Padmaja Yatham, MD
Interventional Pain Management & Addiction Therapy
- 7000 SW 97th Ave, Suite 214, Miami, FL 33173
- 14601 SW 29th ST, STE 103, Miramar, FL 33027

Tel: 786-780-1800, Fax: 786-780-2500
www.ApolloPainCare.com

Welcome To Apollo Pain Care

Your appointment is on __/__/___, at _____ AM / PM for Pain Management Consultation / Injections / EMC from your Therapy Center.

Please be sure to bring all the available items as listed below for your appointment.

1. Films: MRI, CT scan Films must be current. Have your referring doctor or PCP send all medical records to via **fax at 786-780-2500 or email: Fax@ApolloPainCare.com**
2. Driver's License or Valid Government Photo ID and Your Health Insurance card
3. Please complete all the sections of the Patient information and Medical History forms enclosed in the packet prior to arriving for your appointment to speed up your registration and consultation

Directions to our Sunset/Kendall Office in **Miami**:

Sunset Int'l Center Building
7000 SW 97th Ave #214, Miami, FL 33173
- It's at the intersection with SW 97th Ave and Sunset Dr
- Behind CVS Pharmacy, Opposite the 7-11 Store
- Use Free Valet Service, if needed for parking

Directions to our **Miramar** Office

Palm Gardens at Miramar Building
14601 SW 29th St (Hotel Rd), Ste 103
Miramar, FL 33027
- Go East on Miramar Parkway from I-75
- North / left at SW 148th Ave at Chevron Gas
- Right on SW 29th St (Hotel Rd)
- We are next to Public Storage Building

Visit our website at www.ApolloPainCare.Com to know about our providers and services. We have video animations of some of the services we provide.

Revised on 06/12/2019

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Patient Information - Demographics

PATIENT INFORMATION					
Today's Date / /	Name (Last)		First	M.I.	Gender M / F
SSN	Date of Birth / /	Age ___ years	Marital Status: S / M / W/ Divorced/Separated/Partnered	Height: Ft/In	Weight: Lb
Address City, State, ZIP			Preferred Contact: E-mail / Cell / Home / Work		
Email:	Cell Tel:		Home:	Work:	
Emergency Contact Name				Relationship to Patient	
Number					

Race:	**Ethnicity:**	**Smoker:**	**Preferred Language:**
☐ American Indian or Alaska Native ☐ African American or Black ☐ Asian ☐ Caucasian or White ☐ Native Hawaiian / Other Pacific Islander ☐ Other Race _____	☐ Hispanic or Latino ☐ Not Hispanic ☐ Other	☐ Current Every day ☐ Current Some days ☐ Former Smoker ☐ Never Smoked	☐ English ☐ Spanish ☐ Other

Work Status: If employed, Employer's Name, required: Job Title: Duties:	☐ Unemployed ☐ Student ☐ Retired	☐ Worker's Comp ☐ Disability

REFERRAL INFORMATION / TREATING PHYSICIAN INFORMATION	
Primary **C**are **P**hysician:	Phone
Who Referred You?	Phone
Current Treating Physician(s)	Phone
Are you currently being treated by another Pain Management Doctor: Yes / No, Details:	

PHARMACY INFORMATION	
Pharmacy Name/City	Phone

****We do not accept MEDICAID and its products as Primary or Secondary Insurance ****

PRIMARY HEALTH INSURANCE INFORMATION (Please Provide this, even if your visit is injury related)		
Insurance Name	Policy Number	Group Number
Claims Address City, State, ZIP	Phone Number	
Primary Subscriber, if different	Date of Birth	Relation to patient

SECONDARY HEALTH INSURANCE INFORMATION (Please Provide this, even if your visit is injury related)		
Insurance Name:	Policy Number	Group Number
Claims Address City, State, ZIP	Phone Number	
Primary Subscriber, if different	Date of Birth	Relation to patient

Are you involved in any **pending litigation**, related to any type of **injury** / treatment by **another provider**?	**YES / NO**	Explain

AUTO, WORKER'S COMP PATIENTS, SLIP AND FALL		
Circle where you were injured Auto / Work / Slip and Fall / Others	Date of Injury	Details:
Represented by Attorney? Attorney's Name and Phone #	Adjuster Name and Phone # Case Manager's Name and Phone #	

Patient Information – History & Physical

PAIN HISTORY:

What is your chief complaint?

☐ Neck Pain	☐ Right Leg Pain	☐ Right Arm Pain
☐ Upper Back Pain	☐ Left Leg Pain	☐ Left Arm Pain
☐ Lower Back Pain	☐ Pain in Both Legs	☐ Pain in Both Arms
☐ **Other**:_____		

What aggravates the pain?

☐ Walking	☐ Lying Down	☐ Nothing in particular
☐ Standing	☐ Activity in general	☐ **Other**: _____

What decreases the pain?

☐ Walking	☐ Lying Down	☐ Nothing in particular
☐ Standing	☐ Activity in general	☐ **Other**: _____

What time of day is the pain worst? _____

Rate your worst pain 1-10 _____

What time of day is the pain least severe? _____

Rate your least pain 1-10 _____

MEDICAL HISTORY / REVIEW OF SYSTEMS: Check (✓) symptom you currently have or have had **in the past year:**

GENERAL
- ☐ AIDS/HIV
- ☐ Cancer, Type_____
- ☐ Chills
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non- Insulin
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Headaches
- ☐ Hepatitis
- ☐ Loss of Sleep
- ☐ Kidney Disease, Type_____
- ☐ Thyroid Disease, Type____
- ☐ Ulcers, Type_____
- ☐ Weight Gain
- ☐ Weight Loss

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Heart Murmur
- ☐ Heart Attack

GENITO-URINARY
- ☐ Frequent Urination
- ☐ Loss of Bladder Control (Incontinence)
- ☐ Painful Urination

EYE, EAR, NOSE, THROAT
- ☐ Blurred Vision
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Ringing in Ear
- ☐ Visual Loss
- ☐ Glaucoma
- ☐ Cataracts

MUSCULOSKELETAL
- ☐ Joint Swelling
- ☐ Joint Popping
- ☐ Joint Stiffness
- ☐ Arthritis Type ___

GASTROINTESTINAL
- ☐ Acid Reflux
- ☐ Bowel Changes Type_____
- ☐ Heart Burn
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Loss of Bowel Control (Incontinence)

NEUROLOGICAL
- ☐ Epilepsy
- ☐ Nervousness
- ☐ Numbness
- ☐ Seizures
- ☐ Stroke
- ☐ Tremors

PSYCHIATRIC
- ☐ Anxiety
- ☐ Bi-polar
- ☐ Depression
- ☐ Suicide Attempt
- ☐ Other_____

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chest Pain
- ☐ Emphysema
- ☐ Lung Disease
- ☐ Shortness of Breath
- ☐ Wheezing

SKIN
- ☐ Dermatological Conditions
- ☐ Itching
- ☐ Rashes
- ☐ Scars

Are you pregnant
Yes / No / Not Sure

No of Children: _____

SURGICAL HISTORY:	
Type of Surgery	Date
Do you have **needle phobia?** **Yes / No**	

SOCIAL HISTORY:				
Do you consume any of the following :				
Cigarettes	Yes	No	How much per day/week?	# of years?
Alcohol	Yes	No	How much per day/week?	# of years?
Caffeine	Yes	No	How much per day/week?	# of years?
Illegal Drugs	Yes	No	How much per day/week?	# of years?
Narcotics	Yes	No	How much per day/week?	# of years?

FAMILY HISTORY:				
	Age	Health Condition	If applicable,	
			age at time of death	cause of death
Father				
Mother				
Brother				
Sister				

CURRENT MEDICATIONS:				
Medication Name	Strength	Times a day	Status	Comments
			Current / Discontinued	
			Current / Discontinued	
			Current / Discontinued	
			Current / Discontinued	
			Current / Discontinued	
			Current / Discontinued	
			Current / Discontinued	
			Current / Discontinued	
Are you currently receiving **narcotics** from any other physicians? Yes / No				
Name of the **doctors** / **medications**:				
Have you taken any **Pain Medications** in the past**? Yes / No,** If yes, please explain				
Are you currently taking **antibiotics?** **Yes / No**				
Are you currently taking **Blood thinners** like **Aspirin, Coumadin, or Plavix?** **Yes / No**				

ALLERGIES:
Any Known Allergies in Food: Yes /No, If Yes, Type of reaction:
Any Known Allergies in Medications: Yes /No, If Yes, Circle below
Iodine, Latex, Cortisones, IV Contrast, Lidocaine, or any other:

CURRENT / PREVIOUS TREATMENT:				
☐ **Yes (please complete below)**		☐ **No Current Treatment**		
Type	**Being Treated**	**For How Long?**	**Helped?**	**If not treated, would you need information from your Doctor?**
Back Brace	Yes / No		Yes / No	Yes / No
Knee/Wrist or Other Brace	Yes / No		Yes / No	Yes / No
Joint Injections (Shoulder / Knee / Ankle)	Yes / No		Yes / No	Yes / No
Nerve Blocks	Yes / No		Yes / No	Yes / No
Spinal Injections	Yes / No		Yes / No	Yes / No
Trigger Point Injections	Yes / No		Yes / No	Yes / No
Acupuncture	Yes / No		Yes / No	Yes / No
Iontophoresis Patch	Yes / No		Yes / No	Yes / No
				Comments
Active Exercise	Yes / No		Yes / No	
Biofeedback	Yes / No		Yes / No	
Chiropractor	Yes / No		Yes / No	
Ice / Heat	Yes/No		Yes/No	
Massage Therapy	Yes/No		Yes/No	
Physical Therapy	Yes / No		Yes / No	
Occupational Therapy	Yes / No		Yes / No	
Holistic or Alternative Treatments	Yes / No		Yes / No	
Hypnosis	Yes / No		Yes / No	
Osteopathic	Yes / No		Yes / No	
Traction	Yes / No		Yes / No	
TENS / Electrical Simulation	Yes / No		Yes / No	
Counseling	Yes / No		Yes / No	

INVESTIGATIONS:				
Test	Done	If yes Name of Facility	Date	Body Part(s) / Results
X-ray	Yes / No			
CT scan	Yes / No			
MRI	Yes / No			
Other Tests	Yes / No			
NCV / EMG	Yes			
	No	If no, do you have radiating pain, Tingling, Numbness, Muscle weakness in legs/arms/joints **Yes / No**		

Demographics and H & P Forms Scanned by:	

PAIN DIAGRAM

Apollo Pain Care

Patient:_____ Exam Room #: _____

Date of Birth: ____/____/____ Blood pressure:_____ Date:_____/_____/_____

Type of Visit: INITIAL VISIT **/** FOLLOW UP **/** PROCEDURE **/** NCV-EMG **Allergies:**_____

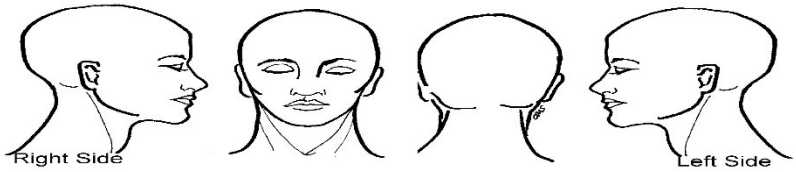
P A I N S C A L E *(PLEASE CIRCLE ONE)*

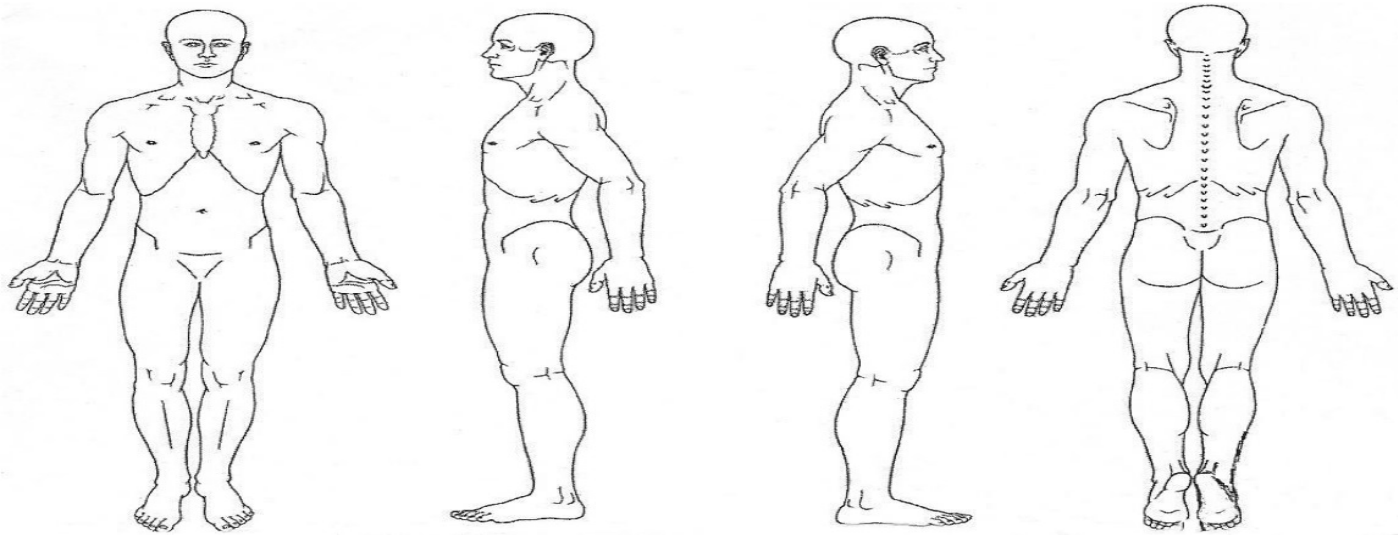
1	2	3	4	5	6	7	8	9	10

Mark the appropriate letters below or shade your areas of pain

T= TINGLING **B=** BURNING

P= PAIN **N=** NUMBNESS





FRONT **LEFT** **RIGHT** **BACK**

Have you for any reason attended the **ER** or any other medical facility in the past two weeks? **YES / NO**

Have you recently had any conservative treatment (Physical Therapy/Chiropractic) ? **YES / NO**

If YES: Type and date of last treatment: _____

Are you being referred to us for treatment related to any accident or any kind of litigation? **YES / NO**

If YES, circle one: AUTO **/** WORK COMP **/** SLIP&FALL **/** LITIGATION

Are you currently taking: Antibiotics OR Blood Thinners like Aspirin / Coumadin / Plavix? **YES / NO**

Are you DIABETIC? **YES / NO**

Do you have needle PHOBIA? **YES / NO**

Female patients: Are you currently pregnant? **YES / NO**

Are you currently breast feeding? **YES / NO**

Any comments / concerns / any changes to your health conditions / any kind of injuries / Have you been asked by your doctor (or taken) any MRIs/CT/X-Rays/NCV-EMGs since your last visit? **YES / NO**

If YES, Please Specify: _____

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Acknowledgement of Privacy Practices

I hereby acknowledge that I have received a copy of Apollo Pain Care, LLC Notice of Privacy Practices as required by federal law.

_____ _____ _____
Date Patient Name Patient Signature

Reason Patient / Personal Representative failed to sign:

_____

_____

_____
Staff Signature

Patient Consent for use and disclosure of Protected Health Information

Patient Name: _____ Date of Consent: _____

I authorize Apollo Pain Care to disclose protected health information to the following:

Name and relationship of person(s) authorized to receive information:

_____

_____

_____

Please circle one:
I **do** **do not** authorize Apollo Pain Care to leave telephone messages regarding my protected health information on the voicemail or answering machine.

_____ _____ _____
Date Patient Name Patient Signature

Authorization for Release of Confidential Information

I, _____ hereby authorize _____ to release medical, diagnostic, psychiatric, drug and/or alcohol abuse or HIV testing and AIDS information in my medical records to:

Apollo Pain Care

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For the purpose of medical care.

I understand that this consent is revocable upon written notice to _____, except to the extent that action by _____ has been taken in reliance of this authorization and that this authorization shall remain in force for a reasonable time order to effect the purpose which it is given.

Alcohol abuse information, if present has been disclosed from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibit making any further of it without the specific written consent of the undersigned, or as otherwise permitted by such regulations. HIV testing and/or AIDS related diagnosis is prohibited from further disclosure by State Regulations without consent from the patient.

_____

Patient Signature in full — Date of Authorization

_____

Date of Birth — Parent, Legal Guardian or Authorized Representative

_____

Social Security Number — Witness

*****Patient may delete any of the categories above by marking through**

Office Use Only

_____

Specific records Released

_____

Date of Release — Released by

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Financial Policy

This is an agreement between Apollo Pain Care, LLC, as creditor, and the Patient/Debtor named on this form.

By executing this agreement, you are agreeing to pay for all services that are received. Payment is expected at the time services are rendered. We accept cash, personal check, money orders cashier's check, Visa and Master Card. We collect copay, coinsurance and any deductible at the time services are rendered.

Insurance:
Insurance is a contract between you and your insurance company. We will file insurance claims **only** for plans with whom we have a contract with. We participate in some managed care plans. In order to file your claims, we require a legible copy of the front & back of the insurance card, photo ID, social security number and verification of benefits by your insurance company prior to visits. It is the responsibility of the insured/patient to supply current and accurate information for claims submissions. All copay, coinsurance and deductibles are due at the time services are rendered.

If you are covered by a plan that we are not participating providers for, payment is expected when services are rendered. We will provide you with an itemized receipt for you to file your insurance. Your insurance company will be responsible for reimbursing you for any coverage you may have.

Collection fee: A fee totaling 30% of the balance due will be added to your account if we have to send your account to a collection agency. You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account to any credit reporting agency such as a credit bureau.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Returned checks: There is a fee currently of $25.00 for any checks returned by the bank. Payment made on a returned check must be made in cash or by a money order.

Copying of records: You will need to request in writing, and pay a reasonable copying fee ($1/page for the first 25 pages and 25 cents for every page thereafter) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

My signature below certifies that I have read (or the form has been read to me) and I understand the contents on this form.

Patient's name: _____ Date: _____
Responsible party (if not the patient): _____

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OFFICE POLICIES REGARDING OPIOID PRESCRIPTIONS

As a Pain Management Specialist, I am well aware of the rules and regulations governing the use of opioid (narcotic) medications. I am also aware of the potential abuse of this type of treatment. For this reason, many physicians avoid prescribing opioid medications for the treatment of pain. However, due to the benefits I have seen in patients who are treated with opioids for their chronic pain, I may utilize this class of medication as part of your overall treatment plan.

You are here so that I can help you get your pain under control. It is unrealistic to think that I can "cure" your pain or make you pain free. My goal is to provide you with the highest quality of medical care and help you return to an active lifestyle as quickly as possible. This is why this specialized treatment is referred to as "Pain Management".

There has been much media attention lately regarding the use of opioid medications. While most patients are sincere and have legitimate findings that cause their acute or chronic pain, there are those people that exaggerate their symptoms in order to obtain medications for non-medical use. I can assure you that in our practice we are extremely careful about documenting and keeping track of all of our prescriptions. If we feel there is a problem developing, it will be discussed with you immediately.

Our patients depend on us for their chronic pain management. Our policies and procedures regarding opioid medication abuse are fair and also strict.

- Early releases of medications for vacations may be given at our discretion. A visual pill count may be performed to verify that you have been using your medications on schedule.
- Please be advised that we do not accept police reports for stolen medications. Your medications are your responsibility and they should be kept in a secured location. If your medications are lost or stolen, please contact the office immediately.
- Failure to provide a urine specimen when asked may result in the discontinuation of opioid medications and possible discharge from the practice.
- On-call physicians will not address opioid medication changes or routine refills. These requests need to be addressed during office hours when we have access to your chart.

I am hopeful that you will understand the reasons for our concern. If you need a medication change or a dosage increase, we will be happy to discuss this with you during office hours, but you absolutely cannot increase or change the dosage on your own without our approval. The only thing I ask of you as a patient is that you let us be the one to manage your medications. I promise you that I will do my best to help decrease your pain, improve your quality of life and help you live a more functional and active lifestyle. The best reward I get is when a patient comes in for a follow up visit and thanks me for the relief they received from the treatments or medications we are providing.

I look forward to working with you.

Padmaja Yatham, MD

INFORMED CONSENT FOR USE OF OPIOID (NARCOTIC) MEDICATIONS FOR PAIN CONTROL

1. The use of medication is not to completely eliminate pain, rather the medication is used to help decrease pain and increase level of activity.
2. Medication will be prescribed by a single physician. This physician will be the one in control of dosage. Obtaining pain medications from another doctor and "doctor shopping" is unacceptable.
3. The individual must report significant side effects to the doctor. For example, over-sedation, nausea, vomiting, or "high" feelings should be reported.
4. It is clearly understood that the use of this medication may result in physical dependence. Physical dependence is not a dangerous problem, as long as the individual avoids abrupt discontinuation of the drug. Medication can be safely discontinued after a period of slow tapering.
5. Psychological addiction can also occur, but this is infrequent in patients who have been diagnosed with an organic problem causing chronic pain. Psychological addiction is recognized when the individual abuses the drug to obtain a high (euphoria), when the patient shows drug-craving behavior, or "doctor shopping", when the drug is quickly escalated without correlation with pain relief, and when the patient shows a manipulative attitude toward the physician in order to obtain the drug. If the individual exhibits such behavior, the drug will be tapered and such a patient is not a candidate for continued opioid use.
6. Tolerance is a condition which can occur with the use of opioid medications. It is defined as a need for a higher opioid dose to maintain the same pain control. This condition may be controlled by switching to a different opioid or adding a second different drug to the opioid medication. If tolerance to opioids becomes unmanageable, the opioid will be tapered and discontinued.
7. If the individual develops drowsiness, sedation or dizziness, he or she may not drive motor vehicles or operate machinery that can jeopardize, his/her or other individuals' lives.
8. Once the maintenance opioid dose has been achieved, the individual will be given a supply according to a schedule as determined by the physician.
9. The individual should not stop taking the opioid medication abruptly. If this happens, withdrawal symptoms usually occur 24 to 48 hours after the last dose. The individual may begin to experience yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot or cold flashes (goose bumps), abdominal cramps or diarrhea. The withdrawal symptoms are usually self-limited, but could be dangerous. Withdrawal may last for several days. In order to avoid withdrawal, the patient should contact the office several days prior to needing a new prescription.
10. The individual should not take other drugs such as tranquilizers or sedatives without first consulting the physician. The individual may not use alcohol. A combination of the opioids with these drugs or alcohol may produce profound sedation, respiratory depression, and blood pressure drop.
11. Female patients should notify the physician if they are pregnant or at possible risk to become pregnant. It should also be known that children born when the mother is on opioid maintenance therapy, will likely be physically dependent at birth.
12. If there is any evidence of drug hoarding, acquisition of drugs from other physicians, or uncontrolled dose increase, the opioids will be tapered and discontinued.
13. By signing this agreement, I authorize Padmaja Yatham, M.D. and her clinical staff to perform urine drug testing at their discretion.
14. I also authorize Padmaja Yatham, M.D. and her clinical staff to contact other providers and/or pharmacies for information about past or current treatment and medications.

Noncompliance with any of the above may result in discharge from this practice.

I have received, read and understand the consent regarding the use of opioids.

Date	Signature of Patient	Printed name of patient

Signature of Witness	Printed name of witness

Apollo Pain Care Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices and **we will not use or disclose your protected health information without your authorization unless it has been included in this Notice of Privacy Practices.** We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Permitted Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: With your consent, your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, your name and address may be used to send you a newsletter about our practice and health and wellness information. You may contact our Privacy Contact to request that these materials not be sent to you.

Others Involved in Your Healthcare: We may disclose your protected health information to your legal representative or other persons you consent to and identify in writing. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. **We will not use or disclose your protected health information for marketing purposes, sell your protected health information, or, in most cases, use or disclose any psychotherapy notes without your authorization.**

2. Other Permitted and Required Uses and Disclosures That May Be Made Without your Consent or Authorization

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may also disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medial examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved and the use or access to your protected health information has been determined to be necessary by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

3. Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described above. You may revoke this authorization, at any time, in writing, except to the extent that your physician or Lagos Pediatric Care has taken an action in reliance on the use or disclosure indicated in the authorization.

4. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and Advance Interventional Pain Clinic use for making decision about you. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does not agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by submitting your request in writing to our Privacy Contact.

You have the right to request that protected related to any service, treatment, or product you receive not be disclosed to your insurance provided that: (a) the disclosure is for payment or health care operations not required by law; and (b) you have paid for the service, treatment, or product in full. We will notify you in the event of a breach of your unsecured protected heath information.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you. You have the right to receive specific information regarding these disclosures that occurred after March 01, 2016. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us. You have the right to request a paper copy of this notice. No later than the date of the first service delivery on or after March 01, 2016, a copy of this notice shall be provided to you.

You have the right to a copy of changes to this notice. We reserve the right to change this notice and to make the revised or changed notice also effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at our office location in the front lobby reflecting its effective date.

5. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Contact (786) 780-1800 for further information about the complaint process.

Padmaja Yatham, MD
Interventional Pain Management, Addiction Therapy
Ĭ 7000 SW 97th Ave, Suite 214, Miami, FL 33173
Ĭ 14601 SW 29th St, Suite 103, Miramar, FL 33027
Tel: 786-780-1800, Fax: 786-780-2500
www.ApolloPainCare.com

Worker's Compensation

Patient Name: _____, DOB: _____

Employer at the time of the accident: _____, Phone: _____

Employer Address: _____

Prior Treatment: Yes / No, If so, When? _____ Where: _____

Date of injury: _____ Are you currently working? _____ Last date worked: _____

Please describe in your own words how the accident happened: _____

_____

Workerôs Comp Company Name: _____

Address for Claims: _____

_____ _____, Phone number: _____

Claim Number: _____ Body Part Covered: _____

Adjuster name: _____ Phone Number: _____

Nurse case manager name: _____ Phone number: _____

Do you currently have legal representation for this workerôs compensation claim? _____

Attorney Name: _____ Phone: _____

Referring Physician: _____MD/DC, Phone: _____

I do hereby consent to any medical care which is deemed advisable or necessary by my physician and grant authority to Apollo Pain Care, to administer and perform all examinations, treatments and diagnostic procedures needed now or in the future. I guarantee payment for all services rendered. All medical benefits including major medical benefits, private insurance and any other health plan, are assigned to Apollo Pain Care. The signature below confirms all of the information provided herein is true and accurate. Photocopy of this consent is to be considered as valid as the original.

Signature: _____ Date: _____

QUESTIONNAIRE FOR INJURY (Auto / Work Related / Slip & Fall)

Patients Name: _____ **Gender**: M / F **D.O.B**: _____/ _____/ _____
Accident **DATE**: _____ **Time**: _____ **City**: _____ **State**: _____ **At:** FAULT / NO-FAULT

Type of Accident: Auto / Work Related / Slip & Fall / Other _____

- **BRIEFLY EXPLAIN HOW YOU WERE INJURED:**

_____
_____
_____

- **Area of Injury to the body from the accident:**
  Head / Neck / Back / Upper Extremities / Lower Extremities / Other_____
- **Did you lose consciousness at the site of the accident?** **Yes / No**
- **Did you go to the ER** **Yes / No**
  - If yes, what treatment did you receive? _____
- **Were you hospitalized after the accident?** **Yes / No**
  - If so, how long were you in the hospital? _____
- **Did you have *this* pain before the accident?** **Yes / No**
- **When did you begin experiencing *this* pain?** _____/_____/_____

Diagnostic tests done before and/or after the accident: NONE / X-RAY / MRI / CT / NCV / EMG
_____

PLEASE CIRCLE if you have seen / are seeing a:

o Pain Specialist	o Neurologist	o Chiropractor	o Massage Therapist
o Family Physician	o Surgeon	o Physical Therapist	o Acupuncturist

WORK STATUS

- Were you employed at the time of Accident: **Yes / No**
- Describe Work Activities: _____
- Has the accident affected your work status? **Yes / No**, If yes: Explain _____
- Did you miss work because of accident **Yes / No**, If yes, Explain:_____
- Are you currently working? **Yes / No**, If yes, Explain:_____
- After accident do you have any functional limitations and restrictions? **Yes / No**
  - If yes: Explain: _____

AUTO ACCIDENT

- IMPACT**:** Head on Collision / Front Ended (Right/Left) / Rear Ended (Right/Left) / Side (Right/Left)
- What kind of Car were you travelling on? **Model**_____/ **Year**_____/ **Size**_____
- How much Damage to your automobile? **$**_____, If not assessed, approximate estimate: **$** _____
- Were you the driver or passenger? **Driver / Passenger**
- Did the Air Bag Deployed? **Yes / No**
- Were you wearing a seatbelt at the time of the accident? **Yes / No**
- Describe the opposite Car in the accident: **Model**_____/ **Year**_____/ **Size**_____

HEALTH CONDITIONS PRIOR TO THIS ACCIDENT

- Were in Pain or being treated for any other medical conditions prior to this accident? **Yes / No**
  - **If Yes**, please explain: _____
- Were in any other accident prior to this accident: **Yes / No**
  - **If Yes**, please explain: _____