**Patient Information**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Last First Middle**

**Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Permanent Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Daytime Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext:\_\_\_\_\_\_\_\_\_ Evening Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ SSN:\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_ Martial Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(If workers’ comp, indicate employer where accident occurred)**

**Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Injury/Accident/Illness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Closest friend or relative not living with you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Direction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Daytime Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext:\_\_\_\_\_\_\_\_\_\_\_\_ Evening Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Information**

**Primary Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscriber’s Relationship to Patient: SELF SPOUSE PARENT OTHER**

**Spouse Name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Last First Middle**

**Spouse’s Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Spouse SSN: :\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Spouse Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_**

**Secondary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Third Insurance, if applicable:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referral Information**

(Please tell us how you were referred to our practice)

□ **Referring Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Health Plan Provider List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**□ Other Source\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (W/C Adjuster, Case Manager, Website, Friend, etc.)

**Please read the following authorization. Initial and sign below for our files.**

**\_\_\_\_\_\_\_\_\_\_\_ I understand that any appointment changes must be made at least 24 hours in advance or a $30 fee will be applied.**

**SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Man Q. Le, MD**

**1397 Medical Park Blvd, Suite 480**

**Wellington FL 33414**

**Phone: 561-791-1141 Fax: 561-296-3004**

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_**

**Gender: (Please Circle)** Male /Female

**Who referred you to us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who is your family doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is your visit related to an injury?** Yes / NO **If Yes, specify:** Auto Work Comp Other

**Have you been to any previous pain management? Yes or No** (circle one)

 **Name of Physician(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work Status: \_\_\_\_\_ Regular Duty \_\_\_\_\_\_\_ Light Duty \_\_\_\_\_\_\_\_ Restrictions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_ OFF Work: last worked: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_ Disabled: Since \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by what doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_ Retired: since what year \_\_\_\_\_\_\_\_\_\_\_**

**Location of Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**In the diagram below, please shade the areas of your pain**

**(Circle your answer)**

**Pain Scale: From 0-10 what is your pain level today?**

**(No Pain)** 0 1 2 3 4 5 6 7 8 9 10 **(Worst Pain)**

**What is your range of pain the the past month?**

**(No Pain)** 0 1 2 3 4 5 6 7 8 9 10 **(Worst Pain)**

**What treatments have you had for your pain? Check all that apply.**

\_\_\_Physical Therapy \_\_\_Favorable Results \_\_\_ Poor Results

\_\_\_Acupuncture \_\_\_Favorable Results \_\_\_ Poor Results

\_\_\_Chiropractor \_\_\_Favorable Results \_\_\_ Poor Results

\_\_\_Trigger Point Injections \_\_\_Favorable Results \_\_\_ Poor Results

\_\_\_TENS Unit \_\_\_Favorable Results \_\_\_Poor Results

\_\_\_Nerve Blocks \_\_\_Favorable Results \_\_\_Poor Results

Type of Nerve Block: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Back or Neck Surgery Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Spinal Chord Stimulator Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Implanted\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Morphine Pump Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Implanted\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient History: (Check each that apply):**

**Tobacco**: \_\_\_Do not some \_\_\_Smoke \_\_\_Pack(s) per day

**Alcoho**l: \_\_\_Do Not Drink \_\_\_Drink # of drinks per \_\_day \_\_\_ week

**Social History**: \_\_\_Married \_\_\_Single \_\_\_Divorced

**Lives With:** \_\_\_Spouse \_\_\_Children \_\_\_Other \_\_\_Alone

\_\_\_Blind \_\_\_Glasses \_\_\_Contacts \_\_\_Hard of Hearing \_\_\_Deaf \_\_\_\_Hearing Aids

\_\_\_Cancer \_\_\_Thyroid Disease \_\_\_Gallbladder Disease \_\_\_Birth Defects \_\_\_\_HIV+

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**Under each Category, please check any symptoms that apply:**

**Cardiovascular Gastrointestinal Neurological Musculoskeletal**

\_\_\_Hypertension (High) \_\_\_Chronic Diarrhea \_\_\_Migraines \_\_\_Arthritis

\_\_\_Hypotension (Low) \_\_\_Chronic \_\_\_Frequent \_\_\_Osteoarthritis

\_\_\_Anemia Constipation Headaches \_\_\_Rheumatoid

\_\_\_Heart Disease \_\_\_Incontinence \_\_\_Epilepsy \_\_\_Low Back

 \_\_\_Sleeping Syndrome

\_\_\_Stroke \_\_\_Ulcers Disorders \_\_\_Cane

\_\_\_Swelling on feet \_\_\_Hepatitis \_\_\_Restless \_\_\_Walker

\_\_\_Chest Pain \_\_\_Ulcers Leg \_\_\_Wheelchair

\_\_\_Rheumatic fever Other:\_\_\_\_\_\_\_\_ \_\_\_Prosthesis

 \_\_\_Diabetes Type:\_\_\_\_\_\_\_\_\_\_

 \_\_\_Gout \_\_\_Other:\_\_\_\_\_\_\_\_\_\_

 \_\_\_Other:\_\_\_\_\_\_\_

**Psychiatric Genitourinary Respiratory**

\_\_\_Depression \_\_\_Urinary Incontinence \_\_\_Asthma

\_\_\_Anxiety Disorder \_\_\_Kidney Disease \_\_\_COPD

\_\_\_Bipolar \_\_\_Chronic Cough

\_\_\_Alcoholism \_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_ \_\_O2 Therapy

\_\_\_Drug Addiction

\_\_\_Suicide Attempt

\_\_\_Schizophrenia

\_\_\_Other:\_\_\_\_\_\_

**Medications you are presently taking include: Over the counter & prescription drugs.**

**Pain Medications, Muscle Relaxants, Sleep Aid, Anti-Anxiety, and Antidepressants.**

**Medications Dose Frequency (use back of paper if needed)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**All Others (Including Over-the-counter)**

**Medications**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Surgeries DATE (Month/Year)**

**(Please list below)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Pain Disability Index Sheet**

 **Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.**

 **For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.**

**Family/ Home Responsibilities:** This category refers to activities of the home or family. It indicates chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).

**No Disability 0.\_\_\_ 1.\_\_\_ 2.\_\_\_ 3.\_\_\_4.\_\_\_5.\_\_\_6.\_\_\_7.\_\_\_8.\_\_\_9.\_\_\_10.\_\_\_Worst Disability**

**Recreation:** This disability includes hobbies, sports, and other similar leisure time activities..

**No Disability 0.\_\_\_ 1.\_\_\_ 2.\_\_\_ 3.\_\_\_4.\_\_\_5.\_\_\_6.\_\_\_7.\_\_\_8.\_\_\_9.\_\_\_10.\_\_\_Worst Disability**

**Social Activity :** This category refers to activities, which involve participation with Friends and acquaintances other tan family members. It includes parties, theatre, concerts, dining out, and other social functions.

**No Disability 0.\_\_\_ 1.\_\_\_ 2.\_\_\_ 3.\_\_\_4.\_\_\_5.\_\_\_6.\_\_\_7.\_\_\_8.\_\_\_9.\_\_\_10.\_\_\_Worst Disability**

**Occupation:** This category refers to activities that are part of or directly related to one’s job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

**No Disability 0.\_\_\_ 1.\_\_\_ 2.\_\_\_ 3.\_\_\_4.\_\_\_5.\_\_\_6.\_\_\_7.\_\_\_8.\_\_\_9.\_\_\_10.\_\_\_Worst Disability**

**Sexual Behavior:** This category refers to the frequency and quality of one’s sex life..

**No Disability 0.\_\_\_ 1.\_\_\_ 2.\_\_\_ 3.\_\_\_4.\_\_\_5.\_\_\_6.\_\_\_7.\_\_\_8.\_\_\_9.\_\_\_10.\_\_\_Worst Disability**

**Self Care:** This category includes activities, which involve personal maintenance and independent daily living (e.g. taking aa shower, driving, getting dressed, etc.)

**No Disability 0.\_\_\_ 1.\_\_\_ 2.\_\_\_ 3.\_\_\_4.\_\_\_5.\_\_\_6.\_\_\_7.\_\_\_8.\_\_\_9.\_\_\_10.\_\_\_Worst Disability**

**Life-Support Activities**: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.

**No Disability 0.\_\_\_ 1.\_\_\_ 2.\_\_\_ 3.\_\_\_4.\_\_\_5.\_\_\_6.\_\_\_7.\_\_\_8.\_\_\_9.\_\_\_10.\_\_\_Worst Disability**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please Print \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**

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**Authorization For Release Of Medical Records**

**Print Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_\_/\_\_\_\_\_**

**Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I authorize release of my health information records to South Florida Pain Relief Centers to enable a comprehensive review of my medical care. I authorize the following physician offices, clinics, hospitals, other health care providers, pharmacies and legal offices to provide copies of my health information to:**

**1397 Medical Park Blvd., Suite 480 Wellington, FL 33414**

**Phone: 561-791-1141**

**Fax: 561-296-3004**

**(List of all facilities, clinics, and offices from which information will be requested)**

**Physician Offices** (please list all physicians you have seen in the past two years)

 **Physicians Name** **Address**  **Phone Number**

|  |  |
| --- | --- |
| **1.** |  |
| **2.** |  |
| **3.** |  |
| **4.** |  |

**Pharmacy:** (please provide an updated list of all pharmacies that you have used in the past two years)

**Pharmacy Name** **Address**  **Phone Number**

|  |  |
| --- | --- |
| **1.** |  |
| **2.** |  |
| **3.** |  |
| **4.** |  |

**Hospital AND OTHER FACILITIES** (for surgery/ procedures, MRI/CT-SCANS and any LAB and X-Ray reports)

**Facility Name** **Address**  **Phone Number**

|  |  |
| --- | --- |
| **1.** |  |
| **2.** |  |
| **3.** |  |
| **4.** |  |

**Restrictions:**

**\_\_\_\_\_\_\_\_\_\_ There are NO restrictions on the information that can be released.**

**\_\_\_\_\_\_\_\_\_\_\_ The following information CAN NOT be released**

**Man Q. Le, MD**

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**Family History Current State of Health & History of Problems**

**Mother:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Father:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sibilings:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***South Florida Pain Relief Center physicians and allied health professionals are prescribing Opioid medicine, sometimes called narcotic analgesics o me for pain management. This decision was made because my condition is serious or other treatments have not helped my pain.***

**I am aware that the use of such medicine has certain risks associated with it. Including but not limited to sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerate to analgesia, addiction and possibility that the medicine will not provide complete pain relief.**

**I am aware about the possible risks and benefits of other types of treatments that do not involve the use of Opioids. I will tell my physician about all other medicines ant treatments that I am receiving. I will not be involved in any activity that may be dangerous to me or someone else if I fell drowsy or am not.**

 **I am aware that certain other medicines such as nalbuphine (Nubain), pentazocaine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol), may reverse the action of the medicine I am using for pain control. Taking any of these medications while I am taking my pain medicines and to tell any other physicians that I am taking an Opioid as my pain medicine and cannot take any of the medicines listed above**

**I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug feeling that need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has family or personal history of addiction. I agree to tell my physician my complete and honest personal drug history and that of my family to te best of my knowledge.**

**I understand that the physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that Opioid withdrawal is uncomfortable but not life threatening.**

**I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help, and may cause unacceptable side effects. Tolerance or failure to respond well to Opioids may cause physician to choose another form of treatment.**

**Males Only: I am aware that chronic Opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my physician or family physician may check my blood to see if my testosterone level is normal.**

**Females Only: If I plan to become pregnant or believe that i have become pregnant while taking this medicine, i will immediately call my obstetric physician and this office to inform them. I am aware that, should I carry a baby to my delivery while taking these medicines; the baby will be physically dependent on Opioids. I am aware that the use of Opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an Opioid.**

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**Consent For Chronic Opioid Therapy**

**Summary of Guidelines for prescribed Opiates:**

1. **The patient must provide copies of reports from previous and concurrent treating physicians**
2. **The patient must provide LRPC accurate patient address and pone number and keep us up to date of any changes in their personal information.**
3. **South Florida Pain Relief Center physicians and allied health professionals will be the only providers to prescribe controlled substances for pain**
4. **The patient must provide us with the name and pone number of the pharmacy that the patient is using and keep us up to date with any changes.**
5. **The patient must be seen for regular office visits to receive a medication refill. Prescriptions will be written for a 30-day supply and will not be filled earlier than one (1)month.**
6. **The safety of the patient’s medication is the patients’ responsibility.**
7. **The patient is responsible for all prescriptions/medications given and must understand that is the prescriptions/medications are lost, misplaced or destroyed; the prescription/medications cannot be replaced.**
8. **No refills will be made afterhours, on weekends or on holidays. The patient will need to notify the office for a refill at least three(3) days in advance.**
9. **Other therapies may be ordered to assist in pain management and limit opiate use.**
10. **Other therapies may be ordered to assist in pain management such as nerve blocks, TENS, physical or occupational therapy, psychological counseling as appropriate to the diagnosis.**
11. **The patient understands that no trustworthy patient-doctor relationship can be had with a patient that abuses illegal drugs. “Street Drugs” such as marijuana, cocaine, amphetamines, etc. are in and out of themselves dangerous. Mixed with some of the medications often used in pain management, the combination could be lethal.**
12. **We will periodically check the patient’s urine for compliance with therapy. The urine will be tested for the presence of the prescribed drugs as well as several other drugs, including illegal drugs.**
13. **The patient understands that if we find a urine simple that contains illegal substances, we may end the patient- doctor relationship.**
14. **The patient has the right to refuse such random or periodic urine testing. South Florida Pain Relief Center reserves the right to end the patient- doctor relationship on a patient the refuses to comply with out urine drug testing policy.**

**The patient authorizes any physician office, hospital or clinic to provide full details of medical history and treatment to SFPRC for the use of continuity of care by completing a medical release form up to date.**

**Any breach of these guidelines may result in the patient being discharged from the practice of South Florida Pain Relief Centers.**

**I have read this form or have had this form read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with Opioid pain medications.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness Printed name and Signature Date**

**Man Q. Le, MD**

**1397 Medical Park Blvd, Suite 480**

**Wellington FL 33414**

**Phone: 561-791-1141 Fax: 561-296-3004**

**CONSENT FOR CARE & TREATMENT**

**I, the undersigned, do herby agree and give my consent for South Florida Pain Relief Center to furnish medical care and treatment to myself, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_considered necessary and proper in diagnosis or treating his/her physical and mental condition.**

**Patient/Guardian/Responsible\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_/\_\_\_\_/\_\_\_\_**

**Benefit Assignment/ Release of Information**

**I hereby assign all medical and/ or surgical benefits to include mayor medical benefits to which i am entitled, including Medicare, Medicaid, private insurance, and third party payers to South Florida Pain Relief Center. A photocopy of this assignment is to be considered as valid as the original. I herby authorize said assignee to release all information necessary, including medical records, to secure payment.**

**Information Privacy: South Florida Pain Relief Center will use and disclosure your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, and have copies available for distribution. The undersigned acknowledges receipt of this I information.**

**Patient/Gurardian/Resposible\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_/\_\_\_\_/\_\_\_\_**

**Financial Policy Statement**

**We bill your insurance carrier solely as a courtesy to you. you are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made due to policy termination, you will be responsible for the amount of money refunded to your insurance company. We reserve he right to asses a finance charge of 18% annually for balances carried over an extended period of time. Benefits and eligibility are verified prior to your visit as a courtesy and as a result, we are not responsible for incorrect information provided by your insurance company as it relates to co-pay or benefit plan limitations. Your policy must be in effect at the time of service and subject to individual plan limitations and exclusions as mandated by your plan. An authorization is not a guarantee of payment.**

***If any payment is made directly to you for services billed by us, you recognize and obligation to promptly submit same to SOUTH FLORIDA PAIN RELIEF CENTER.***

**The above may not apply for those patients that are considered Worker’s Compensation. However, be advised if you claim Worker’s Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount charges for services rendered to you.**

**I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.**

**I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT**

**Patient/Guardian/Resbonsible\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**

**Witness printed name and signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**

**Man Q. Le, MD**

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**PATIENT FINANCIAL RESPONSIBILITY FORM**

**Thank you for choosing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.**

**Patient Financial Responsibilities**

* **The patient (or patient’s guardian, if a minor) is ultimately responsible for the payment for treatment and care.**
* **We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.**
* **Patients are responsible for the payment of co-pays, co-insurances, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards and our office.**
* **Patients may incur, and are responsible for the payment of additional charges at the discretion of \_\_\_\_\_\_\_\_\_. These charges may include (but are not limited to):**
* **Charge for returned checks**
* **Charge for missed appointments without 24 hours advance notice**
* **Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions.**
* **Charge for the copying and distribution of patient medical records**
* **Charge for extensive for completion**
* **Any costs associated with collection of patient balances.**

**Patient Authorizations**

* **By my signature below, I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and the physicians, staff, and hospitals associated with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care.**
* **I understand that I must check one or more of the following types of health information to indicate that I authorize that information type to be released to the necessary insurance companies, third party payers, and/ or other physicians and/or healthcare entities required to participate in my care. By checking on or more of the following boxes, the health information I authorize to be released may include any of the following:**
* **Diagnosis, evaluation, and/or treatment for alcohol and/or drug abuse.**
* **Records of HTLV-III or HIV testing (AIDS test) result, diagnosis, and/or drug abuse.**
* **Psychiatric and/or psychological records, or evaluation and/or treatment for mental, physical, and/or emotional illness, including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluations.**
* **By my signature below, I hereby authorize assignment of financial benefits directly to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.**
* **By my signature below, I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_personnel to communications by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.**

**I have read, and agree to the provisions of this Patient Financial Responsibility Form:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**Signature of Patient or Guardian Date**

**Waiver of Patient Authorizations**

**I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**Signature of Patient or Guardian Date**

**Man Q. Le, MD**

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**AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION**

|  |
| --- |
| **Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **LAST FIRST MIDDLE****Date of Birth: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_** **MM DA YYYY****Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,FL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Phone Number\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_****My Health Information To be Disclosed:****By signing this Authorization, I authorization South Florida Pain Relief Center to disclose the following health information about me:** * **A copy of my entire medical record and any other health information about me maintained by Provider.**
* **Other (Please Describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****My Sensitive Information to be Disclosed** **By checking any of the boxes below, I specifically authorize the Provider to use and disclose the type of information indicated next to the box pursuant to this Authorization.*** **Information about mental health services**
* **Information about HIV/AIDS testing or treatment (including the fact that an HIV test was ordered, performed or reported)**
* **Information about sexually transmitted diseases**
* **Information about alcohol or drug abuse treatment program services**
* **Information about DNA analysis or other genetic test results or information.**

**Recipient: Name of person or class of persons who may receive my health information from the Provider:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Address of the Recipient or delivery Location:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****TERM: This Authorization will remain effect:*** **From the date of this Authorization until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_.20 \_\_\_\_\_\_\_\_**
* **Until the Provider fulfills this disclosure request**
* **Until the following event occurs:**
* **Other:**

**Purpose: This Provider is authorized to use or disclose my health information identified above to the Recipient for the following specific purpose(s): (“At the request of the patient” is sufficient if the patient is initiating this Authorization.****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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**I understand that once the Provider discloses my health information to the recipient, the Provider cannot guarantee that the Recipient will not re-disclose my health information to a third party. Any third party may not be required to abide by this Authorization or applicable federal and state law protecting the privacy of my health information.**

**I understand that the Provider will not receive remuneration from a third pary for the use or disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Provider’s treatment of me.**

**I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Provider’s Privacy Office at the address notice revocation, except that the revocation will not have any effect on any use or disclosure of health information or other action of revocation.**

**If I have questions or wish to revoke his authorization, I may contact the Provider’s Privacy Officer at:**

**Privacy Officer**

**Jennifer Baldock**

**615-234-5900**

|  |
| --- |
| **I have read and understand this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, I authorize the Provider to use or disclose my health information (including the specified categories of my sensitive information) in manner described above.****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_****Signature of Patient Date** |

**If the patient is a minor or is otherwise unable to sign this Authorization, I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize the Prvider to use or disclose the patient’s health information (including the specified categories of sensitive information) in the manner described above.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_**

**Signature of Personal Representative Description of Authority Date**

**Man Q. Le, MD**

**1397 Medical Park Blvd, Suite 480**

**Wellington FL 33414**

**Phone: 561-791-1141 Fax: 561-296-3004**



**ACKNOWLEDGEMENT OF RECEIPT OF PROVACY NOTICE**

**I acknowledge that I have received the attached Privacy Notice.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**

**Patient or Personal Representative Signature Date**

**If Personal Representative’s signature appears above, please describe Personal Representative’s relationship to the patient:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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