the Practice: emailing me, calling my home, cell phone or other designated location and leaving a message on my voicemail or in-person; mailing to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment TPO, such as appointment reminder cards and patient statements. I understand that I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Practice's use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information. I understand that I may revoke my consent in writing, except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that the Practice may decline to provide treatment to me.

ANY DISPUTE BETWEEN THE PARTIES, SHALL AT THE OPTION OF ANY PARTY, BE DETERMINED BY BINDING AND FINAL ARBITRATION BEFORE A SINGLE INDEPENDENT ARBITRATOR ADMINISTERED BY ARBITRATION SERVICES INC., ITS SUCCESSORS AND ASSIGNS, UNDER ITS ARBITRAITON RULES AT WWW.ARBITRATIONSERVICESINC.COM, EXCEPT THAT NO PUNITIVE OR CONSEQUENTIAL DAMAGES MAY BE AWARDED. These disputes may include, but are not limited to, malpractice claims, claims for money owed for services rendered and issues of arbitrability. The arbitrator shall be bound by the terms of this provision and is authorized to conduct proceedings by telephone, video or by submission of papers. By agreeing to this arbitration provision you are waiving your right to a jury trial, waiving your right to appeal the arbitration award and waiving your right to participate in a class action. Service of process or papers in any legal proceeding or arbitration between the parties may be made by First-Class Mail delivered by the U.S. Postal Service addressed to the party's address in these forms or another address provided by the party in writing to the party making service. The parties submit to the jurisdiction and laws of Florida and agree that any litigation or arbitration between the parties may be commenced and maintained in Palm Beach County, Florida. **YOU ACKNOWLEDGE THAT THIS PROVISION TO ARBITRATE DISPUTES AND ANY SUBSEQUENT ARBITRATION BETWEEN THE PARTIES IS BINDING AND FINAL AND THAT YOU ARE WAIVING YOR RIGHT TO TRIAL IN A COURT OF LAW AND OTHER RIGHTS.**

BY SIGNING BELOW, I AGREE TO THE FINANCIAL AND CONTACT POLICIES OF THE PRACTICE SET FORTH HEREIN.

_____ _____

Signature of Patient or Legal Guardian Email Address

_____ _____ _____

Patient's Name Date Phone (Cell/Home/Work)

Advanced Directives

Advanced Directives: A document called a Living Will advises your family and physicians of your desires should you become incapacitated and unable to make decisions regarding your healthcare.

Do you have a living will? ☐ Yes ☐ No If yes – please provide a copy to the Clinic
Do you have a durable power of attorney? ☐ Yes ☐ No If yes – please provide a copy to the Clinic

Do you have a legal document designating anyone (other than your family/guardian) to make health decisions for you in the event you are incapacitated and cannot make them for yourself? ☐ Yes ☐ No
If Yes: Name: _____ Phone: _____ Are they aware of your choice ☐ Yes ☐ No
Would you like a copy of Advance Directive Information ☐ Yes ☐ No

Consent for Treatment

General Consent for Treatment: I hereby consent and authorize to the rendering of care and treatment, including but not limited to medical, surgical, diagnostic, administration of anesthesia or other treatments/procedures **("Treatments")** considered necessary or advisable by employees and authorized agents of the Florida Pain Management Institute.

General Acknowledgments: I understand that the practice medicine in is not an exact science. I understand the medical and surgical treatment and diagnosis may involve risks of injury and even death. No guarantees have been made to me with respect to the results for my examinations or Treatments. I understand and agree that I may be observed and/or receive care from medical, nursing and other health care students in training at Florida Pain Management Institute. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care as directed by Florida Pain Management Institute.

I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Florida Pain Management Institute to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

Right to Refuse Treatments: I understand that I have the right to make informed decisions regarding all care and treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any treatments.

_____	_____	_____	_____
Signature of Patient/Responsible Party	Date	Print Name	Relationship to Patient

FLORIDA PAIN MANAGEMENT INSTITUTE

PATIENT CONTRACT

Welcome to the FLPMI, LLC. We are committed to our patient's health and wellness. In return for our commitment to you, our patient, we require you acknowledge and adhere to FPMLI's basic operating procedures, set forth in this Patient Contract, as follows:

_____ *(initial)* FLPMI will offer you access to your own personal patient portal where you can obtain your records and contact the office. The portal can be used to message your provider, request appointments or referrals, and to manage your prescriptions. The portal is not for urgent issues, messages sent through the portal will not be checked until the next business day. Please provide your email address for this function.

_____ *(initial)* FLPMI is open Mon-Fri: 8:00 am to 5:00 pm. Urgent same day appointments may be available with your provider. For emergencies please call 911 or go to the nearest ER. To reach the on-call provider after hours please call: 561-331-5050 and follow prompts. This service is available for urgent matters and is not for routine calls or prescription refills. Please note hours of operation may change at discretion of FLPMI.

_____ *(initial)* In order to keep your records accurate and avoid potentially harmful drug interactions, we may need to verify your medications through an external database or with your pharmacist. This allows FLPMI providers to know what medications other doctors have prescribed for you.

_____ (*initial*) I agree to arrive on time to my appointment (we recommend 15 minutes early); FLPMI requires 24-hour notice if I am unable to keep my appointment, I understand that missed appointments with less than 24-hour notice may incur a fee of **$25.** Missed appointments for lab may result in cancellation and rescheduling of the corresponding follow-up.

_____ (*initial)* Labs and diagnostic tests ordered prior to your visit or at your visit may require an additional follow-up appointment with your provider to discuss results. If you are unable to keep your scheduled appointment you will be required to reschedule to discuss your results. HIV testing and other sensitive labs will <u>always</u> require a follow-up with your provider.

_____ *(initial)* I hereby consent that I will not use any recording device of voice or image on the premise of FLPMI. This includes but is not limited to cameras, voice recorders, phones and Google glasses.

_____ *(initial)* I acknowledge and agree that I have received a copy of FLPMI's Privacy Practices.

_____ *(initial)* I understand and agree that I may be observed and/or receive care from medical, nursing and other health care students in training at FLPMI.

_____ *(initial)* I understand that the practice medicine in is not an exact science. I understand the medical and surgical treatment and diagnosis may involve risks of injury and even death. No guarantees have been made to me with respect to the results for my examinations or treatments. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care as directed by FLPMI.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient's Name

FLORIDA PAIN MANAGMEENT INSTITUTE

Agreement of Financial Responsibility

The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s), coinsurance or deductible(s) which are payable at time of service, and then bill you for any remaining amount determined to be your responsibility by your insurance company. Any balance you owe that remains unpaid 60 days after you were billed will be transferred to a collection agency for recovery.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of coverage and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In- Network rate.

Fee for Service

_____ (*initials*) I agree to pay my account at the time service is rendered or will make financial arrangements satisfactory to FLPMI for payment. If my account is sent to collections, I agree to pay collection expenses, court fees and reasonable attorney fees as established by the court. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefit of any type under any policy of insurance insuring the patient, or any party liable to the patient, is hereby assigned to FLPMI. If Co-payments and/or deductibles are designated by my insurance company or health plan; I agree to pay them to FLPMI. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Non-Covered Services:

_____*(initials)* I understand that FLPMI contracts with health care plans which specifically state services which are "covered" by the health care plan. Accordingly, the undersigned accepts full financial responsibility for all services, which are determined by the health care service plans not to be covered. I agree to cooperate with FLPMI to obtain necessary health care service authorizations. I understand that not all services provided are considered medically covered services by my health plan and payment will be due at the time of service.

MEDICARE PATIENTS ONLY:

_____**(*initials*)** FLPMI accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for any deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to FLPMI. If I receive payment, then I am responsible to provide payment and EOB to FLPMI upon receiving such payment.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party **Date**

_____ _____

Name of Patient/Responsible Party (please print) **Relationship to Patient**

MRN: _____

Assignment of Benefits Form

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Known by all these present that: the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint Florida Pain Management Institute ("Health Care Provider") and any of its duly authorized agents and employees as and to be the undersigned's tur and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and Florida Pain Management Institute which checks, drafts or money orders are made payable for services which have been rendered by Florida Pain Management Institute at the request of or with the knowledge and approval of the undersigned and/or maker of the check, draft or money order.

This assignment incudes, but is not limited to, all rights to collect benefits directly from my insurance company ("Insurer") for services that I have received and all rights to proceed against my insurance company in any action including legal suit of for any reason by insurance company fails to make payments of benefits due to my assignee or me. This assignment also includes any rights to recover attorney's fees and costs for such action brought by the Health Care Provider as my assignee.

The undersigned by these presents does give and grant Florida Pain Management Institute as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said check and concerned as well as any other document.

At any time after Insurer fails to render the applicable payment within thirty (30) days upon receipt of Health Care Provider's medical bills for any date of service, this agreement may be revoked. Health Care Provider's said revocation will be effective on the thirty-first (31st) day after Insurer has received Health Care Provider's medical bill(s) that Insurer has denied, withdrawn, reduced, or failed to pay in accordance with Florida Statute 627.736. Said revocation shall include any and all dates of service subsequent to the thirty-first (31st) day after Insurer has received Health Care Provider's medical bill(s) that Insurer has denied, withdrawn, reduced, or failed to pay in accordance with Florida Statue 627.736.

A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do and cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I hereby authorize my contracted insurance company, previously identified, to pay and to mail directly to Florida Pain Management Institute the medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby irrevocably assign to Florida Pain Management Institute any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statues for any services and charges provided by Florida Pain Management Institute.

Patient's Signature: _____ Patient's Name: _____ Date: _____

FLORIDA PAIN MANAGEMENT INSTITUTE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM (HIPAA OMNIBUS RULE)

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

_____ _____

Please ***print*** patient name Please ***sign*** your name

_____ _____

Legal Representative if signing for minor/other Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Work Phone Confirmation

☐ Text Message to my Cell Phone ☐ Email Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Work Phone Confirmation

☐ Text Message to my Cell Phone ☐ Email Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Work Phone Confirmation

☐ Text Message to my Cell Phone ☐ Email Confirmation ☐ **Any of the Above**

By signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only: As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because: ☐ It was emergency treatment ☐ I could not communicate with the patient ☐ The patient refused to sign ☐ The patient was unable to sign because Other (please describe) _____

Signature of Privacy Officer: _____ Date _____

FLORIDA PAIN MANAGEMENT INSTITUTE

Authorization to Release Medical Records

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name: _____ Date of Birth: _____

Address: _____ Last 4 of SS#: _____

City: _____ State: _____ Zip: _____ Phone: _____

Initial each section below:

_____ I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to this authorization. I understand that if I revoke this authorization I must do so in writing and present my written request to the Medical Records Department.

_____ I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign and the facility of Florida Pain Management Institute will not base treatment, payment or eligibility for benefits on whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect a copy of the information to be disclosed, as provided in 45 CFR 164.524 (with reasonable charge).

_____ I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient of the information and no longer protected by federal confidentiality laws or Ideal.

I Authorize (print name of party releasing the records): _____ to release my health information to Florida Pain Management Institute for the purpose of my healthcare and treatment.

Information to be Disclosed (please check all that apply):
_____ All Records _____ Imaging _____ Lab _____ EKG _____Other: _____

Purpose for Disclosure: _____ Continuation of Care _____ Other _____

Unless otherwise revoked, this authorization will expire 36 months from the date of the signature listed below.

Patient/Patient's Representative: _____ Date: _____

FLORIDA PAIN MANAGEMENT INSTITUTE

4675 Linton Blvd. Suite 200
Delray Beach, FL 33445

PAIN MEDICINE PRACTICE CONTROLLED DRUG PRESCRIPITON AGREEMENT

I am a patient of the Florida Pain Management Institute. As part of my overall treatment I am being prescribed medication(s), including opiates (narcotic) medications, and/or other controlled drugs. I understand that:

1. Federal and State law prohibits misuse or misrepresentation of the use of controlled drugs, and I understand that I am at risk for federal prosecution if I do so.
2. These medications are controlled by the United States Food and Drug Administration, Florida State, and regulated by the Drug Enforcement Administration.
3. These medication(s) are being used to reduce the intensity of my pain, and to improve my activities of daily living, overall function, and ability to work.
4. I will obtain and use these medications only as prescribed by my physician, whether it be my outside doctor or the Florida Pain Management Institute. I will NOT attempt to get pain medications form more than one physician office. I will notify the Florida Pain Management Institute if I receive medication from another office or the Emergency Room.
5. Use of opiate medications is a risk for development of tolerance, physical dependence, addition or sedation.
6. I will NOT consume alcohol, and other medications that may cause sedation (benzodiazepines, antihistamines, sedatives, barbiturates) or illegal controlled substances.
7. I will not share, sell, or trade prescribed opiate medications.
8. If I need to alter the dose of medication, particularly to take more than what is prescribed by the doctor, I will immediately contact the Florida Pain Management Institute at 561-331-5050. I will NOT increase any dose of medication until I have received clear permission from the Pain Medicine doctor.
9. It is my responsibility to keep myself and others from harm, which includes driving safely, and operation of heavy machinery. If there is any impairment in my ability to safely perform these activities, I agree that I will not attempt to do so until my ability has been evaluated, or I have not used my medication for one week.
10. It is my responsibility to keep track of my medication, and not let my prescription “run out”. I understand that refills will not be made if I “run out early” or “spill” controlled medications. I will safeguard my medications from loss or theft. A police report is necessary for lost or misplaced controlled narcotic prescriptions or medications.
11. Abuse of these medications or use in any way not prescribed by Florida Pain Management Institute will NOT be tolerated and is grounds for dismissal.
12. I will have laboratory monitoring of medications, including random urine or blood testing.
13. I will use only one pharmacy, the name of which will be kept up-to-date in my medical records.
14. Regular monthly follow-up visits are required to monitor medical treatment and obtain prescription renewals for the safety of the treatment plan.
15. I am personally responsible for keeping monthly scheduled follow-up appointments. If I miss three (3) or more, I may be discharged from the Florida Pain Management Institute.
16. I understand that the Florida Pain Management Institute physician I see, Is my primary Pain physician. Unless in the event of an emergency or the primary pain physician is unavailable, under no circumstances will care be transferred from one physician to another in the practice.
17. If I violate this agreement, the Florida Pain Management Institute will discontinue writing prescriptions for controlled substances and may result in discharge from the Florida Pain Management Institute.

_____

Patient’s Signature Print Name