Fabian A. Ramos, M.D.
FIPP, DABA, DABIPP, DABPM
John J. D'Auria, M.D.
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Jose E. Sarria, M.D.
DABA, DPM-ABA

Ramos Center
for Interventional & Functional Pain Medicine

First Name		Middle Initial	Last Name
Local Address		City, State, & Zip Code	
Date of Birth	Age	Sex: Male Female	Marital Status: Single Married Divorced Widowed
Preferred Language		Race	Ethnicity
Home Phone		Work Phone	Cell Phone
E-mail Address		Social Security No (For insurance & record keeping only)	
Employer		Occupation	
Guarantor Full Name/Person Responsible for Payment		Relation to Patient: Self Spouse Legal Guardian	
Whom may we thank for referring you to us: Insurance Advertisement Yellow pages Doctor, friend or family:			
Medical Insurance Co. Name		Medical Insurance ID/Contract Number	
Policy Holder/Insured's Full Name		Patient's relation to insured: Self Spouse Legal Guardian	
Policy Holder/Insured's Date of Birth		Insured's Employer Name	

Today's Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
By signing below, I acknowledge that I have viewed or have been given a copy of Notice of Privacy Practices. A copy of our Notice of Privacy Practices is posted in the reception/waiting area of our office.
NO SHOW FEE: Please give us 24 hours advance notice if you cannot make your appointment. A No-Show fee will be charged if you do not make your appointment and fail to give us advanced notice.

Patient or Patient representative_____ Date: _____

SIGN BELOW IF WE ARE BILLING INSURANCE ON YOUR BEHALF
I hereby authorize the physician to release any information required to process this claim. If the physician is accepting insurance, I also authorize my insurance benefits be paid directly to the physician, and I understand I am financially responsible for non-covered services. I authorize the use of this signature on all my insurance submissions.

Patient or Patient representative:_____ Date:_____

SIGN BELOW IF YOU HAVE MEDICARE PART B FOR YOUR HEALTH INSURANCE
I request that payment of authorized Medicare benefits be made to Fabian Ramos, M.D. for services rendered to my by him. I authorize any holder of medical information about me to be released to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits. I understand my signature request that payment be made and authorizes release of medical information necessary to pay this claim. If other health insurance is listed in Item 9 of the CMS 1500 or elsewhere, my signature authorizes release of medical information to the insurer or agency shown. In Medicare assigned cases, Fabian Ramos, M.D. agrees to accept the charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient or Patient representative: _____ Date:_____

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PRIVACY AUTHORIZATION & VERIFICATION

Please answer the following questions to help us protect your privacy.

1. Is it okay to leave a detailed message on your answering machine? **YES OR NO**
   Is it okay to leave a detailed message for you at Work? **YES OR NO**

   If the answer is **NO,** please let us know how you wish to be notified by our office:
   _____

2. Is it okay to release information to anyone **other than** you or a physician? **YES OR NO**

   If the answer is **YES,** please list each person, relationship to you, and contact phone number:
   Name: _____ Relationship: _____ Phone: _____
   Name: _____ Relationship: _____ Phone: _____

REMINDER! WE WILL <u>NOT</u> RELEASE INFORMATION TO ANYONE <u>NOT</u> LISTED ABOVE.

This is to verify that I have read and understand the above information. By signing this statement, I Authorize the Ramos Center and its' staff consent to release my medical information as described above.

I acknowledge that I have read a copy of the Ramos Center's Privacy Policy and have been given an opportunity to ask questions.

Signature: _____ Date: _____
Print Name: _____

Or person legally authorized to sign for the above-mentioned patient:

Signature: _____ Relationship: _____
Print Name: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION

I hereby request and authorize the Ramos Center to obtain the health records of:
Name _____ DOB _____

( ) All general medical records, including HIV/AIDS, substance abuse, and psychiatric records.

( ) Limited records (i.e. lab results, EKG, MRI, X-rays, CT, etc.)

To: **Ramos Center for Interventional & Functional Pain Medicine**
100 3rd Ave. West, Suite 110 Bradenton, FL 34205
Phone Number: (941) 708-9555 Fax Number: (941) 708-5465

PROHIBITION ON RE-DISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosures of such information without the express written consent of the person to who such information pertains, or as otherwise permitted by state law. With regard to HIV/AIDS, substance abuse, or psychiatric records; a specific written consent is required – a general authorization for the release of medical or other information is NOT sufficient for this purpose.

In the event these records are being requested other than for the personal use of the patient or an attending physician, a charge of $1.00 per page will be assessed in accordance with Florida State Statute 395.3025.

_____ _____
Date signed Signature or patient or authorized representative

Authorized Representative: ( ) Parent ( ) Surviving Spouse
( ) Legal Guardian/Administrator/Executor*
*If Legal Guardian, Administrator, or Executor, legal proof of this status must accompany this authorization.

The patient or authorized representative may revoke this authorization at any time after it is signed by submitting a written request to the facility.

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Information and Agreement Regarding Controlled Substances

We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of chronic pain and related anxiety and depression, which is strictly regulated by both state and federal agencies. The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of 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, you, the patient, as consideration for and a condition of the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain agree to the following policies:

This agreement is a tool to protect both you and your physician by establishing guidelines, within the laws, for proper controlled substance use. The words "we" and "our" refer to the facility, and the words "I", "you", "your", "me", or "my" refer to you, the patient.

1. I understand that chronic opioid therapy has been associated with not only addiction and abuse, but also multiple medical problems including the suppression of endocrine function resulting in low hormonal levels in men and women which may affect mood, stamina, sexual desire, and physical and sexual performance.

2. **For female patients:** If I plan to become pregnant or believe that I have become pregnant while taking this medication, I am aware that, should I carry the baby to delivery while taking these medications; the baby will be physically dependent upon opioids. I will immediately call my obstetrician and this office to inform them of my pregnancy. I am also aware that opioids may cause a birth defect, even though it is extremely rare.

3. I have been informed that long-term and/or high doses of pain medications may also cause increased levels of pain known as opioid induced hyperalgesia (pain medicine causing more pain) where simple touch will be predicted as pain and pain gradually increases in intensity and also the location with hurting all over the body. I understand that opioid-induced hyperalgesia is a normal, expected result of using these medicines for a long period of time. This may be helped with addition of non-steroidal anti-inflammatory drugs such as Advil, Ibuprofen, etc., or by reducing or stopping opioids.

4. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped, or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome.

5. 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, and could even result in heart attack, stroke, or death.

6. I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. 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 my doctor to choose another form of treatment, reduce the dose, or stop it.

7. All controlled substances must come from the physician whose signature appears below or during his/her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment).

8. I understand that I must tell the physician whose signature appears below or during his/her absence, the covering physician, all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death.

9. I will not seek prescriptions for controlled substances for chronic pain from any other physician, health care provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician's knowledge. Prescriptions for pain from a surgical procedure given by the surgeon, can be exceptions if all doctors informed in advance and authorized.

10. I also understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician or his/her staff or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed).

11. All controlled substances must be obtained at the same pharmacy, where possible, our office must be informed.

    The pharmacy that you have selected is: _____ Phone:_____.

12. 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.

13. You may not share, sell, or otherwise permit others to have access to these medications.

14. These drugs should not be stopped abruptly, as abstinence or withdrawal syndrome will likely develop.

15. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below or during his/her absence, by the covering physician, as set forth in Section 1 above. I will not use, purchase, or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance or any combination of substances (e.g., alcohol and prescription drugs), which impairs my driving ability, may result in DUI charges.

16. Unannounced urine or serum toxicology screens may be requested and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder and/or dismissal from this practice. I understand that the facility may call me for a pill count at any time. I will go the same day that I am called with the original vials and all remaining pills. If I don't go the same day, I might not be eligible to continue receiving these medications.

17. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescriptions. They should not be left where others might see or otherwise have access to them.

18. Original containers of their medications should be brought in to each office visit.

19. Since the drugs may be hazardous and/or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

20. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft an exception may be made.

21. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen, it will not be replaced unless an explicit narrative report detailed enough, naming all people that could have had access and the circumstances around it and is given to the authorities. A report on what you told the authorities is not enough. I will provide the complete and official police report.

22. Medication changes will not be made between appointments unless medically necessary, which will be determined by the physician. Early refills will generally not be given

23. Unscheduled "drop in" visits for prescription refills are not allowed, as the physicians are busy seeing scheduled patients.

24. Prescription refill requests may be phoned into the Ramos Center (941-708-9555) at least 48 hours prior to needing the refill.

25. Prescriptions <u>cannot be mailed</u> to you.

26. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends. Since this would be considered a next day call and 48 hours will apply from next day.

27. It should be understood that any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit.

28. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).

29. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.

30. I also understand that the prescribing physician has permission to discuss all diagnostic and treatment details, including medications, with dispensing pharmacists, other professionals who provide your health care or appropriate drug and law enforcement agencies for the purpose of maintaining accountability.

31. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

32. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at the facility and that law enforcement officials may be contacted. I affirm that I have full right and power to sign and to be bound by this agreement, that I have read it, and understand and accept all of its terms. A copy of this document has been given to me. A copy of this document is uploaded to RamosCenter.com for my review at any time.

_____	_____
Physician Signature	Patient Signature
_____	_____
Date	Patient Name (Printed)

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History & Physical **Date** _____

Patient Name: _____

Date of Birth: _____ Sex: _____ Age: _____ Height: _____ Weight: _____

R or L Handed (please circle) Occupation _____

Are you taking aspirin or any other blood thinner? Y N

Name of blood thinner (if yes) _____

Consultation: Requested by Dr. _____

Referral: Patient comes referred by _____

Primary Care Physician's Name _____

Worker's Compensation Case? Y N

Auto Accident? Y N

Represented by Attorney? Y N Attorney's Name _____

Lawsuit Pending? Y N

Chief Complaint: **(You may X more than one if applicable)**

- □ Leg pain □ Left □ Right □ Both
- □ Low back pain
- □ Neck pain
- □ Shoulder pain □ Left □ Right □ Both
- □ Thoracic pain
- □ Headache
- □ Other _____

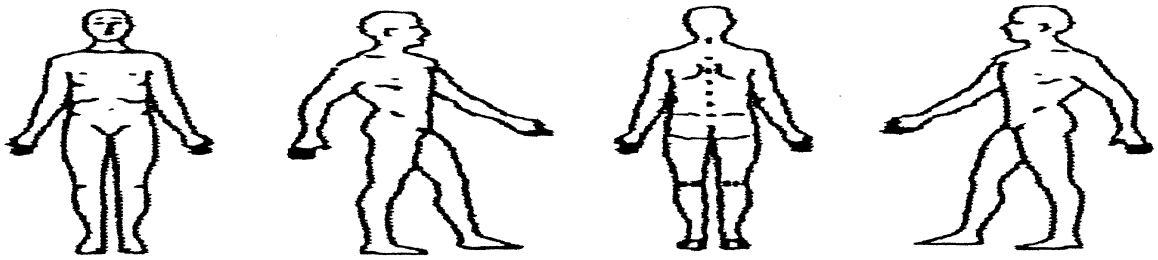
Physician use only: Reviewed: _____

History of Present Illness:

Location of Pain:

Physician use only: Reviewed: _____

On the diagram below **"SHADE"** all areas where you feel pain and **"X"** the areas that hurt the most.



Events associated with the onset of pain:

- □ Car accident □ Lifting □ Fall □ Work Related □ Unknown
- □ Other _____

When did the first sign/symptom occur? Year _____ Month _____

Quality of Pain: **Use one box per body site where you experience pain TODAY.**

(Example: one box for back, one for leg and another for neck)

Circle the words that **best** describe the pain at that site. Also indicate the intensity of the pain.

Body Site_____ Circle the words that best describe the pain

Sharp Numb Burning Intermittent Exhausting
Shooting Throbbing Cramping Continuous Miserable
Stabbing Aching Gnawing Penetrating Unbearable

Intensity Scale 0 1 2 3 4 5 6 7 8 9 10
No pain Worst Pain

Body Site _____ Circle the words that best describe the pain

Sharp Numb Burning Intermittent Exhausting
Shooting Throbbing Cramping Continuous Miserable
Stabbing Aching Gnawing Penetrating Unbearable

Intensity Scale 0 1 2 3 4 5 6 7 8 9 10
No pain Worst Pain

Body Site _____ Circle the words that best describe the pain

Sharp Numb Burning Intermittent Exhausting
Shooting Throbbing Cramping Continuous Miserable
Stabbing Aching Gnawing Penetrating Unbearable

Intensity Scale 0 1 2 3 4 5 6 7 8 9 10
No pain Worst Pain

Modifying Factors: **Circle the number below that best describes the amount of pain relief that treatment is providing or has provided in the past.**

	Never Tried	No Relief	Complete Relief	✓ If Receiving Now
Physical Therapy	□	0 1 2 3 4 5 6 7 8 9 10		□
Surgery	□	0 1 2 3 4 5 6 7 8 9 10		□
Injection/Nerve Block	□	0 1 2 3 4 5 6 7 8 9 10		□
Drug/Medication Therapy	□	0 1 2 3 4 5 6 7 8 9 10		□
Chiropractic Adjustment	□	0 1 2 3 4 5 6 7 8 9 10		□
TENS	□	0 1 2 3 4 5 6 7 8 9 10		□
Acupuncture	□	0 1 2 3 4 5 6 7 8 9 10		□
Biofeedback	□	0 1 2 3 4 5 6 7 8 9 10		□

Physician use only: _____

_____

_____

_____

_____

Does any of the following make your pain worse?

Y N Coughing or sneezing
Y N Sitting If yes, after how many minutes? _____
Y N Standing If yes, after how many minutes? _____
Y N Walking If yes, after how many minutes? _____
Y N Physical activity If yes, what types?_____
Y N Do you use either a cane or walker because of your pain?
Y N Do you lean on a shopping cart or a counter to help decrease your pain?

Do you have any of the following symptoms where your pain is?

Y N Numbness or Tingling ("pins and needles")
Y N Bladder or Bowel problems (incontinence or leakage without your control)
Y N Muscle spasms or cramps ("Charley horses")
If yes, are these at night or during the day? _____
Y N Muscle Weakness

Specific Studies Done: (circle)

MRI X-Rays CT/Myelogram Bone Scan

Previous Pain Treatment Procedure:

Date	Procedure	Physician	Phone#	Facility where performed	Any help/relief?

Review of Systems: **Signs & Symptoms that you have TODAY** (circle all that apply)

Cardiovascular:	chest pain	palpitations	poor circulation	
Constitutional:	fever	chills	nausea	vomiting
Pulmonary:	cough			
Hepatic:	yellow eye	bleeding	jaundice	
Renal:	kidney stones	blood in urine	pain upon urination	
Endocrine:	high blood sugar	low blood sugar	unexplained weight loss	
Gastrointestinal:	stomach upset	diarrhea	heartburn	
Neurological:	tremor	foot drop	paralysis	
Cancer:	abnormal mass or lump			
Musculoskeletal:	arthritis	joint stiffness	pain	
Visual problems:	wear glasses or contacts			
Hearing problems:	hearing aids	hearing loss		
Psychiatric:	hallucinations	suicide attempts	nervous breakdown	

Past Medical History: Please check Medical problems you have had in the past or still have

Yes	No	Cardiovascular Disease
□	□	Heart Attack
□	□	High Blood Pressure
□	□	Low Blood Pressure
□	□	Chest Pain/Angina
□	□	Arrhythmias or Palpitations
□	□	Heart Failure
□	□	Valvular Disease
□	□	Pacemaker
□	□	Shortness of breath when climbing stairs
□	□	Angioplasty

Other _____

Yes	No	Pulmonary Disease
□	□	Asthma
□	□	Emphysema/COPD
□	□	Lung Surgery
□	□	Bronchitis
□	□	Sleep Apnea

Other _____

Yes	No	Neurologic Disease
□	□	Seizures/Epilepsy
□	□	Stroke
□	□	Mini-Stroke/TIA
□	□	Alzheimer's
□	□	Parkinson's
□	□	Multiple Sclerosis

Other _____

Yes	No	Gastrointestinal Disease
□	□	Acid Reflux/GERD
□	□	Hiatal Hernia
□	□	Gastric Ulcer

Other _____

Yes	No	Cancer
□	□	Location_____

Yes	No	Skin Disease
□	□	Psoriasis

Yes	No	Blood Disease
□	□	Sickle Cell Anemia
□	□	Clotting/Bleeding Problems

Other_____

Yes	No	Kidney Disease
□	□	Kidney Failure

Last Dialysis _____

Other _____

Yes	No	Endocrine Disease
□	□	Diabetes (High Blood Sugar)
□	□	Thyroid Problems

Yes	No	Musculoskeletal Disease
□	□	Fibromyalgia/Chronic Fatigue Syndrome
□	□	Arthritis
□	□	Raynaud's Disease
□	□	Scoliosis
□	□	Lupus
□	□	Osteoporosis

Other_____

Yes	No	Psychiatric Disease
□	□	Depression
□	□	Anxiety
□	□	Drug Addiction
□	□	Suicidal Ideas/Attempts
□	□	Child Abuse
□	□	Eating Disorders

Yes	No	Immunologic Disease
□	□	HIV

Yes	No	Liver Disease
□	□	Hepatitis/Jaundice

Other _____

Other Significant Medical Conditions/Diseases

_____

_____

Family History: Describe any relevant medical history in you family that relates to your chronic pain

_____

_____

_____

Previous Surgeries: (Year and surgery performed)

_____
_____
_____
_____

Medications: (currently used)

_____
_____
_____
_____

Herbs: (over-the-counter): _____

Medications that you have tried in the past for your chronic pain and you no longer take:

Medication	Reason you are no longer taking it
_____	_____
_____	_____
_____	_____
_____	_____

Allergies:

Allergic to Latex?	Y	N
Allergic to Iodine or Shellfish?	Y	N
Allergic to IV Dye or Contrast Dye?	Y	N
Allergic to Medication?	Y	N

List ALL Medications to which you are allergic to: _____
_____

Social History: □ Single □ Married □ Divorced □ Widowed □ Children How Many? ____

Domestic Situation:
Do you live alone? Y N
Are there any substance abuse issues in the household? Y N
If yes, please explain_____
Are you able to take care of yourself? Y N
If no, please enter name of caregiver _____

Employment:
Employed? Y N
If yes, please describe job performed _____
Years worked? _____ Why did you leave? _____

Substance Abuse: **Next to each drug or substance that you circle, indicate if you use or have used:**
Never (N) Infrequently (I) Frequently (F) Regularly (R)

Which of the following drugs or substances, if any, have you used in the **past**? (circle all that apply)
Alcohol_____Barbiturates_____Cocaine_____Heroin_____Amphetamines_____Marijuana_____

Are you **presently** using any of the following drugs or substances? (circle all that apply)
Alcohol_____Barbiturates_____Cocaine_____Heroin_____Amphetamines_____Marijuana_____

Smoke?: □ Y □ N _____Packs/Per day _____Years □ Quit When? _____

Are you or could you be pregnant?: □ Y □ N □ Not Applicable

Patient's signature _____ **Date** _____

Physical Examination: B/P _____ P _____ R _____

GENERAL	SKIN	NECK	CARDIO
____ A & O X 3 ____ Affect proportionate ____ Attention span good Ambulatory Status: □ Normal □ Limited □ Cane □ Walker □ Wheelchair ____ Well Nourished ____ No Acute Distress ____ Distress □ mild □ moderate □ severe Due to _____ _____	____Normal turgor ____No rashes ____No sign of infection ____No significant lesions ____ Trophic changes	____Supple ____FROM ____Adenopathy ____Thyromegaly ____Bruits R L ____JVD ____Pain: □ w/flexion □ w/extension □ w/lat flexion □ w/rotation □ against resistance Trigger Points: _____ _____	_____Normal Rate _____Reg rhythm ____S1, S2 WNL ____S3 ____S4 ____Murmur ____Peripheral pulses palpable □ upper □ lower
	HEENT		RESPIRATORY
	____Normocephalic ____PERRLA ____EOMI ____Conversational Hearing WNL ____Throat unremarkable		____CTA, BBS ____Rales ____Rhonchi ____ Wheezing ____Thorax NL
NEURO	VASCULAR	MUSCULOSKELETAL	BACK
____Motor intact □ upper □ lower ____Sensory intact □ upper □ lower ____CN II-XI WNL ____Cerebellar WNL ____Speech WNL ____Gait WNL ____Leg extension test: L_____ R_____ ____DTR's:	____Varicose veins ____Venous insufficiency ____Stasis Ulcer R L ____Cap refill seconds _____ ____Color WNL ____ Temperature to touch WNL ____Acrocyanosis ____Extremity Edema	ROM: ____upper ____active ____passive ____upper ____active ____passive ____Symmetrical strength ____Symmetrical tone ____DJD changes ____Muscle spasm	____Spine straight ____Kyphosis ____Scoliosis ____Levo ____Dextro Levels _____ ____Spinous processes: □ tender □ nontender ____Paraspinal muscle tenderness Facet maneuvers: C T L SIJ maneuvers: Deep palpation _____ Patrick's Test _____ ____Piriformis recess tenderness ____Trochanteric bursa tenderness ____Gluteal tenderness
	ABDOMEN	TRIGGER POINTS	
	____Soft ___NTND ____Rebound ____Bowel Sounds ____Organomegaly ____Scars ____Hernia	_____ _____ _____ _____	

	B	BR	T	P	A
L					
R					

Impression – Differential Diagnosis: _____

Last UDS Date: _____

Plan: _____

PATIENT RECEIVED THESE MEDICATIONS TODAY

Medication	**Quantity**	**Patient's Signature**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

Physician Signature Date Provider Signature Date

Fabian A. Ramos, MD
John A. D'Auria, MD
Jose E. Sarria, MD
100 3rd Ave W Suite 110 Bradenton, FL 34205
5741 Bee Ridge Road Suite 550 Sarasota, FL 34233
Phone: (941) 708-9555 Fax: (941) 708-5465

Ramos Center
for Interventional & Functional Pain Medicine

CONSENT FOR URINARY DRUG SCREEN TEST

PATIENT NAME: _____ DOB: _____

DATE OF SERVICE: _____ MRN # : _____

I CERTIFY THAT I VOLUNTARILY CONSENT TO THE COLLECTION AND TESTING OF MY SPECIMEN, THAT THE SPECIMEN IDENTIFIED ON THIS FORM IS MY OWN; IT IS FRESH AND HAS NOT BEEN ADULTERATED IN ANY MANNER.

I CERTIFY THAT THE INFORMATION PROVIDED ON THIS FORM AND ON THE LABEL AFFIXED TO THE SPECIMEN IS CORRECT.

I FURTHER AUTHORIZE THE RAMOS CENTER TO RELEASE THE RESULTS OF THIS TEST AND MY SPECIMEN TO A CERTIFIED TESTING LABORATORY SHOULD IT BECOME NECESSARY TO QUANTIFY OR CONFIRM THE RESULTS OF THIS TEST OR TO PERFORM ADDITIONAL TESTS.

I AUTHORIZE THE RAMOS CENTER TO BILL MY INSURANCE PROVIDER AND TO RECEIVE PAYMENT OF BENEFITS FOR THIS TEST. THIS AUTHORIZATION INCLUDES THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

I AUTHORIZE THE RAMOS CENTER TO COPY AND SEND THE RESULTS OF THIS TEST TO ANY PHYSICIANS INVOLVED IN MY CARE.

IF THE SAMPLE PROVIDED DOES NOT FALL WITHIN THE ACCEPTABLE RANGE FOR FRESH URINE SAMPLE, I WILL PROVIDE A NEW SAMPLE.

_____ _____ _____
Signature of Patient or Guardian Witness Date

The patient is unable to sign due to_____ and the undersigned, who is the

_____ hereby consents for the patient.

FOR OFFICE USE ONLY! FOR OFFICE USE ONLY! FOR OFFICE USE ONLY! FOR OFFICE USE ONLY!

Patient Denies use of THC _____ Patient Admits use of THC _____ Patient Admits use of: _____

Medications Patient is Prescribed			
Oxycodone	Oxycontin	Clonazepam	Xanax
Morphine	Opana	Amitriptyline	Lorazepam
Hydrocodone	Fentanyl	Soma	Diazepam
Methadone	Butrans	Lyrica	Other:
Nucynta	Hydromorphone	Fioricet	Other:

☐ HCL Confirmation ☐ Send out for confirmation ☐ URGENT(Need results within 45 days)

A. Notifier: Ramos Center
B. Patient Name:
C. Medical Record Number:

Ramos Center
for Interventional &
Functional Pain Medicine

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

Note: If Medicare or other insurance does not pay for Anesthesia, or any other medical care deemed necessary by our provider you may be responsible for payment. We may expect your insurance may not pay for the Anesthesia for the reasons below.

D. Anesthesia
E. Reason Medicare May Not Pay: Non-Coverage
F. Estimated cost: $150 (we cap anesthesia services at $150 if your insurance does not pay).

What you need to know:

Read this notice, so you can make an informed decision about your care. Ask us any questions that you may have after you finish reading. Choose an option below about whether to receive the Anesthesia listed above.
Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare or any other insurance cannot require us to do this.

G. OPTIONS:

Check only one box. We cannot choose a box for you.

O Option 1. I want the Anesthesia listed above. You may ask to be paid now, but I also want Medicare or any other insurance billed for an official decision on payment, which is sent to me on a Summary of Notice. I understand that if my insurance does not pay, I am responsible for payment, but I can appeal to my insurance by following the directions. If my insurance does pay, the practice will refund any payments made, less co-pays or deductibles. Even if my insurance does pay. they may change the decision later and request a refund.

O Option 2. I want the Anesthesia listed above, do not bill my insurance. You may ask to be paid now as you are responsible for payment. I cannot appeal if my insurance is not billed.

O Option 3. I don't want the Anesthesia listed above. I understand that with this choice I am not responsible for payment and I cannot appeal to see if my insurance will pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare or any other insurance decision. Signing below means that you have received and understand this notice. You will also receive a copy.

_____ _____ _____
Signature Date

Ramos Center
for Interventional & Functional Pain Medicine

Behavioral Health Screening Questionnaire

Name: _____ Age: _____ Date: _____ Physician: _____

Instructions: The following questionnaire should take less than 5 minutes to complete. This information is vital in your pain management care to better assist you in improving your ability to manage and cope with your pain. The questions address issues regarding how your pain may affect your emotional coping, stress, memory, and alcohol and other substance use. Please do your best to answer **every** question by circling either **YES** or **NO**. The questions relate to how you have been functioning over the past year unless otherwise indicated. ***All information obtained on this questionnaire is confidential and will not be shared with anyone without your consent.***

YES	NO	I sometimes think that I or my family would be better off without me around.
YES	NO	I have thought seriously in the past year of harming myself.
YES	NO	My pain is significantly affecting my relationships with my family.
YES	NO	I cry more than I used too.
YES	NO	I find myself irritable, anxious, or nervous a great deal of the time.
YES	NO	My mood has been down for most of the past month.
YES	NO	My mood and my pain are directly related (My mood improves when my pain is less; my mood is worse as my pain gets worse).
YES	NO	Almost the only thing I think about is whether my pain will get better.
YES	NO	I am certain that my situation will never get any better.
YES	NO	I expect my pain to always be what it is now.
YES	NO	I feel I need more support from my family in terms of helping me deal with my pain.
YES	NO	I feel like a burden to my family.
YES	NO	I feel like a failure.
YES	NO	I sleep poorly not just due to pain but also due to what's going through my mind.
YES	NO	I feel like I have no control over my life.
YES	NO	I have difficulty dealing with all the problems in my life.
YES	NO	I have difficulty coping with stress.
YES	NO	There are times now that I feel that I am or about to panic.

YES NO When I feel panicky, my heart races, my hands tremble, or my hands get sweaty.

YES NO I sometimes drink too much.

YES NO I have a history of alcohol or drug problems.

YES NO I frequently have had more to drink or have taken more medication than I intended.

YES NO I have been treated for anxiety or depression sometime in the past 2 years with medication or mental health treatment.

YES NO In the past year, I have had to deal with alcohol or drug problems brought on by family (children, spouse, parents, siblings) or close friends.

YES NO I sometimes use marijuana, alcohol or another non-prescribed drug to help my pain.

YES NO I sometimes use marijuana, alcohol or another non-prescribed drug to help my nerves.

YES NO I would like to stop smoking cigarettes but feel that I need some help to do this.

YES NO I need to drink in order to express my feelings.

YES NO I become more depressed after I have sobered.

YES NO I typically have 3 or more drinks at least twice per week.

YES NO Do you currently have a psychologist? If yes, name: _____

YES NO Do you currently have a psychiatrist? If yes, name: _____