GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES., PA
Gulf to Bay Integrative Pain Medicine And Rehabilitation

Administration Office
118 S. Oregon Ave.
Tampa, FL 33606

Practice locations: ☐ Fletcher USF, Northwest Tampa ☐ Lutz, Van Dyke ☐ Riverview ☐ South Tampa Oregon ☐ Sun City ☐ Wesley Chapel

Tel 813.253.2273
Fax 813.253.2279
1/19/2012 edited -current WEB format

Today's Date ____________________ **PLEASE PRINT** ***CLEARLY*** **Provider Seen:** ***Carissa Stone MD***

Patient Name ________________________ **Social Security #** _______-_______-_______ DOB ____________________

Gender: ☐ **Male** ☐ **Female** Address ____

City ______________________ State ____________________ Zip____________________

Home Phone # ____________________ Cell # ______________________ Work # ______________________

May we leave messages' on your cell or e-mail? ☐ **Yes** ☐ **No** **E-mail** ______________________ ☐ **may we contact you by e-mail?**

Race: ____________________ Ethnicity: ____________________ Language spoken: ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow /ed

Employer: ______________________ Employer address: ______________________________

Drivers License Number: ______________________ ☐ **Copy of License given to staff Y N**

____ Initial Here Agreement statement to copy DL picture and / Insurance I.D./ and or other Photo I.D. (fill in blanks here)

Pharmacy Name ______________________ **Pharmacy** address/ **phone #**______________________

Referral source: ☐ Primary care name ______________________ Primary Ph# ______________________

☐ **Specialist referral**__________________ ☐ **Friend** ________________ ☐ **Newspaper** or other **direct mail (circle one)**

How did you hear about us? ______________________________

In Case of an Emergency please contact: Spouse name: ______________________ Phone # ____________________

Emergency Contacts:
Name ______________________ Relationship ____________________ Phone # ____________________

Primary Ins Co ____________________ Policy # ____________________ Group # ____________________

Policy Holder ____________________ Relationship ____________________ DOB (if different from patient) _ ____________

Secondary Ins. Co____________________ Policy # ____________________ Group # ____________________

Policy Holder ____________________ Relationship ____________________ DOB (if different from patient) ____________

☐ **Auto Related Injury? If yes, list the Auto Accident Carrier** ____________________ **Date of accident:** ____________________

Claim #________________ Adjuster Name: ________________ Adjustor Phone # ________________ State of Accident ___________

☐ **Workers comp. Related Injury? Workman's Comp Carrier** ______________________ Claim # ________________

Adjusters name______________________ Adjustors Ph# ____________________ Date of Injury ____________________
Attorney: ______________________
Patient Signature:______________________

For Office Use Only:
System Updated: ☐ **Yes** ☐ **No N/A Employee Initials:** _________ **Date :** ________________

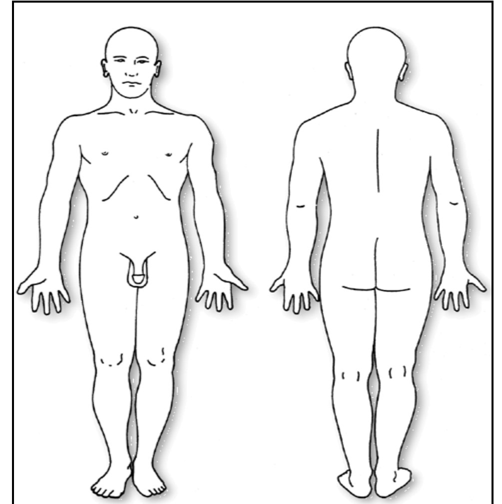
GENERAL INFORMATION: Patient name: ___________________________ Date: ______________

ALLERGIES: __ **None** **Medications:** **(LIST THEM PLEASE)** ____

Allergy to Contrast Dye or IVP dye **(Circle)** **Yes** **No** **Adverse reactions:(list them and what happens)** _______
____

Chief Complaint: What is the reason for your visit today? ____

☐ Male ☐ Female



Please provide some background information about this problem.

Indicate your area of pain on the diagrams to the right, try to be specific.

Time course of Pain: How long have you had the pain?______________

How long ago did your pain begin? ______________________________

Cause of pain if you know: __ Disease condition __ After an operation
__ unknown __ Other ____

Frequency of Pain: ☐is always present ☐comes and goes ☐has variable intensity
☐Constant ☐Other ________________________________

CHARACTER OF PAIN : (Please check one box per line that describes your pain in words and severity)

Aching	☐ none	☐ mild	☐ moderate	☐ severe
Burning/ Hot	☐ none	☐ mild	☐ moderate	☐ severe
Cramping	☐ none	☐ mild	☐ moderate	☐ severe
Heavy	☐ none	☐ mild	☐ moderate	☐ severe
Punishing-Cruel	☐ none	☐ mild	☐ moderate	☐ severe
Sharp	☐ none	☐ mild	☐ moderate	☐ severe
Shooting	☐ none	☐ mild	☐ moderate	☐ severe
Sickening	☐ none	☐ mild	☐ moderate	☐ severe
Stabbing	☐ none	☐ mild	☐ moderate	☐ severe
Splitting	☐ none	☐ mild	☐ moderate	☐ severe
Tender	☐ none	☐ mild	☐ moderate	☐ severe
Tiring-Exhausting	☐ none	☐ mild	☐ moderate	☐ severe
Throbbing	☐ none	☐ mild	☐ moderate	☐ severe

Intensity of the Pain has: __ the same __ Worsened __ Improved

Rate your pain intensity by circling the number that best describes your pain: **RIGHT NOW (Circle one #)**
No pain 0 1 2 3 4 5 6 7 8 9 10 **Intolerable** **Pain Score: _____/ 10**

Pain on best day ______/ 10 **Pain on Worst day ______/10** **Pain score without meds: _____/10**

Patient initials: _______
Symptoms Associated with Pain: __Headaches __ Joint swelling __ Mood changes
__ Memory Loss __ Nausea __ Weight Loss __ Shortness of Breath

What aggravates your pain? ☐Anxiety ☐Lying down ☐ Sitting ☐Walking ☐Coughing
☐Sex ☐Running ☐Cold ☐Heat ☐Straining ☐Standing

What alleviates or makes your pain better? ____
____

Your Daily function has remained: __ the same __ Worsened __ Improved
Your Quality of Life has remained: __ the same __ Worsened __ Improved

Past Treatments for the pain: **Have you had any steroid/cortisone injections for this problem?**

Type of injection	When?	Doctor	Effectiveness
1.			
2.			
3.			
4.			

What other treatment have you received for this problem?

Treatment Modality	Y / N	When?	Effectiveness
Physical therapy			
Occupational therapy			
Massage therapy			
Chiropractic care			
TENS/ Acupuncture			
Counseling			
Surgery			

Please list the medications you are currently taking for you PAIN ONLY.
Please list all previous medications for pain

Medication	Dose and Frequency	Effectiveness	Side effects
1.			
2.			
3.			
4.			

List all other current medications

Medication		
1.	6.	11.
2.	7.	12.
3.	8.	13.
4.	9.	14.
5.	10.	15.

Patient initials: ______

Review of Systems: (symptoms you are having now)

General
☐ Fevers
☐ Chills
☐ Night sweats
☐ Malaise
☐ Dizziness
☐ Weight gain
☐ Weight loss
☐ Loss of sleep
☐ Poor appetite

Respiratory
☐ Persistent cough
☐ Recent cold or flu?
☐ Coughing blood
☐ Do you Snore?
☐ do you Use CPAP?
__ yes __ no

GYN history
☐ Irregular cycles
☐ Birth control pills
☐ Vaginal bleeding
☐ other ____________

Skin
☐Do you have itching anywhere?
☐Unusual bruising
☐Unusual shaped moles/ or other patches

Hematological
☐ Bleeding problems
☐ Bleeding gums do you take
☐Other bleeding issues?
____

HEENT: Eye, Ear, Nose, Throat
☐ Sinus infections
☐ Daytime tiredness
☐ Double vision
☐ Snoring
☐ Earache

Gastrointestinal
☐ Heartburn
☐ Acidic stomach
☐ Gluten allergy
☐ Constipation
☐ Vomiting
☐ Vomiting blood
☐ Nausea
☐ Bloating
☐ Diarrhea
☐ Rectal bleeding

Musculoskeletal Muscle/Bone/Joints
☐Fainting spells
☐Muscle spasm anywhere
☐ Numbness in legs
☐ Radiating pain legs
☐ Burning pain legs
☐ Painful swollen joints
☐ Numbness in arms
☐ Burning pain arms
☐ Radiating pain arms
☐ Swelling in ankles

Psychiatric/ Mental health
☐ Depressed but never diagnosed
☐ Do you cry uncontrollably
☐ Ever tried to hurt yourself?
☐ Do you feel like hurting self now?
☐ Addiction treatment
When? ____________
What? ____________

Allergy / Immunology
☐ Shellfish allergy
☐ environmental allergies
☐ HIV positive
☐ HIV tested negative
☐ Immune disorder
Type?______________

Rheumatology
☐ Joint pain all over
☐ Pain in joints in the mornings
☐ Swelling in joints

Cardiovascular/Cardiac
☐ Previous heart cath
☐ Shortness of breath
☐ Ankle swelling
☐ Chest pain with activity
☐ Low blood pressure
☐ High blood pressure
☐ Irregular heart beat
☐ Poor circulation
☐ Rapid heart beat
☐ Take water pills
☐ Poor exercise ability

Genito-Urinary
☐ Blood in urine
☐ Hard time getting urine out
☐ Burning when urinate
☐ Feels like passing as stone
☐ No control of bladder

Neurological
☐Lightheadedness
☐ Poor concentration
☐ Fogginess
☐Memory loss
New? ______________

Endocrine
☐ Severe thirst
☐ Severe fatigue
☐ Dry skin
☐ Take cortisone
☐ Rough skin, or rough elbows

Cancer , concern for?
☐ Prostate
☐ Breast
☐ Colon
☐ Lung
☐ Other ____________
☐ Cured Yes No

Cont….next page for questions, thanks.

Patient initials: _______

PAST MEDICAL HISTORY: General Medical Questions or Medical Diseases (problems now or past)

General: ☐ Not feeling right, explain ____

HEENT: Eye, Ear, Nose, Throat	**Gastrointestinal**	**Muscle/Bone/Joints**	**Psychiatric/ Mental health**	**Allergy / Immunology**
☐ Allergies ☐ Sinus problems ☐ Eye problems ☐ Loss of hearing	☐ Hepatitis A, B, or C ☐ Stomach Ulcer ☐ Jaundice ☐ Liver Disease	☐ Osteoarthritis ☐ Osteoporosis ☐ Fibromyalgia ☐ Herniated discs ☐ Other pain________	☐ Depression ☐ Bipolar Disorder ☐ Schizophrenia ☐ Situational depression ☐ Addiction When? _____________ What? _____________	☐ Shellfish allergy ☐ environmental allergies ☐ HIV positive ☐ HIV tested negative ☐ Immune disorder Type?______________
Cardiovascular/Cardiac	**Genito-Urinary**	**Neurological**	**Endocrine**	**Rheumatology**
☐ Damaged Heart valves ☐ Rheumatic heart dz ☐ Artificial Valve ☐ Heart Murmur ☐ Heart Attack When? _____________ ☐ High blood pressure ☐ Low blood pressure	☐ Kidney Stones ☐ Interstitial Cystitis ☐ Bladder infections ☐ Kidney function ☐ Prostate problems	☐ Seizures ☐ Nerve damage ☐ Multiple Sclerosis ☐ Stroke ☐ TIA or mini stroke ☐ Alzheimers ☐ Parkinsons ☐ Neuropathy	☐ Thyroid problems ☐ Immune problems ☐ Diabetes ☐ Diabetic neuropathy ☐ Take cortisone ☐ Low Testosterone ☐ Low Estrogen ☐ Low Progesterone	☐ Lymes disease ☐ Rheumatoid arthritis ☐ Crohns disease ☐ Gluten or Celiac dz ☐ Other ___________
Respiratory	**Obstetrical history**	**Skin**	**Hematological**	**Cancer**
☐ Tuberculosis ☐ Asthma ☐ Emphysema ☐ Bronchitis / Chronic ☐ Sleep apnea ☐ Do you use oxygen How much? _____L/M	☐ Uterine fibroids ☐ Uterus problems ☐ Endometriosis ☐ Menopause ☐ Hormone therapy Bioidentical ☐ Hormone therapy synthetic ☐ Menstruating Last LMP _________ ☐ Pregnant? ☐ Birth control pill use	☐ Cancer ☐ Acne ☐ Eczema ☐ Psoriasis ☐ Unusual shaped moles	☐ Blood transfusions? ☐ Blood disorder ☐ Coumadin use ☐ Lovenox use ☐ Plavix use ☐ Heparin use ☐ Other blood thinner Other _____________	☐ Prostate ☐ Breast ☐ Colon ☐ Lung ☐ Other ____________ Cured? Yes No

PAST SURGICAL HISTORY: (check or list all surgeries you have had)

__ Appendectomy
__ Adenoids and or Tonsils or Ear Nose or Throat surgeries ________________________________
__ Brain Surgery, type? ____
__ Breast Implants when ____________________________________
__ Bone Surgery of any kind /joint replacements or repaired fractures __________________________
__ Cholecystecomy (gall bladder removal) ____
__ Eye surgery type ____
__ Gastric By pass surgery of stomach ___ if yes when? ____________________________________
__ Heart Surgery (type) ____
__ Hysterectomy, when? ____
__ Sinus Surgery ____
__ Splenectomy (spleen removal) if yes last Pneumovax? ________________________________
__ Spine surgery, type? ____
_______Neck, Cervical, Skull when? ____
_______Low back, when? ____

Patient initials: _______

INJURY History: ☐ No Injuries OF ANY TYPE (check here and skip to next section "Family History")

1. Have you had any **AUTO/ injuries?** Yes No if yes when? ____________________________
   a. Is case Open? Yes No
   b. Is case closed? Yes No
2. Have you ever had any **sports injuries**? Yes No if yes when ? ______________________________
3. Have you ever **broken any bones**? Yes No if yes when? And what? ________________________
4. Have you ever had a **Workers compensation claim**? Yes No
   a. Currently? Yes No b. In past? Yes No
   c. Closed case? Yes No d. Open Case? Yes No
   e. Settled/settlement Yes No
5. **Have you ever been disabled**? Yes No Are you currently disabled? Yes No Type? SSD SSI

PAST OR FAMILY HISTORY: __ Adopted __ Any adoption medical history? Yes No If yes then
What history do you know about birth parents ? ____

Family history Positive for: __ Diabetes __ Cancer ___ Hypertension (high blood pressure)
__ Heart attack before age 50yo __ Bleeding problems ___ Alcoholism ___ Drug abuse __________________
__ Other:____

Mother:__ living __ deceased (why?) ____
Father: __ living __ deceased (why?) ____

SOCIAL HISTORY:

Do you **smoke**? Yes No

If you answered yes: how much do you smoke per day?_______________________________________

Have you tried to quit? Yes No Was it successful? Yes No NA

Have you been counseled on smoking cessation before? Yes No NA

Do you **drink** alcohol? Yes No __ Socially? How much? ______________________________________

Do you have history of:
Use or abuse of illegal drugs/ recreational / or used prescription drugs illegally? Yes No
Have you ever taken a pain pill of a friend or family member? Yes No

Marital Status: ☐ Married ☐ Remarried ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Members of household: who lives with you? ____

Highest level of education: __ less then high school/GED, __ High School, __ Vocational tech / business

__ Junior College, __ College, __ Graduate or professional school or degree (type?) ____________________

__ Other ____

Occupation/ Employment/ Do you work currently? Yes No __ Retired __ On Unemployment?

If you answered yes: Full time_____ Part time_____ Other ________________________________

Present Source of financial support:

☐ Disability ☐ Workman's Comp ☐ Insurance ☐ Personal Earnings

☐ Pension ☐ Spouses Earnings ☐ None Other:________________

Patient initials: _______

Sexual History: (optional questions- leave blank is not applicable)

Do you have loss of libido or interest in sex? Yes No

Do you have loss of sexual arousal? Yes No

Have you been tested for Hormone deficiency? Yes No

Any Old Tests:

__ X rays Yes No of what? ____

__ CT Scans Yes No of what? ____

__ MRI Yes No of what? ____

____

__ EMG tests Yes No of what? ____

__ Bone density testing Yes No If yes was it normal? __ Yes __ No

__ Bone scans Yes No Of what body part? __________________________________

Name all your current doctors

Doctor	Specialty	Telephone

CERTIFICATION

- I have read and understand the above review.
- I acknowledge that my questions, if any about the inquires set forth above have been answered to my satisfaction and to the best of my ability. I will not hold my physician or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.
- To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health information.
- I understand that if I fail to cancel an appointment or don't give 24 hours notice of cancellation before a scheduled procedure I can be charged a $100.00 failure to cancel fee.
- I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me.
- I permit a copy of this to be used in place of the original.

____ ______________________________

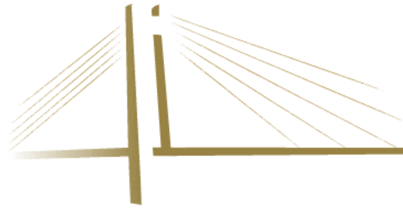
Signature of Beneficiary, Guardian or Personal Representative Date

____ ______________________________

Please print name of Patient, Parent or Guardian Relationship

I, _________ (Carissa Stone MD) the physician have personally reviewed this information and referred the patient back to their primary care or other regular physician for follow up of any critical issues noted as new in the patients history, or referred the patient to the Emergency Department for further evaluation if the issue was of an urgent nature.

Physicians signature: X ____



Gulf-to-Bay Pain Medicine

118 S. Oregon Avenue
Tampa, FL 33606
Phone: (813) 253-2273
Fax: (813) 253-2279
www.gtbpain.com

Patient Name: _____________________ Date: __/__/___

Ordering Physician Name: ___________________

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

	Never	Seldomn	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	o	o	o	o	o
2. How often have you felt a need for higher doses of medication to treat your pain?	o	o	o	o	o
3. How often have you felt impatient with your doctors?	o	o	o	o	o
4. How often have you felt that things are just too overwhelming that you can't handle them?	o	o	o	o	o
5. How often is there tension in your home?	o	o	o	o	o
6. How often have you counted pain pills to see how many are remaining?	o	o	o	o	o
7. How often have you been concerned that people will judge you for taking pain medication?	o	o	o	o	o
8. How often do you feel bored?	o	o	o	o	o
9. How often have you taken more pain medication than you were supposed to?	o	o	o	o	o
10. How often have you worried about being left alone?	o	o	o	o	o
11. How often have you felt a craving for medication?	o	o	o	o	o
12. How often have others expressed concern over your use of medication?	o	o	o	o	o

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Gulf-to-Bay
Integrative Pain Medicine & Rehabilitation

Name: ______________________________	Never	Seldomn	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	o	o	o	o	o
14. How often have others told you that you had a bad temper?	o	o	o	o	o
15. How often have you felt consumed by the need to get pain medication?	o	o	o	o	o
16. How often have you run out of pain medication early?	o	o	o	o	o
17. How often have others kept you from getting what you deserve?	o	o	o	o	o
18. How often, in your lifetime, have you had legal problems or been arrested?	o	o	o	o	o
19. How often have you attended an AA or NA meeting?	o	o	o	o	o
20. How often have you been in an argument that was so out of control that someone got hurt?	o	o	o	o	o
21. How often have you been sexually abused?	o	o	o	o	o
22. How often have others suggested that you have a drug or alcohol problem?	o	o	o	o	o
23. How often have you had to borrow pain medications from your family or friends?	o	o	o	o	o
24. How often have you been treated for an alcohol or drug problem?	o	o	o	o	o
Has any relative had a problem with: **(Please circle Y/N for each question Below)** - Alcohol? Y/N - Addiction? Y/N - Mental Illness? Y/N					

Please include any additional information you wish about the above answers.
Thank you.

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Score: ______________________

INSURANCE ASSIGNMENT AND RELEASE

Gulf-to-Bay Anesthesiology Associates, PA
DIVISION OF PAIN MEDICINE
118 S. Oregon Avenue
Tampa, FL 33606

Telephone: (813) 253-2273 / (352) 567-4095
Fax: (813) 253-2279

I certify that I , and/or my dependant (s) have insurance coverage with:

____

and assign directly to ***Gulf-to-Bay Integrative Pain Medicine & Rehabilitation*** all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I authorize the use of my signature on all insurance correspondence and submissions. I permit a copy of this to be used in place of the original.

The above named physician may use my health care information and my disclose such information to the above-named insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for such services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________________ ______________________

Signature of Beneficiary, Guardian or Personal Representative Date

______________________________ ______________________

Please print name of Patient, Parent or Guardian Relationship

PRIVACY PRACTICES ACKNOWLEDGMENT

ACKNOWLEDGEMENT STATEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: ____ Date of Birth: ____________________

Date: ____

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy act gives individuals the right to request a restriction on uses and disclosures of Personal Health Information (PMI). The individual is also provided the right to request confidential communication.

I wish to be contacted in the following manner…

Please check all that apply:

☐ Home Phone # _______________ ☐ Work Phone # _______________ ☐ Cell Phone # _______________

___ Ok to leave detailed messages ___ Ok to leave detailed messages ___ Ok to leave detailed messages

Please send all written communication to the following address : ____

Please choose one of the following options:

☐ **Option 1**:

Information about my treatment at Florida Gulf-to-Bay Pain Clinic may be released to the following individuals:

This includes prescription pick-ups*

Name & Relationship: ____ Phone # ________________

Name & Relationship: ____ Phone # ________________

Name & Relationship: ____ Phone # ________________

☐ **Option 2**:

I DO NOT want my medical information released to anyone

____ _______________ ______________________________

Signature of Patient/Legal Guardian Date Relationship to Patient

____ _______________

Witness Date

I understand that this health information may include HIV related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form I am specifically authorizing the release of information relating to:

- ☐ Substance Abuse (including alcohol/drug abuse)
- ☐ Mental Health
- ☐ Psychotherapy Notes
- ☐ HIV related information (including AIDS related testing)

The confidentiality of this record is required under Chapter 899 of the Connecticut General Studies, as well as, Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

* I understand that this form will expired in one year from my last date of service visit. A photocopy of this form will be considered as valid as the original.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive from our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you.

2. OUR LEGAL DUTY

Law Requires Us To:

1. Keep your medical information private
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have The Right To:

1. Change out privacy practices and terms of this notice, provided changes are permitted by law.
2. Changes that are made will effect all medical information, including previously received information.

If any changes are made, the new notice will be available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following are ways that we will be using and disclosing your medical information

FOR TREATMENT: We may share medical information about you to doctors, nurses, technicians, medical students, or other people taking care of you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. When billing your insurance company, the information on, or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use your medical information for our health care operations. This might include: quality improvement, training programs, evaluating the performance of employees etc.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at, or get copies of your medical information. You must make your request in writing. You may obtain this form from our office's front desk.
2. Receive a list of all the times we have shared your medical information for purposes other than treatment, payment and health care operations.
3. Request that we place additional restrictions on our use or disclosure of your medical information.
4. Revoke your authorization to share your medical information at any time by notifying our office in writing, and the authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

If you have any questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit request involving any of your rights in Section 4 of this notice by writing to the following address:

Gulf-to-Bay Pain Medicine
118 S. Oregon Avenue
Tampa, FL 33606 813-253-2273 (phone) 813-253-2279 (fax)

Patient Opioid Agreement

This is an agreement between ______________________________(print patient name) and ***Gulf-to-Bay Pain Management*** concerning the use of opioid medications for the treatment of chronic pain.

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

Please read each statement carefully and initial next to each to indicate your agreement.

Patient Initials	Statement
	1. I understand that Opioid medications are strong medications for pain relief and I have been informed of the risks and side effects involved with taking them.
	2. I understand that opioid medications could cause physical dependence. If I suddenly stop or decrease the medication, I could experience withdrawal symptoms that may occur within 24-48 hours of the last dose. Therefore, it is my responsibility to make sure I do not run out of my medications on weekends or holidays. ***Prescriptions will not be refilled without an appointment***
	3. I understand that if I am pregnant or become pregnant while taking opioid medications, my child would be physically dependent on the opioids, and withdrawal can be life-threatening for my baby.
	4. I understand that if the medication causes drowsiness, sedation, or dizziness, I should not drive a motor vehicle or operate heavy machinery that could put my life or someone else's life in danger.
	5. I understand that it is my responsibility to notify the physician of any/all side effects I am experiencing from the medication(s).
	6. I agree to take this medication ***only as prescribed*** by my physician, and that I will not change the amount or frequency of the medication without discussing it with the prescribing physician.
	7. I agree that my opioid medication(s) will be prescribed by only ***Gulf-to-Bay Pain Management***, and I agree to fill my prescriptions at only one pharmacy. (** We understand that in rare instances, your designated pharmacy may experience a medication shortage. In that instance, please *notify us* & we will obtain approval from the physician to use your second pharmacy of choice**) 8. I agree not to take any pain medications prescribed by any other physician without first discussing it with Gulf-to-Bay. I give permission to Gulf-to-Bay to verify that I am not seeing other physicians for opioid medication.
	9. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.
	10. I agree not to sell, lend, or in any way give my medication to any other person.
	11. I agree not to drink alcohol or take mood altering drugs while I am taking opioid medication. I agree to submit a urine specimen at any time that my doctor requests, and give my permission for it to be tested for alcohol and/or drugs.
	12. I agree that I will attend all of my required follow-up visits with the doctor to monitor this medication, and I understand that failure to do so will result in discontinuation of this treatment.
	13. I will not go the emergency room for pain management for my chronic condition for which Gulf-to-Bay is treating me. **** This agreement does not restrict me from going to the emergency room for new acute pain of any nature. I shall report to Gulf-to-Bay within one week of such an ER visit.****
	14. I understand that pain medications are only one aspect of my pain treatment plan. I also agree to follow other modalities of treatment as recommended by my physician. Failure to follow the treatment plan may indicate that I no longer respect the treatment suggestions of Gulf-to-Bay, and may result in my discharge from the care of Gulf-to-Bay Pain Management.

The Pharmacy at which I will fill all of my Controlled Substance prescriptions is:

Name of Pharmacy : ____ Pharmacy phone # ___________________
2nd Pharmacy of Choice*: ____Pharmacy Phone# ____________________
(Only to be used in the event of a medication shortage at your primary pharmacy)

This agreement shall remain in effect until either party withdraws from it in writing, or until I violate the agreement.

_____________________________________ ________ _________________________________ ________
Patient Signature Date Physician Signature