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Minimally Invasive Spine Care

By West Florida Pain Management P.A.
Gerald Trimble, M.D.
Susan Samlaska, MD

Dear Patient,

We would, like to thank you in advance for entrusting us with your health care needs at West Florida Pain Management, P.A. dba Minimally Invasive Spine Care, we treat a wide variety of chronic pain conditions ranging from back pain to pain resulting from cancer.

Apart from "hurting", long standing pain can interfere with all aspects of a person's. life. Family life, employment, social activities, sleep and emotions all may be affected.

In order to care for you as effectively as possible, we need you to provide us with information about your health and pain problems. We require this information, so that we may comprehensively evaluate your pain. Please complete the enclosed questionnaire and bring any MRI and X-ray reports that you may have in your possession. **We need to know about any pain treatments in the past 6 months from any physician. We need notes if possible.**

Please complete the enclosed paperwork and bring it with you to your appointment. **If this paperwork is not completed prior to your scheduled appointment, your visit will likely be cancelled and rescheduled**

We do emphasize a program of minimizing or eliminating addictive pain medications. If this is not your goal, you should consider treatment elsewhere.

Following your initial evaluation, we will formulate a treatment program, *which will be discussed and* explained to you in detail. We hope that we can at *least reduce your pain, if* not eliminate it entirely and help you lead a normal and *productive life.*

Once again, please bring your completed paperwork to your appointment.
Our doctors and staff look forward to meeting you.

Gerald E. Trimble, M.D.

Susan Samlaska, M.D.

Minimally Invasive Spine Care

By West Florida Pain Management, P.A.
Gerald Trimble, M.D.
Susan Samlaska, M.D.

Privacy Policy
Minimally Invasive Spine Care

It is the intention of **Minimally Invasive Spine Care** to respect our patient's right to privacy and to safeguard our patient' records.

The patient must sign a consent form before treatment is provided authorizing **Minimally Invasive Spine Care** to use the patient's records for treatment, payment or health care operations (including compliance efforts).

Minimally Invasive Spine Care will not reveal patient information without a signed release except for purposes of treatment, payment or health care operations (including compliance efforts). The patient must sign an authorization before West Florida Pain Management; P.A. can use or disclose their records for any purpose beyond treatment, payment, or health care operations (e.g. clinical trials).

Minimally Invasive Spine Care will make reasonable efforts to limit the use and disclosure of our patient records to the minimum necessary to accomplish the intended purpose. West Florida Pain Management may rely on the judgment of the requesting party as to minimum amount of information needed in a particular instance.

Minimally Invasive Spine Care will make a good faith attempt to provide all patients with a copy of our privacy policy at or before the time that the consent is signed.

The patients of **Minimally Invasive Spine Care** will have the right to: 1. Inspect their patient records 2. Obtain a copy of their records (see Florida Administrative code 64B8-10.003 Costs of reproduction). 3. Request in writing an amendment of their records. 4. Request an accounting of those who have accessed their records.

Minimally Invasive Spine Care anticipates your records will be used to provide medical treatment for you including consulting with other physicians and pharmacies. We also anticipate your records will be used for billing purposes. There is the possibility your record will be used in our on going compliance plan with Medicare. Should you wish to make an inquiry or complaint these should be addressed to Practice Administrator, **Minimally Invasive Spine Care** 603 7th Street South, Suite 320 St. Petersburg, FL 33701. Should you wish to make any limitation on the disclosure of your records you are asked to do so in writing to the above address.

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By West Florida Pain Management, P.A.

Gerald Trimble, M.D.
Susan Samlaska, M.D.

NAME:___________________________ **DATE:** ______________________

The **Opioid Risk Tool** as developed by Dr Lynn Webster

As you may know, there are several legal, medical, ethical and social issues associated with pain medicine. Because pain is subjective and just cannot be proven, the medical community has developed several questionnaires and forms to help evaluate pain. You are already familiar with the typical paperwork that you fill out at each visit. We have tried to make this form simple and clear.

In order to provide the best care, it is important that we obtain additional information about each patient. At the next several visits, you may be asked to complete an extra form as we gather more and more information. Here is today's additional form:

OPIOID RISK TOOL: Many patients are concerned about the risk of addiction to their pain medications. The risk of addiction actually is quite low when the medications are used properly for pain. Sometimes, a patient already has an addiction disorder. This does not mean that the patient is not deserving of pain control, but it does mean that we need to use extra caution so as to provide the pain control without worsening the addictive disorder. Dr. Webster formulated a questionnaire that can help us determine your risk of addiction with the medications. Please complete the ORT below honestly, and we can then discuss your level of risk of becoming addicted or having an addictive disorder, Please remember that this questionnaire is not a judgment of you as a human being and that we did not develop this questionnaire.

Directions: If you are a female complete only the **female** side of the questionnaire and if you are a **male** complete only the male side of the questionnaire.

	Female	Male
Is there a history of substance abuse in your family?	**Yes / No**	**Yes / No**
Alcohol	**Yes / No**	**Yes / No**
Illegal drugs	**Yes / No**	**Yes / No**
Prescription drugs	**Yes / No**	**Yes / No**
Have you had a history Of substance abuse?	**Yes / No**	**Yes / No**
Illegal drugs	**Yes / No**	**Yes / No**
Prescription drugs	**Yes / No**	**Yes / No**
Is your age between 16 and 45?	**Yes / No**	**Yes / No**
Is there a history of preadolescent (childhood) sexual abuse?	**Yes / No**	**Yes / No**
Do you have a history of any of the following conditions?		
ADD, OCD, bipolar, schizophrenia	**Yes / No**	**Yes / No**
Depression	**Yes / No**	**Yes / No**

I understand it is a felony to be untruthful to obtain drugs.

Signed____ Date: ________________________

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By West Florida Pain Management, P.A.
Gerald Trimble, M.D.
Susan Samlaska, M.D.

Patient Health Questionaire

Over the last 2 weeks, how often have you been	Not at all	Several Days	More Than Half the days	Nearly every Day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having Little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

If you checked any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely Difficult
☐	☐	☐	☐

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PM

WEST FLORIDA PAIN MANAGEMENT, P.A. dba **MINIMALLY INVASIVE SPINE CARE**

Diagnostic & Interventional Pain Medicine
Gerald Trimble, M.D.
Susan Samlaska, M.D.

Patient Demographics (fill in appropriate information)

Name:________________________________ Phone:______________________________

Date of Birth __________________________ Alternative Phone:____________________

Social Security Number: (We need this for billing purposes)_____________________________

Local Address:____

____

Permanent Address: ____

____

Primary Care Doctor ______________________________ Phone:________________________

Referring Doctor _________________________________ Phone:________________________

Primary Insurance Name:_____________________________ Policy Number ______________

Secondary Insurance Name:___________________________ Policy Number ______________

Closest Relative ____

Phone of Closest Relative ____

Is this a Work Comp Injury? ______________ Body Part Injured_________________________

Adjuster Name_________________________ Phone Number_____________________________

Date of Injury _________________________ W/C Insurance Co_________________________

Is This Auto Injury?____________________ Auto Claim Number _______________________

Date of Accident_______________________ Claim Adjuster ____________________________

Claim Adjuster Phone ___________________ Auto Insurance Co_________________________

Patient Signature___________________________________ Date_________________________

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Gerald Trimble, M.D.
Susan Samlaska, M.D.

Name:____ Age:______ Date: ________________________

I. **Patient Data**
Family physician: ____
Who referred you to West Florida Pain Management? ____

II. **Medical History**
Have you ever, or do you now have, any of the following conditions?

__ Heart Attack
__ Irregular heart rhythm
__ Chest Pain
__ High blood pressure
__ Stomach / Intestinal Problems
__ Ulcers
__ Liver disease / Hepatitis
__ Bleeding / bruise easily
__ Emphysema
__ Asthma
__ Thyroid problems
__ Diabetes
__ Arthritis
__ Cancer
__ Stroke
__ Kidney problems
__ Epilepsy / Seizures
__ Cigarette use
__ Alcohol use

List any Surgeries you have had: Including Pain Procedures

Type of Surgery	Date	Type of Surgery	Date

List all Medications you are currently using <u>and</u> how often you use them. Please indicate below:

1. ___________________________________
2. ___________________________________
3. ___________________________________
4. ___________________________________
5. ___________________________________
6. ___________________________________
7. ___________________________________
8. ___________________________________
9. ___________________________________
10. ___________________________________

Medication Allergies:

____
____
____
____

List any tests you have had:

Tests	Date & Place done	Results	Tests	Date & Place done	Results
X-rays			CAT SCAN		
MRI			EMG		

PLEASE NOTE!

We do not perform disability ratings at this practice. Should you need this service performed, we will refer you to the appropriate physician.

III. Social History

What is your occupation? _____________________________ What duties do you perform?____________________
When did you last work? ___________________________________ Part or Full time? _______________________
Years of Education _____________ Married Yes No How long?________ # of children _______ Ages _______

IV. SYSTEMS REVIEW

General: Comments
Recent chills and / or fever __ Y __ N _________________
Recent night sweats __ Y__ N _________________
Weight gain __ Y__ N _________________
Weakness __ Y__ N _________________
Weight Loss __ Y__ N _________________

Skin:
Sores __ Y__ N _________________
Rash __ Y__ N _________________
Change in body hair __ Y__ N _________________
Skin Cancer __ Y__ N _________________
Warts or moles removed __ Y__ N _________________
Nodes: any change in glands__ Y__ N _________________

HEENT: Comments
Head-headaches __ Y __ N _____________________
Dizziness __ Y __ N _____________________
Eyes- glasses __ Y __ N _____________________
Episodic blindness __ Y __ N _____________________
glaucoma __ Y __ N _____________________
cataracts __ Y __ N _____________________
Ears- hearing problems __ Y __ N _____________________
infection __ Y __ N _____________________
Nose – bleeding __ Y __ N _____________________
allergies __ Y __ N _____________________
sinusitis __ Y __ N _____________________
Mouth – hoarseness __ Y __ N _____________________
pain when chewing __ Y __ N _____________________
ulcers __ Y __ N _____________________
Dentures __ Y __ N _____________________

Respiratory (lungs): Comments
Shortness of breath __ Y__ N _________________
Chronic cough __ Y__ N _________________
Pleurisy- pain on breathing __ Y__ N _________________
Cough up blood __ Y__ N _________________
Asthma __ Y__ N _________________

Cardiovascular:
Have you ever been examined for heart disease __ Y__ N
Heart attack __ Y__ N _________________
Angina __ Y__ N _________________
Chest pain __ Y__ N _________________
Rapid heartbeats __ Y__ N _________________
Smothering at night __ Y__ N _________________
Discomfort in legs when walking __ Y__ N _________________
Painfully cold hands __ Y__ N _________________
Blood clot __ Y__ N _________________
Describe your exercise program_______________________

Gastrointestinal: Comments
poor appetite __ Y__ N ______________________
Painful swallowing __ Y__ N ______________________
Difficult swallowing __ Y__ N ______________________
Food intolerance __ Y__ N ______________________
Indigestion / heartburn __ Y__ N ______________________
Change of bowel habits __ Y__ N ______________________
Inability to retain stool __ Y__ N ______________________
Gas / bloating __ Y__ N ______________________
Abdominal pain __ Y__ N ______________________
Bleeding hemorrhoids __ Y__ N ______________________
Blood in stool __ Y__ N ______________________
Black stools __ Y__ N ______________________
Nausea or vomiting __ Y__ N ______________________
Jaundice __ Y__ N ______________________
Constipation __ Y__ N ______________________
Diarrhea __ Y__ N ______________________

Genitourinary: Comments
Do you get up at night to urinate? __ Y__ N _____________
Bladder, kidney infection __ Y__ N _________________
Difficult urination __ Y__ N _________________
Blood in urine __ Y__ N _________________
Kidney stone __ Y__ N _________________
Inability to retain urine __ Y__ N _________________

Musculoskeletal:
Bursitis, tendonitis __ Y__ N _________________
Arthritis, rheumatism __ Y__ N _________________
Sciatica __ Y__ N _________________
Neck pain __ Y__ N _________________
Leg pain on exertion __ Y__ N _________________
Leg pain at night __ Y__ N _________________

Musculoskeletal (cont): Comments
Back pain __ Y__ N ______________________
Total joint replacement __ Y__ N ______________________

Neurologic:
Memory problems __ Y__ N ______________________
Fainting or blackouts __ Y__ N ______________________
Depression __ Y__ N ______________________
Anxiety __ Y__ N ______________________
Stroke __ Y__ N ______________________
Paralysis __ Y__ N ______________________
Tremor __ Y__ N ______________________
Difficulty walking __ Y__ N ______________________
Frequent falls __ Y__ N ______________________

Family History / Blood relatives Please list any diseases you are aware of.

	Alive?	Age	
Paternal grandfather	__ Y__ N	____	____________________
Paternal grandmother	__ Y__ N	____	____________________
Maternal grandfather	__ Y__ N	____	____________________
Maternal grandmother	__ Y__ N	____	____________________
Mother	__ Y__ N	____	____________________
Father	__ Y__ N	____	____________________

	Alive?	Age	
Brothers	__ Y__ N	____	_____________________
	__ Y__ N	____	_____________________
Sisters	__ Y__ N	____	_____________________
	__ Y__ N	____	_____________________
Aunt	__ Y__ N	____	_____________________
Uncle	__ Y__ N	____	_____________________

V. Description of Pain and Influencing Factors

Location: Mark drawing showing approximate areas of pain

Patient rates the pain. Scale used 1-10 (10= worst pain)
Worst pain gets:__________

Best pain gets: ___________

1. How long have you had this problem?____

2. Please describe how your pain first began. (e.g. accident, illness, etc.):____

____

3. Words that describe your pain (e.g. prick, ache, burn, throb, pull, sharp) :_____________________________________

4. What causes your pain to:
   Increase?____

   Decrease? ____

Effects of pain (note-decreased function, decreased quality of life.):
Accompanying symptoms(e.g. nausea):____

Sleep: ____

Appetite: ____

Physical activity: ____

Relationship with others (e.g. irritability):____

Emotions (e.g. anger, suicidal, crying): ____

Concentration: ____

VI. Treatment

Treatment	Yes/No If Done	How Helpful Was This?
Interventional Pain Injections		
Surgery		
Physical therapy		
Occupational therapy		
Biofeedback		
Psychological therapy		
Other		

____

____

____

____

____

____

____

Litigation

In the past, have you ever been compensated for a work-related injury or a motor vehicle accident? If so please give the date of injury and describe any injuries/ disabilities you were compensated for.

Date of Injury:____

Description of Injury/ Disability: ____

____

____

____

____

____

If your pain is due to an accident, is litigation (legal suit) or an insurance settlement pending?
___ Yes ___ No If yes, describe the current status of the litigation or settlement:

____

____

If your pain is due to a work-related injury what is you official work status as of today's date?

____

____

Is faith important to you in this illness?

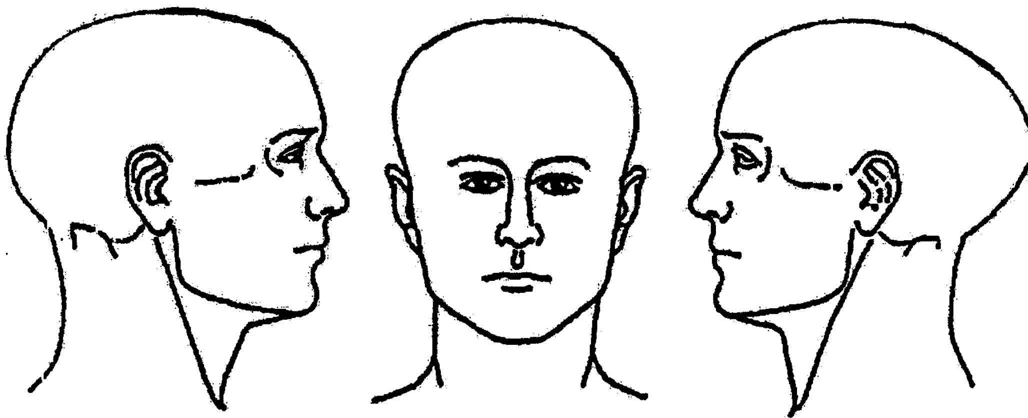
Has faith been important to you at other times in your life?

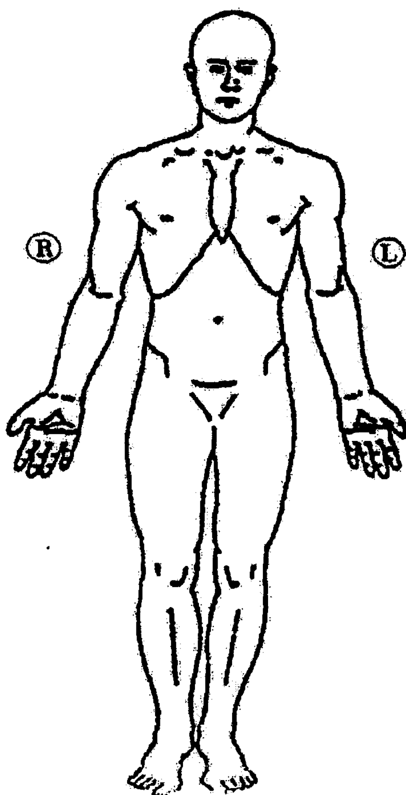
How have you coped in the past with difficult situations?

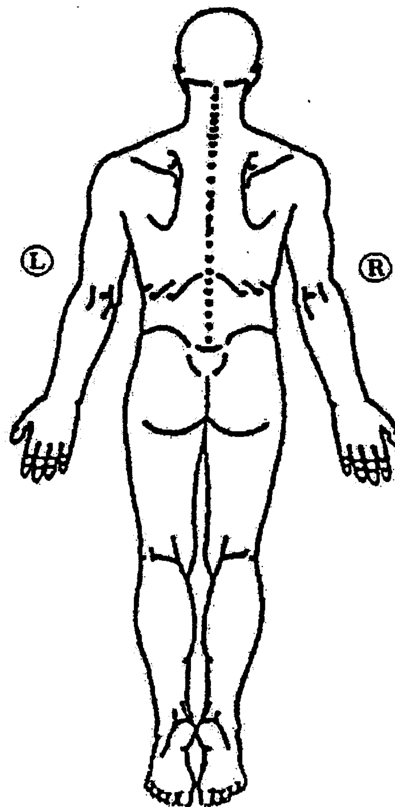
Are you hopeful that your pain can be managed or alleviated?

Signature:_________________________________ Date:____________________________

Please mark approximate location of pain







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Minimally Invasive Spine Care

By West Florida Pain Management, P.A.

Gerald Trimble, M.D.
Susan Samlaska, M.D.

Amended 3/17/2016

Patient Name: ______________________ Date: ______________________

Patient DOB: ______________________ SSN: ______________________

IN CONSIDERATION FOR YOUR CARING FOR ME, I AGREE TO THE FOLLOWING:

1. YOU ARE AUTHORIZED TO RELEASE ANY INFORMATION YOU DEEM APPROPRIATE CONCERNING MY PHYSICAL CONDITION TO ANY INSURANCE COMPANY, OR ADJUSTER IN ORDER TO PROCESS ANY CLAIM FOR REIMBURSEMENT OF CHARGES INCURRED BY ME. I AM RESPONSIBLE FOR PROVIDING MY MOST CURRENT INSURANCE INFORMATION AND KEEPING MY INSURANCE INFORMATION UP TO DATE WITH THE PRACTICE.

2. YOU ARE AUTHORIZED TO RELEASE ANY INFORMATION YOU DEEM APPROPRIATE TO PROVIDE MEDICAL TREATMENT OR FOR HEALTH CARE OPERATIONS

3. I AUTHORIZE THE DIRECT PAYMENT TO WEST FLORIDA PAIN MANAGEMENT, P.A. dba **MINIMALLY INVASIVE SPINE CARE** ANY BENEFITS DUE ME FROM MY INSURANCE COMPANY AND/OR MEDICARE AND/OR FROM THE PROCEEDS OF ANY SETTLEMENT OF CASE RESULTING FROM LEGAL ACTION. I FURTHER AUTHORIZE PAYMENT TO WEST FLORIDA PAIN MANAGEMENT, P.A. FOR YOUR SERVICES

4. I UNDERSTAND THAT HEALTH INSURANCE IS A CONTRACT BETWEEN MYSELF AND THE COMPANY. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT OF MY ACCOUNT WITH WEST FLORIDA PAIN MANAGEMENT, P.A. dba **MINIMALLY INVASIVE SPINE CARE** IN ITS ENTIRETY REGARDLESS OF INSURANCE PAYMENT OR ATTORNEY SETTLEMENT. THIS PROVISION DOES NOT APPLY SHOULD THE PATIENT BE COVERED BY AN APPROPRIATE AND VALID WORKER'S COMPENSATION CLAIM.

5. I AUTHORIZE THE HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE SAID INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION AND THE HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF WEST FLORIDA PAIN MANAGEMENT, P.A. dba **MINIMALLY INVASIVE SPINE CARE,** ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF ANY MEDICAL INSURANCE BENEFITS TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

6. MY INITIALS INDICATE THAT I HAVE RECEIVED A COPY OF **MINIMALLY INVASIVE SPINE CARE** BY West Florida Pain Management, P.A.'S PRIVACY POLICY.

__________initials

Date: ______________________

X____
Signature of Patient or Legally Responsible Person

X____
Witness

Minimally Invasive Spine Care

By West Florida Pain Management, P.A.

Gerald Trimble, M.D.
Susan Samlaska, M.D.

Patient Name: ______________________________ Date: ________________________
Patient DOB: ______________________________ SSN: ________________________

This agreement is between myself,_____________________________, and MINIMALLY INVASIVE SPINE CARE BY WEST FLORIDA PAIN MANAGEMENT, P.A.. It is designed to inform me fully of the manner in which my medication, *especially narcotics*, will be provided. It also outlines the criteria by which the Program Team will determine whether or not to continue to prescribe medication.

The long-term use of such substances as opoids (narcotic analgesics), benzodiazepine tranquilizers, and barbituate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or 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 the following policies are agreed to by you, the patient, as a consideration for, and a condition of, the willingness of the physician whose name appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. Pain medications, *especially of a narcotic type*, will be provided only after it is determined that all reasonable alternatives for adequate pain control have been investigated or attempted.

2. I will agree to try other approaches or techniques as felt appropriate by the team that may assist me in taking the lowest effective dose possible.

3. My “pain medication” will be prescribed by only the doctor whose name appears below and filled at **one** pharmacy. Should the need arise to change pharmacies our office must be informed. The pharmacy you have selected is: ______________________ Phone: _______________
Any attempt, successful or not, to obtain additional medication without the permission of the Pain Management Program may result in discontinuation of medication therapy.

4. Medications will be given in fixed intervals, usually every two to four weeks, and only if I keep my appointments.

5. I may at times be requested to submit to a drug test to confirm that I am taking only those medications prescribed.

6. Medications will be continued as long as:
   a. There is associated pain relief of at least 30% to 50%;
   b. My functional activity is about what would be expected, given my physical limitations, and;
   c. There is not evidence of addiction as suggested by the need for increasing medicine.

7. Evidence of hoarding or other mismanagement of my pain medication may result in discontinuation of services.

8. Exacerbations or “flare-ups” of my pain will be handled by other therapies, such as tens, exercise, ice, heat, relaxation, or non-habit forming medications. Only when it is determined that there is a physiological basis for the “flare-up”, and additional medicine required, will a brief increase be considered.

9. If it is determined that the situation may be out of control, I will agree to be hospitalized where medications and other therapies can be provided in a controlled fashion.

10. 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.

11. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists, family members or other professionals who provide your health care for purposes of maintaining accountability.

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 an abstinence syndrome (withdrawal) will likely develop.

I HAVE READ AND UNDERSTAND EACH OF THE ABOVE POLICIES. I REALIZE THAT THE PAIN MANAGEMENT PROGRAM WILL ASSUME THE RESPONSIBILITY OF ASSISTING ME IN MY THERAPY AS LONG AS I COMPLY WITH ALL OF THE ABOVE POLICIES.

Date: ______________________

X ____
Signature of Patient or Legally Responsible Person

X____
Witness

Gerald E. Trimble, M.D.
Susan Samlaska, M.D.

Treating Physician

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Minimally Invasive Spine Care

By West Florida Pain Management, P.A.

Gerald Trimble, M.D.
Susan Samlaska, M.D.

MEDICAL RECORDS RELEASE

Patient Name: ________________________________ Date: ___________________

Patient DOB: ________________________________ SSN: ___________________

__ I hereby authorize release of my medical records and/or x-rays for services rendered to me by **West Florida Pain Management, P.A.**

Please mail my records to:
____

____

__ I authorize that you discuss my medical information with:

Name_________________________________ Relationship if any:_____________

__I request that my records from ____

____
be sent to **West Florida Pain Management, P.A.** at the address at the bottom of the page.

I realize that there will be a reasonable fee for copying medical record as set forth in the Florida Administrative Code Chapter 64B8-10.003. Records can be sent to a requesting physician at no charge.

X____
Patient/Guardian Signature

X____
Print Name

X____
Witness

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Susan Samlaska, M.D.

Please bear in mind that scheduled appointments are important to the total treatment plan. If you must cancel an appointment, please do so 24 hours prior to your scheduled appointment so another patient can fill that time slot.

Failure to contact our office within 24 hours before your scheduled appointment (including appointments at a surgery center) will result in a $50.00 to you that will not be covered by your insurance. If the scheduled appointment is for an injection/ diagnostic study, there will be an additional $25.00 charge.

Date:____________________________ ______________________________________
Signature of patient or guarantor

ATTENTION
PATIENTS OF Minimally Invasive Spine Care

EFFECTIVE APRIL 1, 2004
MINIMALLY INVASIVE SPINE CARE
BY WEST FLORIDA PAIN MANAGEMENT
WILL CHARGE:

$10.00

TO THE PATIENTS WHO WISH THEIR PRESCRIPTIONS TO BE CALLED IN.

THIS CHANGE IN POLICY IS DUE TO INCREASED REQUESTS FOR THIS SERVICE.
WE ENCOURAGE YOU TO MAKE SURE YOU GET YOUR PRESCRIPTIONS AT YOUR REGULARLY SCHEDULED OFFICE VISITS.

Remember there are some medications, which due to DEA regulations,
Where prescriptions cannot be called in.

______________________________ ______________________________
Signed **Date**

WF
PM

WEST FLORIDA PAIN MANAGEMENT, P.A. **dba** MINIMALLY INVASIVE SPINE CARE

Diagnostic & Interventional Pain Medicine
Gerald Trimble, M.D.
Susan Samlaska, M.D.

Notice of Disclosure

Dear Patient of West Florida Pain Management, P.A. dba **Minimally Invasive Spine Care**

We would like to make you aware that Dr Trimble has a financial interest in:

1. Belleair Same Day Surgery Center located at 1130 Ponce De Leon Blvd., Clearwater, FL 33756.
2. Skyway Surgery Center located at 625 6th Ave. S Ste 150 St. Petersburg, FL 33701

Should you ever be scheduled at the above facilities you can have your procedure there or another local surgery center such as those listed below where Dr Trimble also has privileges:

Bayfront Same Day Surgery Center 603 7th Street South St. Petersburg, FL 33701
St. Anthony's Physicians Surgery Center 705 16th St. N St. Petersburg, FL 33705
Surg Center NE 2438 Dr MLK St N. Suite C St. Petersburg, FL 33704

Dr Trimble has an interest in Florida Neurology a neuro-monitoring company

Dr Trimble has an interest in Medical Resources Solutions a drug compounding company

E-PRESCRIBING CONSENT FORM

ePrecribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan.

- Medication history **transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing West Florida Pain Management P.A. dba Minimally Invasive Spine Care can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to West Florida Pain Management P.A. dba Minimally Invasive Spine Care to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name Patient DOB

Signature of Patient or Guardian Date

Relationship to Patient

Details About Your Health Information In BayCare eHX and the Consent Process:

1. How Your Health Information Will Be Used: Your health information will be used by members of the BayCare eHX only:

- To provide you with medical treatment and related services
- To check whether you have health insurance and what it covers
- To evaluate and improve the quality of medical care provided to all patients
- For administrative management of the BayCare eHX

2. What Types of Health Information About You Are Included: If you give consent, members of the BayCare eHX may access ALL of your health information available through the BayCare eHX. This includes information created before and after the date of this consent form. Your health information available through the BayCare eHX will include all of your demographic, insurance and medical information. For example, your health information may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. As part of this Consent Form, you specifically consent to the release of health information that may relate to sensitive health conditions, including but not limited to:

- Substance abuse
- HIVAIDS
- Psychiatric/mental health conditions
- Birth control and abortion (family planning)
- Genetic (Inherited) diseases or tests
- Sexually transmitted diseases

3. Where Health Information About You Comes From: Health information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid/Medicare program and other health organizations that exchange health Information electronically.

4.Who May Access Information About You, If You Give Consent: Access to the BayCare eHX will be limited to only those members of the BayCare eHX who have agreed to use the BayCare eHX consistent with your permission as set forth In this Consent Form and who have agreed to the overall terms and conditions established for use and operation of the BayCare eHX.

5. Improper Access to, or Use of, Your Information: If at any time you suspect that someone who should not have seen or received access to your health Information has done so please contact the Baycare Privacy Department at (727) 820-8024.

6. Redisclosure of Information: Any electronic health information about you may be re-disclosed by members of the BayCare eHX to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. You understand that the protected health information disclosed pursuant to this Consent Form may not be protected by federal law once it is disclosed by your physician.

7. Effective Period: This Consent Form will remain In effect until the day you withdraw your consent.

8. Withdrawing Your Consent: You can withdraw your consent at any time by giving written notice to Chris Eakes, Manager of eHX, BayCare Health System, 17757 U.S. Highway 19 N., Suite 500, Clearwater, FL 33764. Organizations that access your health information through the BayCare eHX while your consent is in effect may copy or include your health information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove your health information from their records.

9. Copy of Form: You are entitled to get a signed copy of this Consent Form after you sign it.

Electronic Medical Records

Consent to Share My Health Information With the BayCare Electronic Health Exchange

The BayCare Electronic Health Exchange (BayCareeHX)is an exciting program designed to improve your healthcare and make office visits easier and more convenient. This authorization will allow all of your doctors participating in the BayCare eHX to enroll you in the BayCare eHX and to disclose your demographic, insurance and medical information (collectively, your "health information") to the BayCare ehx so that it can be shared with other providers of health care, including doctors, nurses, health professionals, hospitals and other health care facilities. Only health care providers and authorized personnel that participate In the BayCare eHX, and others whose job it is to maintain, secure, monitor and evaluate the operation of the BayCare eHX, will be able to access your health Information. The BayCare eHX will allow your providers access to your health information more quickly and accurately than with paper charts. You may use this Consent Form to decide whether or not to allow the BayCare eHX to see and obtain access to your health information in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to other providers on the BayCare eHX for your medical treatment.

If you check the "I GIVE CONSENT box below, you are saying "Yes, members of the BayCare eHX may see and get access to all of my health Information through the BayCare eHX."

If you check the I DENY CONSENT" box below, you are saying "No, members of the BayCare eHX may not be given access to my health Information through the BayCare eHX for any purpose."

Please carefully read the Information on the back of this form before making your decision. Your Consent Choices: You can fill out this form now or In the future. You have two choices:

☐ YES, I GIVE CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.

☐ NO, I DENY CONSENT for my doctors to enroll me In the BayCare eHX and for the members of the BayCare eHX to access ALL of my health Information as set forth In this Consent Form.

____

Printed Name of Patient/Representative Signature of Patient/ Representative Date

AUTHORITY OF REPRESENTATIVE:

I, ________________________do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: ________________________

____

____

Relationship to Patient: Date:

WF
PM

WEST FLORIDA PAIN MANAGEMENT, P.A. **dba** **MINIMALLY INVASIVE SPINE CARE**

Diagnostic & Interventional Pain Medicine

Gerald Trimble, M.D.
Susan Samlaska, M.D.

Dear Patients,

Due to the increased number of prior authorizations and the amount of time required to complete a prior authorization for medications Dr Trimble is going to charge $50.00 to get a prior authorization. There is no guarantee that the medication will get authorized due to insurance rules and regulations, but the nurses will give it their best effort.

Please understand this is not for every medication. This is for medications that may not be on your insurance plans formulary, so they require additional authorization.

If you have questions, feel free to ask.

West Florida Pain Management

WF PM

WEST FLORIDA PAIN MANAGEMENT, P.A. **dba** **MINIMALLY INVASIVE SPINE CARE**

Diagnostic & Interventional Pain Medicine

Gerald Trimble, M.D.
Susan Samlaska, M.D.

Dear Patients of West Florida Pain Management,

Beginning on January 1, 2017 patient bills will be in your patient portal. This is in keeping with one of the Affordable Health Cares mandates to make as many things as possible electronic. All patients have the ability to view their bills if they submit a good email address so we can activate your account. Bills are due upon receipt. When we give you your user name and password it must be activated within 48 hours or it will no longer be valid.

We will no longer mail patient bills to patients unless this is requested. There will be a fee of $50.00 dollars per patient per year for this service.

___ I have been notified of West Florida Pain Management's change in billing policy.

___ I have been notified of Florida Pain Management's change in billing policy and wish to request that a bill be mailed to my home. I understand it is my responsibility to keep my address current with West Florida Pain Management. I understand there is a $50.00 fee for this service which I am attaching to this form.

________________________________ ________________________________
Printed Name Signature

____
Date

We are pleased to offer the option of credit card payment for the billing service

Payment Method: Visa Master Card Discover Check

Amount: $50.00

Credit Card No. ___________________________ Exp Date: ________________

Signature: ________________________________ Date: ____________________

WEST FLORIDA PAIN MANAGEMENT, P.A.
dba
MINIMALLY INVASIVE SPINE CARE

HIPAA MEDICAL RECORDS AUTHORIZATION FORM

___________________________ ____
Patient's Full Name **Patient's Social Security Number/ Medical Record Number**

___________________________ ____
Address **Patient's Date of Birth**

___________________________ ____
City, State, Zip code **Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific facility/ medical practice is authorized to use or disclose information about me.

WEST FLORIDA PAIN MANAGEMENT, P.A.
603 7TH STREET SOUTH, SUITE 320
ST. PETERSBURG, FLORIDA 33701
FAX 727-317-5601

2. The specific information that should be disclosed is

__X_ **The last office notes and most recent imaging pertaining to the problem or referral.**

3. I understand that the information used or disclosed may be subject to re-disclosure by the doctors/ facility receiving it and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization by notifying **WEST FLORIDA PAIN MANAGEMENT, P.A.** in writing of my desire to revoke said authorization. However, I understand any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
5. My purpose/use of the information is for **diagnosing and treatment.**

6. This authorization expires on ___________, 20____, OR if no expiration date is completed this form does not expire.

7. **FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You will be required to prepay for the copies.**

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING:

________________________________ ________________________________
Signature of Individual **Date of Signature**

____
Date of Birth or Social Security Number