`ST. PETERSBURG PAIN & URGENT CARE
5013 CENTRAL AVE
ST PETERSBURG, FL 33710
Phone: (727) 526 - 8300
Fax: (727) 526 - 8804

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I understand that, under Florida Law, the classification of records checked below relating to treatment rendered to me are privileged & confidential & cannot be released to me or those designated by me or my legal guardian without an expressed & information consent. In addition, I understand that those records will not be released to persons & agencies other than those designated by me or my personal representative or otherwise provided in Florida Law.

Patient Name: _____ Date of Birth _____
Address: _____
I authorize _____ to release health information to:
ST. PETERSBURG PAIN & URGENT CARE.

Please specify the health information you authorize to be released:
Dates of treatment: _____

_____ X-Ray/CT/MRI Reports _____ Lab Results ____ Pharmacy Records

_____ Physician Reports _____ All Medical Records _____ Surgery Reports

____ (initial) I understand this authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization EXCEPT in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

_____ (initial) I understand that the release of information by form of fax, then confidentiality can not be assured & I accept the risk that confidentiality may be breached when faxing information.

_____ (initial) I understand that if I authorize the disclosure of my health information to someone who is not legally required to keep it confidential, it may no longer be protected by ST. PETERSBURG PAIN & URGENT CARE or federal confidentiality laws.

_____ (initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to this authorization. I understand that if I revoke this authorization, I must do so in writing. **Unless otherwise revoked, this authorization will expire six months from the date of the signature listed below.**

Print Patient Name_____Patient/Personal representative Signature_____Date___
Witness Print Name_____Witness Signature _____Date_____

ST. PETERSBURG PAIN & URGENT CARE

Patient Name: _____ Date: _____
Date of Birth; _____ Sex: _____ Marital Status: _____
Telephone Numbers: Home ( )_____ Work ( ) _____
Home Address: _____
City: _____ State: _____ Zip: _____

GENERAL HEALTH REVIEW

Medical History (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illnesses, etc…)

_____
_____
_____
_____

Surgical History (unrelated to pain; such as an appendectomy, etc…)

_____
_____
_____

Surgical History (related to pain; such as a laminectomy, etc…)

_____
_____
_____

Allergies (include medication & food allergies)

_____
_____
_____
_____

Intolerances (include side effects from previous medications, such as gastritis, nausea, constipation, etc…)

_____
_____
_____

Current Medications (include vitamins & birth control pills, if applicable)

_____
_____
_____
_____

ST. PETERSBURG PAIN & URGENT CARE

Symptoms: Circle symptoms you currently have or have had in the past year:

General	Gastrointestinal	Eyes, Ears, Nose, Throat
Chills	Appetite	Bleeding Gums
Depression	Bloating	Blurred Vision
Dizziness	Bowel Changes	Crossed Eyes
Fainting	Constipation	Difficulty Swallowing
Fever	Diarrhea	Double Vision
Forgetfulness	Excessive Hunger	Earache
Headache	Excessive Thirst	Ear Discharge
Loss of Sleep	Gas	Hay Fever
Loss of Weight	Hemorrhoids	Hoarseness
Nervousness	Indigestion	Loss of Hearing
Numbness	Nausea	Nose Bleeds
Sweats	Rectal Bleeding	Persistent Cough
Stomach Pain	Vomiting Blood	Ringing in Ears

Skin	Cardiovascular	Muscle/Joint/Bone Pain
Bruise Easily	Chest Pain	Arms
Hives	High Blood Pressure	Back
Itching	Irregular Heart Beat	Feet
Change in Moles	Low Blood Pressure	Hands
Rash	Poor Circulation	Hips
Scars	Rapid Heart Beat	Legs
Varicose Veins	Swelling of Ankles	Neck / Shoulders

Women Only		Men Only
Hot Flashes	Last Menstrual Period ___/___/___	Erection Difficulties
Nipple Discharge	Last Pap Smear ___/___/___	Lump in Testicles
Painful Intercourse	Last Mammogram ___/___/___	Penis Discharge
Vaginal Discharge	Number of Children _____	Sore on Penis
Extreme Menstrual Pain		

Genito – Urinary

Blood in Urine	Frequent Urination	Painful Urination	Lack of Bladder Control

Other Conditions:

Aids	Chemical Dependency	High Cholesterol	Prostate Problem
Alcoholism	Chicken Pox	HIV Positive	Psychiatric Care
Anemia	Diabetes	Kidney Disease	Rheumatic Fever
Anorexia	Emphysema	Liver Disease	Scarlet Fever
Appendicitis	Epilepsy	Measles	Stroke
Arthritis	Glaucoma	Migraine Headache	Suicide Attempts
Asthma	Goiter	Miscarriage	Thyroid Problems
Bleeding Disorder	Gonorrhea	Mononucleosis	Tonsillitis
Breast Lumps	Gout	Multiple Sclerosis	Tuberculosis
Bronchitis	Heart Disease	Mumps	Typhoid Fever
Bulimia	Hepatitis	Pacemaker	Ulcers
Cancer	Hernia	Pneumonia	Vaginal Infection
Cataracts	Herpes	Polio	Venereal Disease

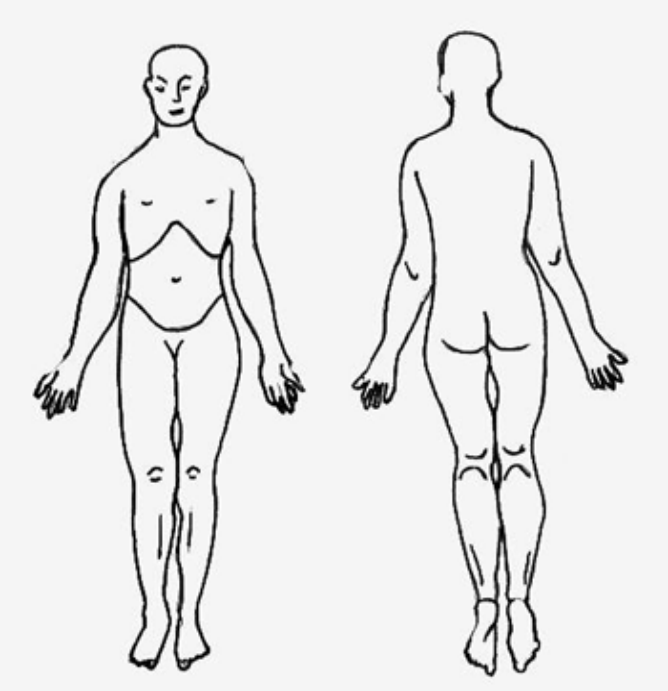
Patient Name: _____ **Date:** ____/____/____

ST. PETERSBURG PAIN & URGENT CARE

Patient Name: _____ Date of Birth: ____/____/____
Referral Source: _____
Is your problem job related? _____ Accident Related? _____ Other _____
Please briefly describe your main problem/complaint: _____
_____
How long have you had this problem? _____
Did your pain start suddenly or progress over time? _____
Current pain description (circle all that apply) Sharp Aching Dull Burning Throbbing
Other: _____
Is your pain (circle one) Intermittent or Constant
Please circle the number indicating how much pain you experience on a usual day.

Does your pain radiate beyond where the pain starts? (Please circle) Yes or No
If yes, where does the pain radiate to? _____
Put a check next to each of the following activities that make your pain worse: Sitting ___ Bending ___
Coughing ___ Walking ___ Bowel Movement ___ Standing ___ Other ___
Do you need support to help you walk? (Circle) Yes or No
If yes, what kind of support do you need? _____
Do you wear a back brace, neck brace or any type of limb brace? (Circle) Yes or No
If yes, what type of brace do you wear and how long have you worn this device? _____
_____
Do you always have control of your bowel? (Circle) Yes or No
Are you able to empty your bowel completely? (Circle) Yes or No

Below is a diagram, please indicate the location of your pain as well as your symptoms, please use the following symbols to mark what type of symptoms you are experiencing:
Sharp Pain – X Numbness – O Pins and Needles/Tingling - * Dull or Aching Pain - /



THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED & DISCLOSED & HOW YOU CAN GET ACCESS TO THIS INFORMATON, PLEASE REVIEW IT CAREFULLY:

Effective Date: _____

If you consent the provider is permitted by federal privacy laws to make uses & disclosures of your health information for purpose of treatment, payment & health care operations. Protected health information is the information we create & obtain in providing our service to you. Such information may include documenting your symptoms, examination, test results, diagnosis, treatment & applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:

- An employee of the provider's office obtains treatment information about you & records it in a health record.
- During the course of your treatment, the provider determines that he/she will need to consult with another specialist in the area. He/She will share the information with such specialists & obtain his/her input.

An example of use of your health information for payment purposes:

- We will provide itemized receipts for you to submit a request for payment to your insurance company. The insurance company requests information from us regarding services rendered. We will provide that information to them about you & the care you receive.
- We verify insurance coverage prior to your first appointment & obtain prior authorization & pre-certification when required to do so by your policy coverage.

An example of use of your health information for health care operations:

- The state licensing authority wants to review records to assure that we have acted consistent with state laws regarding your care, in doing so; it wants to take a sampling, which includes review of your chart. At the licensing authority's request, we will provide it with a copy of your chart.

Your health information rights:

The health record & billing records we maintain are the physical property of this office. The information in it however belongs to you. You have the right to:

- Request a restriction on certain uses & disclosures of your protected health information by delivering the request in writing to our office. We are not required to grant the request, but we will comply with any request granted.
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at our office.
- Request that you be allowed to inspect & receive a copy of your health record & billing record. You may exercise this right by delivering the request in writing to our office using the form we provide to you upon request.
- Appeal a denial of access to your protected health information except in certain circumstances.
- Request that your health care record be amended or correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request.
- File a statement of disagreement if your amendment is denied, & require that the request for amendment & any denial be attached in all future disclosures of your protected health information.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. The accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you & made at your request.
- Request that communication of your health information be made by alternative means or at the alternative location by delivering the request in writing to our office using the form we provide you upon request.

- Revoke any authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

You have the right to review the Notice before signing the consent authorizing use & disclosure of your protected health information.

ACKKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices & that I have read them or declined the opportunity to read them & understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart & maintained for six years.

_____ _____

Print Patient Name Date

_____

Parent, Guardian or Patient's Legal Representative

_____

Patient Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART & MAINTAINED FOR FIVE YEARS.

ST. PETERSBURG PAIN & URGENT CARE

ST. PETERSBURG PAIN & URGENT CARE
DRUG TESTING POLICIES

1. **Patients may be drug tested at anytime & without notice.**

2. **WARNING: If the medications you are prescribed & taking do not register on this test, you will be required to pay for lab confirmation from an outside testing facility. You may be discharged from this practice pending the final results. Failure to test positive for prescribed narcotics is considered diversion, a felony. If you test positive for any illegal drugs/substances or are taking any controlled substances not prescribed to you, you may also be discharged from the practice. New board of medicine rules effective March 2011 requires a referral and consultation with an addiction specialist or board certified pain medicine specialist in order to continue pain management.**

3. You will be required to submit a urine sample during your visit and the result will be available before you see the doctor.

4. If you have any questions regarding the above, please feel free to contact one of our staff.

Print Patient Name: _____

Patient Signature: _____

Date: _____

ST. PETERSBURG PAIN & URGENT CARE
FEE SCHEDULE & POLICIES

- Patient participating in the pain management program may only pay for services with cash or credit card.

- Payment is expected at the time services are rendered unless prior arrangements have been made.

- Referrals for diagnostics (X-Ray, MRI, and NCV), specialists (Orthopedic Surgeon, Neurologist, Neurosurgeon, etc…) lab work & therapy (Massage, Physical, Chiropractic and Physiotherapy) may be billed using insurance, if applicable & accepted. These referrals may be external to providers outside St Petersburg Pain & Urgent Care.

- Although our goal is to provide medically necessary services as conveniently as possible. It is ultimately your choice where you seek and obtain treatment or services.

PAIN MANAGEMENT PROGRAM

Initial Evaluation - $99.00
(Includes: history, physical exam, drug screen, consultation with Doctor and record review, recommendations including prescriptions as indicated.)

Follow up Evaluation - $220.00

Fees may change without notice.

I have read & understand the above.

_____

Print Patient Name

Patient Signature_____**Date**_____

ST. PETERSBURG PAIN & URGENT CARE

PAIN MANAGEMENT AGREEMENT

Patients Name: _____ Date of Birth: ____/____/____

1. _____ (initial) The purpose of this agreement is to prevent misunderstandings about certain medications you may be taking for pain management. This agreement will also help you understand applicable laws & regulations governing the use of the medication that may be prescribed to you. Moreover, adherence to this agreement shall protect your access to controlled substances & protect St. Petersburg Pain & Urgent Care ability to prescribe to you.

2. _____ (initial) I understand that this agreement is essential to the trust & confidence necessary in a doctor/patient relationship & that St. Petersburg Pain & Urgent Care undertakes to treat me based on this agreement.

3. _____ (initial) I understand that a breach of this agreement may result in the termination of my therapy with controlled substances.

4. _____ (initial) I agree that in the event of a breach, my doctor exercising sound medical judgment is authorized to taper off the medication over a period of several days, as necessary to avoid withdrawal symptoms.

5. _____ (initial) I understand that I may be prescribed opioid medication, sometimes called narcotic analgesics, in the treatment of my pain. I am aware that the use of such medication has certain risks associated with it including, but not limited to: allergic reaction, constipation, dizziness, sleepiness or drowsiness, itching, nausea, physical dependence, slowing of breathing rate, slowing of reflexes or reaction time, tolerance to analgesia. Addiction and/or the possibility the medication will not provide complete pain relief.

6. _____ (initial) I am aware of the possible risks & benefits of other types of treatment that do not involve the use of opioids.

7. _____ (initial) I agree to exercise extreme caution when engaging in an activity that may be dangerous to me or others while taking my medication. I am aware that even if I do not recognize the effects of my medication, my reflexes & reaction time may be slowed.

8. _____ (initial) I agree to communicate fully with my doctor about the character & intensity of my pain, the effect of the pain on my daily life, & how well the medication is helping to relieve the pain.

9. _____ (initial) I agree to communicate fully with my doctor about all other medications & treatments I am receiving. I agree to tell any other treating physician that I am taking an opioid for my treatment of pain. I am aware that certain other medications may reverse the action of the medication I am using for pain control.

10. _____ (initial) I agree to inform St. Petersburg Pain & Urgent Care of any new medications or medical conditions & also any adverse effects I may experience from any of the medications that have been prescribed to me.

11. _____ (initial) I am aware that I may develop a tolerance to an analgesia or particular pain medication or treatment. I understand that if I develop a tolerance that I may require more medication to obtain the same pain relief. I also acknowledge that increasing medication doses may not always help, may cause unacceptable side effects or may not be in the best interest of my continued therapy. I understand that tolerance or failure to respond well to opioids may result in my doctor choosing another form of treatment.

12. _____ (initial) I understand that the long term use of opioids posses the risk of developing an addictive disorder or of a relapse occurring in a person with a prior addiction. I agree to inform my doctor of any prior history of drug abuse or addiction or if I believe I am developing an addiction.

13. _____ (initial) I agree that all controlled substances prescribed to me must come from the physician whose signature appears on this agreement, or in his or her absence, by the covering physician unless specific authorization is obtained for an exception.

14. _____ (initial) I will not attempt to obtain controlled medications, including opioid pain medications and controlled stimulants from any other doctors.

15. _____ (initial) I will not use any illegal controlled substances, including marijuana, cocaine etc…

16. _____ (initial) I will not share, sell or trade my medication with anyone.

17. _____ (initial) I will safe guard my pain medication from loss or theft. Lost, stolen or destroyed medications will not be replaced.

18. _____ (initial) I consent to random & unannounced blood or urine toxicology screens, as deemed necessary to ensure my continued compliance with the treatment program. I understand that my refusal to provide a blood or urine sample may result in the termination of my treatment program. I understand that the presence of unauthorized substances discovered through a toxicology screen may result in the termination of my treatment program. Termination shall be done in accordance with the terms of this agreement.

19. _____ (initial) I authorize my physician to discuss all diagnostic and/or treatment details with a dispensing pharmacist or other health care professional for the purpose of maintaining accountability.

Patients Name: _____ Date of Birth: ____/____/____

20. _____ (initial) I agree that refills of my prescriptions for pain medication will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings. Early refills will generally not be given.

21. _____ (initial) I agree that I will obtain all controlled substances at the same pharmacy when possible. I will notify St. Petersburg Pain & Urgent Care in the event I change my filling pharmacy. I have selected the following pharmacy to serve as my primary pharmacy:

22. _____ (initial) I agree to bring all original containers of medications & all unused pain medication to every office visit.

23. _____ (initial) I agree that I will use my medication at a rate no greater than the prescribed rate & that use of my medication at a great rate will result in my being without medication for a period of time & may also result in the termination of my treatment program.

24. _____ (initial) I authorize St. Petersburg Pain & Urgent Care to cooperate fully with any city, state or federal law enforcement agency, including this state's board of pharmacy in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the authorizations.

25. _____ (initial) I have read this agreement or have had it read to me. I understand & consent to all terms provided in this agreement. All of my questions & concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

26. _____ (initial) This agreement enters into effect on this _____ day of _____ 2022.

27. _____(initial) If a female, my signature confirms that I am not pregnant, do not plan to get pregnant, and I will take all necessary precautions to prevent pregnancy during the time I will be taking pain medication. If I become pregnant I will stop the medication immediately and notify St. Petersburg Pain and Urgent Care. I will follow up with high risk Obstetrician.

Patient Signature: _____

Physician Signature: _DR CESAR EURIBE M.D. __

Witnessed by: _____

SWORN AFFIDAVIT

Before me, the undersigned authority, personally appeared _____ (Patient's Name), who after duly cautioned under oath, deposes & says:

1. My name is _____ (Patient's Name) & I make this affidavit upon personal knowledge.

2. I am a resident of the state of Florida, over the age of 18, & competent.

3. I am the Patient of **St. Petersburg Pain & Urgent Care**

4. I am only treating at St. Petersburg Pain & Urgent Care for my pain management care. I am not treating with any other doctor or pain management facility (Doctor Shopping).

5. I authorize St. Petersburg Pain & Urgent Care to cooperate fully with any city, state or federal law enforcement agency, including this state's board of pharmacy in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the authorizations.

(TO BE COMPLETED BY OFFICE STAFF ONLY)

STATE OF: FLORIDA
COUNTY OF: PINELLAS

ST. PETERSURG PAIN & URGENT CARE

PAIN MANAGEMENT TECHNIQUES

For Neck (cervical spine) pain it is recommended you do not hold a phone in between your shoulder and your ear. When reading a book or using your computer monitor, keep them at eye level so your neck is in a neutral position (not flexed or extended up or down) Avoid sudden movements. Moist heat applications for 10 minutes can be soothing. **Never** sleep with a heating pad, since burns may result even on a low setting. Do not do conventional sit ups. Crunches are ok, only with your arms crossed in front of your chest, not with your hands behind your head. Sleep with a cervical pillow for support.

For Back (lumbar or thoracic spine) pain it is recommended that you maintain good posture at all times while sitting, standing, or walking with shoulders back and chest out. When driving, use a lumbar support pillow (available at a medical supply store) if your vehicle does not have this feature built in. Support is important at the workplace also. When possible, stop to stretch periodically. Do not bend over to touch your toes. Wear supportive footwear. Moist heat applications for 10 minutes can be soothing. No lifting or carrying more than 20 pounds.

It is recommended that you keep a daily pain journal to assist in the scheduling of your medications. Keep a list of all medications you take, the purpose of each and its benefits. Do not abruptly stop taking your pain medication unless it has intolerable side effects. Do not take anyone else's medication or let them take your medication. Do not change the amount of medication you take or the frequency unless you consult your doctor first.

Exercise and Activity as tolerated, or otherwise directed by your physician. If you have been given an exercise sheet, do your best to carry them out as tolerated. Apply an ice pack for 10 minutes after a completion of a set of exercises. Pool exercises and isometric exercises are recommended also.

Diet/Lifestyle STOP SMOKING! It robs your tissues of vital oxygen. Take a multi vitamin and multi mineral supplement every day. If you take methadone, take a calcium supplement. Eat fresh fruits and vegetables every day. Drink plenty of water.

To prevent Constipation drink 10 glasses of water every day or more if you work outdoors. Eat plenty of fiber: whole grain breads, fiber cereals, Metamucil powder/wafers/capsules daily, Citrucel or Benefiber. Take stool softener once or twice a day. Do not use laxatives unless absolutely necessary and no more than once per week. Senokot is preferable.

Migraine headaches Nutritional modification can be very beneficial in decreasing the frequency of headaches. Foods to avoid because they can trigger a migraine are: red wine, caffeine, hot dogs, cold cuts, sausage, citrus, peanut butter, aspartame, MSG(monosodium glutamate), chocolate, pickled or marinated foods, ham, yeast and high yeast breads, soy sauce, bratwurst, potato chips, gelatin, salami, corned beef, chicken liver, figs, raisins, bananas, cheese, beer, eggs, sour cream, relishes, salad dressings, liverwurst. GOOD foods which can prevent migraines are: yogurt with active cultures, riboflavin (vitamin B2) 400mg daily. Some natural remedies which may abort a migraine are Niacin (vitamin B1) 500 mg, Ginger 500 mg, or strong ginger tea. Aerobic exercises and smoking cessation are effective in preventing migraines, and so is stress reduction.

Patient Name: _____ Signature: _____ Date: ____/____/____

ST. PETERSBURG PAIN & URGENT CARE

INFORMED CONSENT AND TREATMENT AGREEMENT

This agreement between _____ (Patient), St. Petersburg Pain & Urgent Care and Dr. CESAR EURIBE M.D (Doctor) is for the purpose of establishing the conditions required for the use of Opiate/Narcotic medications the Doctor may prescribe for the patient. The Doctor & the patient agree that this agreement is an essential factor in maintaining a proper doctor/patient relationship.

The patient agrees to & accepts the following conditions for the management of pain medications prescribed by the Doctor for the Patient:

- I understand that a reduction in the intensity of my pain, improved sleeping habits, decreased fatigue, an improvement in your function and to sustain quality of life are the pain management goals set for you.

- I realize that all narcotic medications have potential side effects. In addition to analgesia, narcotics may produce dependency, addiction, respiratory depression, drowsiness, changes in mood; anxiety or mental clouding, & I will report any such side effects to the physician immediately.

- In the event of a need to discontinue taking these medications, I will consult with the doctor, & strictly follow his instructions for the safe tapering of my medications. Failure to do so may result in severe withdrawal effects & possibly even death. I understand that even with the tapering process there may be some discomfort or withdrawal effects.

- I understand the risks, side effects, & benefits of these medications & they have been discussed with me in detail.

- Narcotics may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. I agree that I will not attempt to perform such activity until my ability to perform the activity has been evaluated.

- The individual is informed that he/she should not take other drugs such as tranquilizers, sedatives or antihistamines without first consulting with his/her physician. The individual should not use alcohol. The combination of the above drugs, alcohol & opiates may produce dangerously profound effects such as sedation, respiratory depression & blood pressure drop.

- I will not attempt to get pain medications from any other health care provider without telling them that I am taking pain medications prescribed by the Doctor. I understand it is against the law to do so, & will lead to the discontinuance of my medical treatment at this facility.

PATIENT SIGNATURE: _____ DATE: _____/_____/_____

ST. PETERSBURG PAIN & URGENT CARE
ALTERNATIVE FORMS OF TREATMENT OR MODALITIES

There are many other treatments/modalities for pain control other than opiates/narcotics. These treatments often compliment your opiates so that less narcotics are needed. The following treatments/modalities are highly recommended by the medical community, medical boards, and pain medicine specialists. Therefore, one or more of these treatments/modalities will be recommended to you from time to time. Examples of these treatments/modalities are listed below:

1. **Non-narcotic medications such as as non steroidal anti inflammatory medications (Naprosyn, Ibuprofen, etc..)**
2. **Dietary changes – weight loss, exercise, vitamins, herbal supplements, etc..**
3. **Physical Therapy**
4. **Yoga/Meditation**
5. **Massage Therapy**
6. **Acupuncture**
7. **Chiropractic Treatment**
8. **Aqua Therapy**

Each carries its own risk and benefits, which can be explained to you by your doctor. It is generally recommended that your pain management program include one or more of these treatments/modalities where possible and other non narcotic medications as indicated.

I have read the informed consent and treatment agreement regarding risks & benefits of the proposed treatment & have been given an explanation of these as well as alternative forms of treatment as well as pain management techniques to reduce pain. I understand these & have had ample time to discuss these with my physician.

The purpose of this agreement is to prevent misunderstandings about certain medications.

Patient Signature: _____ **Date:**_____
Physician Signature: DR CESAR EURIBE M.D.

ST. PETERSBURG PAIN & URGENT CARE

The initial visit is $99.00 dollars to be paid in cash or credit card. This fee is for your time with the physician so that the doctor can look over your records, ask you any questions that he may have & examine the area of your pain & check your heart, lungs & etc… the fee will be collected before you are taken back for vitals. The fee also includes a urine drug screen. The doctor will make every reasonable effort to control your pain problem taking into account your history, exam, imaging studies, and current law/medical board rules. Once you are examined and recommendations are made….

There will be no refunds for the office visit.

_____ _____

Print Patient Name Date

_____

Patient's Signature

_____ _____

Print Witness Name Date

_____

Witness Signature

PLEASE SAFEGUARD YOUR MEDICATIONS AGAINST THEFT

KEEP YOUR MEDICATIONS IN A LOCKED CABINET, OR SAFE. IF YOU FLY, DO NOT PLACE YOUR MEDS IN CHECKED LUGGAGE

LOST, STOLEN OR MISPLACED NARCOTICS WILL NOT BE REPLACED UNDER ANY CIRCUMSTANCES

_____	_____	_____
PRINTED NAME	SIGNATURE	DATE