

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



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 me 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: \_\_\_\_\_

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



## 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:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**REMINDER! WE WILL NOT RELEASE INFORMATION TO ANYONE NOT LISTED ABOVE.**

**DISCLOSURE:** I UNDERSTAND THAT THIS IS PROVIDED FOR MY PROTECTION AND THAT **NO** STAFF MEMBER OR ASSISTANT OTHER THAN DR. RAMOS IS AUTHORIZED TO GIVE MEDICAL ADVICE.

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: \_\_\_\_\_



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



### **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 cannot be mailed 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](http://RamosCenter.com) for my review at any time.

---

Physician Signature

---

Patient Signature

---

Date

---

Patient Name (Printed)

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

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

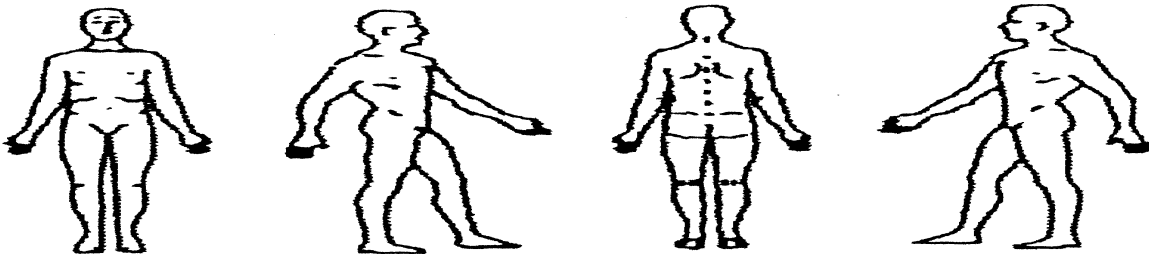
Physician use only: Reviewed: \_\_\_\_\_

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





**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

<b>Yes</b>	<b>No</b>	<b>Cardiovascular Disease</b>	<b>Yes</b>	<b>No</b>	<b>Skin Disease</b>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<b>Yes</b>	<b>No</b>	<b>Blood Disease</b>
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Clotting/Bleeding Problems
<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmias or Palpitations	Other _____		
<input type="checkbox"/>	<input type="checkbox"/>	Heart Failure	<b>Yes</b>	<b>No</b>	<b>Kidney Disease</b>
<input type="checkbox"/>	<input type="checkbox"/>	Valvular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Failure
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	Last Dialysis _____		
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath when climbing stairs	Other _____		
<input type="checkbox"/>	<input type="checkbox"/>	Angioplasty	<b>Yes</b>	<b>No</b>	<b>Endocrine Disease</b>
Other _____			<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (High Blood Sugar)
<b>Yes</b>	<b>No</b>	<b>Pulmonary Disease</b>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<b>Yes</b>	<b>No</b>	<b>Musculoskeletal Disease</b>
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia/Chronic Fatigue Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Lung Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Raynaud's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
Other _____			<input type="checkbox"/>	<input type="checkbox"/>	Lupus
<b>Yes</b>	<b>No</b>	<b>Neurologic Disease</b>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	Other _____		
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<b>Yes</b>	<b>No</b>	<b>Psychiatric Disease</b>
<input type="checkbox"/>	<input type="checkbox"/>	Mini-Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal Ideas/Attempts
Other _____			<input type="checkbox"/>	<input type="checkbox"/>	Child Abuse
<b>Yes</b>	<b>No</b>	<b>Gastrointestinal Disease</b>	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux/GERD	<b>Yes</b>	<b>No</b>	<b>Immunologic Disease</b>
<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>	HIV
<input type="checkbox"/>	<input type="checkbox"/>	Gastric Ulcer	<b>Yes</b>	<b>No</b>	<b>Liver Disease</b>
Other _____			<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice
<b>Yes</b>	<b>No</b>	<b>Cancer</b>	Other _____		
<input type="checkbox"/>	<input type="checkbox"/>	Location _____	<b>Other Significant Medical Conditions/Diseases</b>		
_____					
_____					

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Physical Examination:**

B/P \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_

<b>GENERAL</b> ___ A & O X 3 ___ Affect proportionate ___ Attention span good Ambulatory Status: <input type="checkbox"/> Normal <input type="checkbox"/> Limited <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair ___ Well Nourished ___ No Acute Distress ___ Distress <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe Due to _____ _____	<b>SKIN</b> ___ Normal turgor ___ No rashes ___ No sign of infection ___ No significant lesions ___ Trophic changes <hr/> <b>HEENT</b> ___ Normocephalic ___ PERRLA ___ EOMI ___ Conversational Hearing WNL ___ Throat unremarkable	<b>NECK</b> ___ Supple ___ FROM ___ Adenopathy ___ Thyromegaly ___ Bruits R L ___ JVD ___ Pain: <input type="checkbox"/> w/flexion <input type="checkbox"/> w/extension <input type="checkbox"/> w/lat flexion <input type="checkbox"/> w/rotation <input type="checkbox"/> against resistance Trigger Points: _____ _____	<b>CARDIO</b> ___ Normal Rate ___ Reg rhythm ___ S1, S2 WNL ___ S3 ___ S4 ___ Murmur ___ Peripheral pulses palpable <input type="checkbox"/> upper <input type="checkbox"/> lower <hr/> <b>RESPIRATORY</b> ___ CTA, BBS ___ Rales ___ Rhonchi ___ Wheezing ___ Thorax NL																		
<b>NEURO</b> ___ Motor intact <input type="checkbox"/> upper <input type="checkbox"/> lower ___ Sensory intact <input type="checkbox"/> upper <input type="checkbox"/> lower ___ CN II-XI WNL ___ Cerebellar WNL ___ Speech WNL ___ Gait WNL ___ Leg extension test: L _____ R _____ DTR's: <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width:10%;"></td> <td style="width:10%;">B</td> <td style="width:10%;">BR</td> <td style="width:10%;">T</td> <td style="width:10%;">P</td> <td style="width:10%;">A</td> </tr> <tr> <td>L</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>R</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		B	BR	T	P	A	L						R						<b>VASCULAR</b> ___ Varicose veins ___ Venous insufficiency ___ Stasis Ulcer R L ___ Cap refill seconds _____ ___ Color WNL ___ Temperature to touch WNL ___ Acrocyanosis ___ Extremity Edema <hr/> <b>ABDOMEN</b> ___ Soft ___ NTND ___ Rebound ___ Bowel Sounds ___ Organomegaly ___ Scars ___ Hernia	<b>MUSCULOSKELETAL</b> ROM: ___ upper ___ active ___ passive ___ upper ___ active ___ passive ___ Symmetrical strength ___ Symmetrical tone ___ DJD changes ___ Muscle spasm <hr/> <b>TRIGGER POINTS</b> _____ _____ _____ _____	<b>BACK</b> ___ Spine straight ___ Kyphosis ___ Scoliosis ___ Levo ___ Dextro Levels _____ ___ Spinous processes: <input type="checkbox"/> tender <input type="checkbox"/> nontender ___ Paraspinal muscle tenderness Facet maneuvers: C T L SII maneuvers: Deep palpation _____ Patrick's Test _____ ___ Piriformis recess tenderness ___ Trochanteric bursa tenderness ___ Gluteal tenderness
	B	BR	T	P	A																
L																					
R																					

**Impression – Differential Diagnosis:** \_\_\_\_\_

**Last UDS Date:** \_\_\_\_\_

**Plan:** \_\_\_\_\_

**PATIENT RECEIVED THESE MEDICATIONS TODAY**

<u>Medication</u>	<u>Quantity</u>	<u>Patient's Signature</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician Signature

Date

Provider Signature

Date

**Fabian A. Ramos, MD**

**John A. D'Auria, MD**

**Jose E. Sarria, MD**

100 3<sup>rd</sup> Ave W Suite 110 Bradenton, FL 34205

5741 Bee Ridge Road Suite 550 Sarasota, FL 34233

Phone: (941) 708-9555 Fax: (941) 708-5465



**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!!!

## 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: \_\_\_\_\_



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



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.

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.

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.

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