HEADACHE & PAIN
CENTER OF PALM BEACH

Medical History

Name: _____ Age: _____ SS#:_____ Date:_____

Height: _____ Weight: _____ **Left** or **Right** Handed (circle one) Occupation: _____

Reason for Visit: _____

Approximate date of onset: _____ If injury, how did it happen: _____

Known Health Problems: (Please list)_____

All Surgery or Operations: _____

Please list all **prescription and non-prescription medications** you are taking. If none please write **"None"**

Medication:_____ **Dose:**_____ **Frequency:**_____ **Medication:**_____ **Dose:**_____ **Frequency:**_____

Medication:_____ **Dose:**_____ **Frequency:**_____ **Medication:**_____ **Dose:**_____ **Frequency:**_____

Medication:_____ **Dose:**_____ **Frequency:**_____ **Medication:**_____ **Dose:**_____ **Frequency:**_____

Medication Allergies: **(If none write "None")**_____ **Women: Any chance of pregnancy? Yes ☐ No ☐**

Do you smoke? (How much per day)_____ **Alcohol Consumption**: Daily____Weekly____Monthly___Size_____

Substances: Which of the following drugs or substances, if any, have you used in the past? (Circle all that apply)
Next to each substance that you've circled, indicate if you used it **Occasionally**"**O**" **Frequently**"**F**" **Continuously**"**C**"

Alcohol_____ Barbiturates_____ Cocaine_____ Heroin_____ Amphetamines_____ Marijuana_____ Painkillers_____

Other: _____

Are you presently using any of the drugs or substances below? (Circle all that apply)
Alcohol Barbiturates Cocaine Heroin Amphetamines Marijuana Painkillers Other: _____

Have you ever been treated for or had a professional recommend treatment for alcohol or substance abuse? **Yes ☐ No ☐**

In your opinion, do you have or have you ever had a problem with alcohol or other drugs? Yes ☐ No ☐

Please **describe the type of work** that you do: _____

If you feel **any other activities** may relate to your problem, please describe: _____

_____

Conditions: (Check all conditions you have or have had in the past)

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Pacemaker or Defibrillator
- ☐ Stroke
- ☐ Diabetes
- ☐ Asthma or Emphysema
- ☐ Aids or HIV
- ☐ Liver Disease or Hepatitis
- ☐ Kidney Disease
- ☐ Cancer: TYPE:_____
- ☐ Epilepsy
- ☐ Headaches
- ☐ Multiple Sclerosis
- ☐ Bleeding or Clotting Disorder
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Ulcer/Reflux
- ☐ Psychiatric Care
- ☐ Suicide Attempt
- ☐ Chemical Dependency
- ☐ Alcoholism
- ☐ Anemia
- ☐ Thyroid or Goiter
- ☐ Anorexia
- ☐ Prostate Problem
- ☐ Appendicitis
- ☐ Gout
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Hernia
- ☐ Tonsillitis
- ☐ Breast Lump
- ☐ Herpes
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ Cataracts
- ☐ Typhoid Fever
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Miscarriage
- ☐ Vaginal Infections
- ☐ Mononucleosis
- ☐ Venereal Disease

Review of Systems: (Check all conditions you have or have had in the past)

GENERAL

☐ Unexplained Changes in Weight ☐ Fever or Chill Sweats ☐ Change in Voice ☐ Tiredness

HEAD

☐ Headache ☐ Head Injury ☐ Visual Problems ☐ Hearing Problems ☐ Vertigo (Dizziness) ☐ Ear Pain
☐ Tinnitus (Ringing in Ears) ☐ Sinus Problems ☐ Dental Problems ☐ Any Mental Complaints

NEUROLOGICAL

☐ Head Pain ☐ Head Trauma/Injuries ☐ Seizures/Epilepsy ☐ Tingling (Pins & Needles) ☐ Loss of Consciousness ☐ Tremors/Shaking ☐ Pinched Nerve ☐ Difficulty Walking ☐ Weakness/Paralysis
☐ Numbness/Loss of Sensation ☐ Memory Problems ☐ Disorientation ☐ Difficulty Speaking
☐ Difficulty Swallowing ☐ Double Vision ☐ Loss of Vision ☐ Difficulty Writing ☐ Difficulty Reading

MUSCULAR / SKELETAL

☐ Muscle Aching ☐ Weakness ☐ Joint Swelling ☐ Joint Pain or Stiffness ☐ Neck Pain ☐ Arthritis
☐ Low Back Pain ☐ Injuries: (Specify) _____

SLEEP

☐ Insomnia ☐ Snoring (Excessive) ☐ Daytime Drowsiness (Excessive)

CARDIAC/VASCULAR/HEART

☐ Chest Pain ☐ Palpitations ☐ Heart Murmur ☐ Fainting ☐ Swollen Feet/Legs ☐ Blood Vessel Problems

LUNGS

☐ Coughing/Wheezing ☐ Shortness of Breath ☐ Coughing Up Blood

GASTRO-INTESTINAL

☐ Change in Appetite ☐ Digestion Problems ☐ Gas ☐ Nausea ☐ Vomiting ☐ Constipation
☐ Diarrhea ☐ Abdominal Pain

GENITAL/URINARY

☐ Difficulty Urinating ☐ Incontinence (Loss of Urine) ☐ Kidney Stones ☐ Urinary Infections ☐ Impotence
☐ Other Sexual Problems ☐ Women: Irregular Periods

SKIN/HAIR

☐ Change in Hair ☐ Skin or Scalp Lesions ☐ Rash ☐ Dryness ☐ Itching

ENDOCRINE/HEMATOLOGICAL ALLERGY IMMUNE

☐ Sensitivity to Temperature ☐ Unusual Thirst or Hunger ☐ Excessive Urination ☐ Bloating
☐ Swollen Glands ☐ Pale Color ☐ Multiple Allergies ☐ Frequent Colds/Infections

Family Medical History:

Known Health Problems — Age (or age at death if deceased)

Father: _____ _____
Mother: _____ _____
Sister: _____ _____
Brother: _____ _____
Child: _____ _____

☐ **Yes** ☐ **No** **Have you completed a course of Covid-19 Vaccination?**

☐ **Yes** ☐ **No** **Have you been infected with Covid-19? If yes, when?** _____

Patient Initials: _____ Reviewed by physician: _____

Date: _____ Date: _____

Pain Drawing

Name: _____ **Date**: _____

Date of Birth: _____ **Examiner**: _____

Tell Us Where You Hurt

Please read carefully:
Mark the areas on your body where you feel you pain. Include all affected areas. Mark areas of pain radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > >

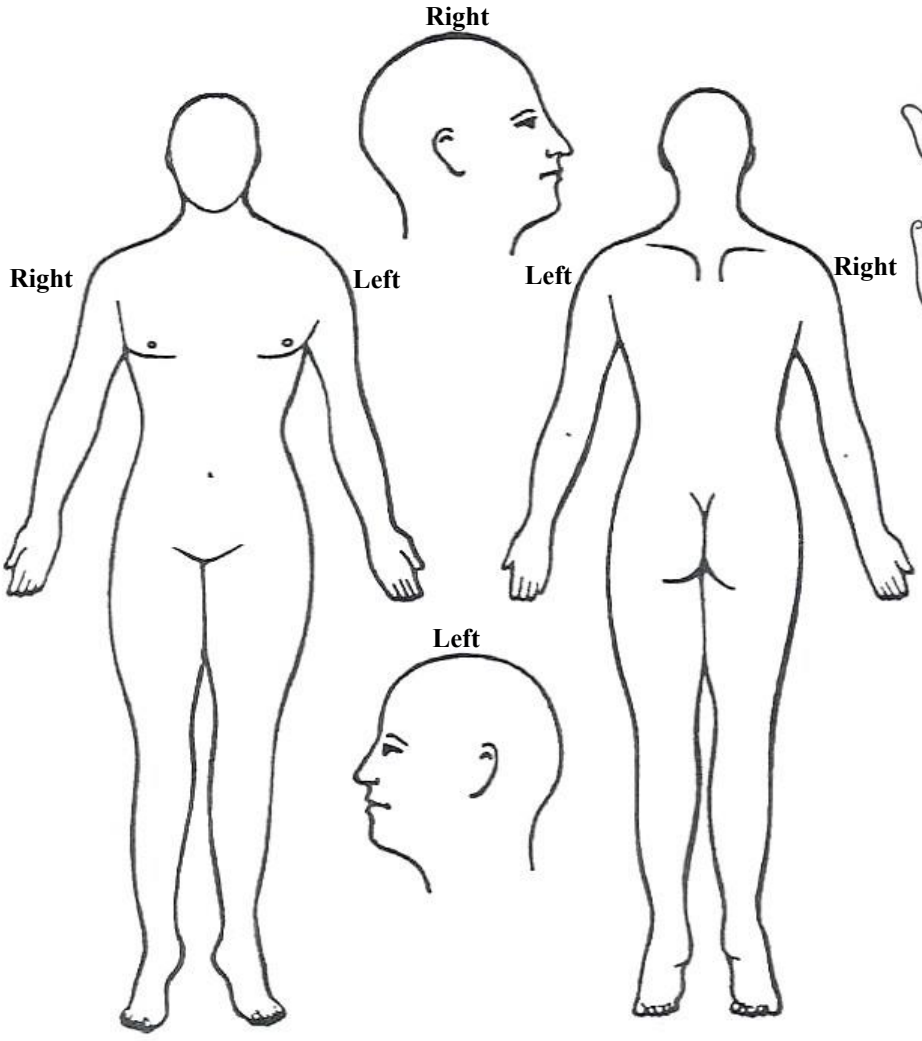
Numbness = = = =

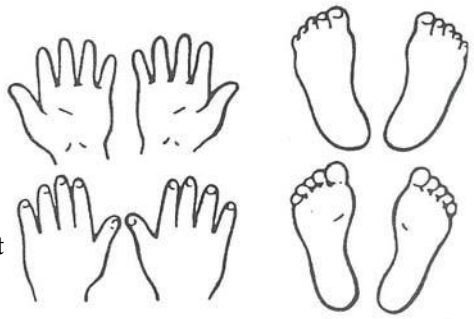
Pins and Needles o o o o
o o o o

Burning x x x x

Stabbing / / / /

Throbbing ~ ~ ~ ~





Severity of Pain

List the region of pain. Circle the severity number.
1=least pain, 10=greatest pain

ex: NECK
0 1 2 3 4 5 6 7 8 9 10

1. _____
0 1 2 3 4 5 6 7 8 9 10

2. _____
0 1 2 3 4 5 6 7 8 9 10

3. _____
0 1 2 3 4 5 6 7 8 9 10

4. _____
0 1 2 3 4 5 6 7 8 9 10

5. _____
0 1 2 3 4 5 6 7 8 9 10

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individuals also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check ALL that apply)

Home telephone_____
☐ O.K. to leave a message with details
☐ Leave message with call-back # only

Written Communication
☐ OK to mail my home
☐ OK to _____

Work Telephone_____
☐ O.K. to leave message with details
☐ Leave message with call-back only

Email
☐ OK to email messages such as appointment reminders at the email I previously provided.

Other:_____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorized request by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record

Note: Disclosures may be permitted without prior consent in an emergency.

Additionally, I have received and was given the opportunity to read the NOTICE OF PRIVACY PRACTICES for Headache and Pain Center of Palm Beach.

Robert J. Friedman, M.D./Headache & Pain Center, its Associates and staff have my permission to speak to the following family members/friends/employees/legal representatives in regards to my medical care:

#1_____ Relationship: _____

#2_____ Relationship:_____

#3_____ Relationship:_____

#4_____ Relationship:_____

Print Name:_____

Signature: _____ **Date**: _____

HEADACHE & PAIN
CENTER OF PALM BEACH

WELCOME TO ROBERT J. FRIEDMAN, M.D., P.A.

AUTHORIZATION AND FINANCIAL AGREEMENT

Insurance Coverage

HPC has made prior arrangements with several insurance companies. We will bill those plans with which we have an agreement and will only require you to pay the applicable co-payment or deductible at the time of service. If you have insurance coverage with a plan that we are not participating with, HPC will file insurance claims for you to your insurance for medical services. These patients are required to pay HPC in advance for the estimated cost of services and procedures.

Your insurance policy is a contract between YOU and your insurance company. All health plans are different and cover different services. In the event your insurance company determines a service to be "not covered or not medically necessary" or over the usual and customary charge, you will be responsible for the complete charge.

If you are a Medicare recipient with Supplemental or Secondary insurance that covers the Medicare 20% or Deductible, WE WILL FILE AS A COURTESY. If your Supplemental/Secondary insurance does not reimburse HPC within sixty (60) days, it will become your responsibility. If you have no supplement, or your supplement is with a company that we know does not "crossover" automatically from Medicare, you will be responsible for the 20% at the time of service.

Laboratory Testing

Patients requiring laboratory testing are sent to an outside lab facility that your insurance requires. These lab tests are done at and by its facility and HPC is not responsible for any billing related to those services. If you have any questions about lab or diagnostic test billing, it is your responsibility to contact these facilities direct, not us.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient for payment. This parent or guardian will be listed as the guarantor in our system.

Our Office Charges for the Following

Telephone calls from the doctor at the patient's request will fall under our TeleHealth Agreement. If you feel you may need these services in the future, please notify our Staff and an Agreement will be made available to you for your review and signature. TeleHealth consults are typically non-covered by insurance and would be your responsibility. Any and ALL forms to be filled out at your request will incur a fee of $10 and up; Patient's requesting a prescription refill by phone in lieu of office visit will cost $25.00. Returned check fees are $50.00.

Before and After Hour Appointments

Patient appointments before 8:30am and after 5:00pm will incur a charge of $50 for New Patients and $30 for Follow-Up appointments. This charge is not covered by insurances and is the patient's responsibility. You will be required to pay this fee in addition to any applicable copays or deductibles.

Cancelation Policy

With the understanding of the significant expenditures for equipment, treatment supplies, staffing, scheduling, and other costs, once appointments are scheduled the patient is responsible for keeping that appointment. Patients who cancel or miss an appointment without prior 48 hour notice will be charged a fee. Extenuating circumstances will be considered on an individual basis. The charges are as follows: Office Visits: New Patients: $ 150.00; Follow-up appointments $ 60.00; Procedures $130.00 If your appointment is canceled or rescheduled by HPC, you will not be charged for the canceled appointment. If you arrive at the office more than 30 minutes late, this will be considered a no-show in most instances. **Exceptions may be made for acute illness or other emergency only at the sole discretion of HPC.** This charge is not covered by insurances and is the patient's responsibility.

I authorize the patient's insurance company, attorney, or Medicare to pay direct to Robert J. Friedman, MD any medical expenses payable under the terms of the contract. I have read and understand the financial policy of Robert J. Friedman, M.D., P.A. and agree to be bound by its terms. Photocopies of this form will be valid. I also agree that any balance not covered will be paid by me. I understand that should this account be referred to an agency or attorney for collection that I will be responsible for all collection and court costs and attorney's fees. Delinquent accounts beyond 90 days are subject to the maximum interest allowed by law. I further authorize the physician in charge of the care of the patient to administer such medical care as may be deemed advisable in the diagnosis (and treatment) of this patient. I certify that the information I have reported with regard to my insurance coverage is true and accurate. If my insurance company has not paid or denied my claim in 30 days, I give Robert J. Friedman M.D. my consent to seek assistance and lodge complaints to the Insurance Commissioner's office on my behalf. I agree to the policies of this office and wish to be seen.

Print Name:_____ **Signature**: _____ **Date**: _____

HEADACHE & PAIN
CENTER OF PALM BEACH

Robert J. Friedman, MD PA
Board Certified in Neurology | Board Certified in Pain Management
Board Certified in Neuromuscular Medicine | Certified Independent Medical Examiner
TELEPHONE: 561-842-PAIN (7246) FACSIMILE: 561-408-0950
www.NewPainTreatments.com
5600 PGA Blvd | Suite 200 | Palm Beach Gardens, FL 33418

Authorization for Release of Protected Health Information

Patient Name: _____ **Date of Birth**: _____

Please accept this document as a formal request for patient information.

****PLEASE FAX RECORDS TO: (561)408-0950****

Please Disclose the Following to the Medical Provider Above:
Office Notes, Diagnostic Reports, Labs, Imaging, Surgical Notes, Hospitalizations and ER Notes
HOSPITAL _____

Sensitive Health Information:
By checking any of the boxes below, I do not imply any of these conditions are present but if so, I agree for their release. I specifically authorize the use and/or disclosure of the type of Protected Health Information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ Information about a Mental Illness or Developmental Disability
- ☐ Psychotherapy Notes
- ☐ Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- ☐ Information about Venereal Disease(s)
- ☐ Information about Alcohol/Drug Abuse Treatment
- ☐ Information about Abuse/Neglect of an Adult with a Disability
- ☐ Information about Sexual Assault
- ☐ Information about Child Abuse/Neglect
- ☐ Information about Genetic Testing

Expiration Date of Authorization This Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation.

I have read and understand the terms of 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, authorize the Practice to use or disclose my health information in the manner described above.

_____ _____
Patient Signature Date

If someone else is signing this Authorization on behalf of the Patient, please provide the following information:

_____ _____ _____
Legal Representative * Date Relationship to the Patient

Note: * Please provide written documentation to support your status as a legal representative and/or guardian.

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OFFICE TELEPHONE: 561-842-PAIN (7246)
FACSIMILE: 561-408-0950
www.PalmBeachPain.com

Telemedicine Informed Consent Form

Patient Name: _____ **Date of Birth**: _____

I, _____ (patient name), hereby consent to engaging in telemedicine with the medical providers at the Headache & Pain Center of Palm Beach as part of my medical treatment. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners. I understand that I have the following rights with respect to telemedicine:

- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
- The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my treatment is confidential.
- I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my medical provider, that the transmission of my medical information could be disrupted or distorted by technical failures.
- In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services.
- I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

I have read and understand the terms of this Consent 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, authorize the Practice to use or disclose my health information in the manner described above.

_____ _____
Patient Signature Date

If someone else is signing this Authorization on behalf of the Patient, please provide the following information:

_____ _____ _____
Legal Representative * Date Relationship to the Patient

Note: * Please provide written documentation to support your status as a legal representative and/or guardian.