Florida Medical Clinic
Non-Interventional Pain Management
Gabriel J Somori, M.D.

38051 Market Square
Building B, Second Floor
Zephyrhills, FL 33542
O 813.788.0570 F 813.355.5086

OFFICE POLICIES AND SERVICE AGREEMENT

Expect to be at our office for at least two (2) hours on your initial visit.

You must bring all your paperwork and complete insurance information, including your active insurance card that shows your effective date, and a referral or authorization, if needed. If you have auto insurance or worker's compensation you must provide all the necessary information to correctly bill the insurance carrier. Failure to not have the proper paperwork will result in your appointment being rescheduled.

If you do not show up for your appointment or do not cancel it at least 24 hours in advance, you will be subject to a $50.00 "No Show" fee.

If you miss more than three (3) appointments in a row without giving the office advanced notice of at least 24 hours, you will be asked to find another physician to serve your medical needs.

Co-pays, deductibles, and co-insurances will be collected at the time of your visit. Be aware that your co-pays, deductibles, and co-insurances are contracted between you and your insurance company. It is our responsibility to collect them and your responsibility to see that they are paid at the time of service.

If you are more than 15 minutes late, for your scheduled appointment, your appointment will be rescheduled.

There is a fee of $50.00 for completion of disability forms and preperation of requested letters. (This may require a seperate office visit). There is a 72 hour advance notice requirement for completion of these types of forms.

Medical records are available on our patient portal. Should you not have access to the portal, there is a fee for providing your records to you. The cost is dependent on the number of copies. There is also a 72 hour advance notice required.

Samples of medications may be given. You must understand that they are not in child-proof containers, and it is your responsibility to see that they are safely stored.

You will only be seen in this office if you have a scheduled appointment, NO walk-ins will be seen. If you feel you need to be seen before your next scheduled appointment, call the office to reschedule.

Arrive at your appointment prepared to provide a urine sample as part of your agreement with Florida Medical Clinic Non-Interventional Pain Management.

Be prepared to come to the office with your medications when contacted for a random pill count per your agreement with Florida Medical Clinic Non-Interventional Pain Management.

Verbal and/or physical abuse of the doctor or his staff will not be tolerated, and will result in immediate discharge from Florida Medical Clinic Non-Interventional Pain Management.

I have read and understand all of the office policies and agree to comply with them as listed.

Patient's Signature:_____ **Printed Name:**_____

Date: _____

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INFORMED CONSENT FOR OPIOID TREATMENT

I have agreed to use opioids (morphine-like medications) as part of my treatment for chronic pain. I understand these medications are useful, but have a potential for misuse and are therefore closely controlled by local, state, and federal government agencies. Because my pain physician is prescribing such medications to help manage my pain, I agree to the following conditions as listed below. I am aware that failure to abide by any of these conditions will be considered a breach of the contract and, at the sole discretion of my physician, may result in the termination of our physician/patient relationship.

1. I am responsible for my pain medications. I agree to take the medication only as prescribed and to contact my pain physician before making any changes, such as:
   a. **Increasing:** I understand that increasing my dose without the close supervision of my pain physician could lead to drug overdose, causing severe sedation, respiratory depression, and possibly death.
   b. **Decreasing/Stopping:** I understand that decreasing or stopping my medication without the close supervision of my pain physician can lead to withdrawal symptoms, which may include sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot/cold flashes, abdominal cramps, and diarrhea. These symptoms can occur 12-48 hours after the last dose and can last up to 1-2 weeks.

2. I will not request or accept opioid medication from any other physician or individual while I am receiving such medication from my pain physician.

3. I understand the side effects that are related to opioid medications may include nausea, vomiting, drowsiness, constipation, confusion/sedation, flushing, respiratory distress, sweating, itching, urinary difficulty, and jerkiness. These side effects usually occur at the beginning of treatment and most go away within a few days, with the exception of constipation, which is an ongoing side effect that must be treated. Less common side effects are severe respiratory depression and death. It is my responsibility to notify my pain physician of any side effects that continue or are severe. I am also responsible for notifying my pain physician immediately if I need to visit another physician or emergency room due to pain, surgery, or if I become pregnant.

4. I agree the opioid medication is strictly for my use, and should never be given/shared with others.

5. I understand I must contact my pain physician before taking Benzodiazepines (medications like Ativan or Valium), sedatives (medications like Soma, Xanax, and Fiorinal), and antihistamines (like Benadryl). I understand the combination use of the above medications and opioids may produce profound sedation, respiratory depression, drop in blood pressure, and even death.

6. I understand that opioid prescriptions **will not be mailed.** During the time my dose is being adjusted. I will be expected to return to the clinic bi-weekly.

7. I am responsible for my opioid prescriptions. I understand that refill prescriptions:
   a. Will only be written for one (1) month supply and will be **filled at the same pharmacy each time.**
   b. Will only be written during regular office hours.

c. **Will not** be written if I "run out early" or "spill or misplace medication". I am responsible for taking the medication in the dose as prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report it to the local police department and obtain a stolen item report. **Replacement prescriptions will not be given.**

8. While physical dependence is to be expected after long term use of opioids, signs of addiction (and psychological dependence) will be interupted as a need for weaning and detoxification.

   a. **Physical dependence** is common to many medications such as blood pressure, anti-seizure medications, and opioids. It results in biochemical changes such that abruptly stopping these medications will cause a withdrawal response.

   b. **Addiction** is a psychological and behavior syndrome that is recognized when a patient abuses the medication to obtain mental numbness or euphoria, when the patient shows a drug craving behavior or "doctor shopping", when the medication is quickley escalated without correlation to pain relief, and/or when the patient shows a manipulative attitude toward the physician in order to obtain the medication. Any patient exhibiting such behavior is not a canidate for continued opioid use. The medication will be tapered, and the patient will be discharged and referred for drug rehabilitation.

   c. **Tolerance** is a pharmacological property of certain medications and is defined as a need for higher doses to maintain the same medication related relief.

9. I understand that my pain physician's treatment may include continued use of opioids, usually in combination with other non-opioid medications. If it appears there is no improvement in my daily functioning or quality of life with the use of opioids, the opioids will be discontinued, and I will gradually taper my medications as prescribed.

10. I agree to submit to urine and blood screens and random pill counts at any time as determined by my pain physician to detect the use/abuse of both prescribed and non-prescribed medications/drugs. I am expected to appear at the Non-Interventional Pain Management Clinic in Zephyrhills, with my medications, within 48 business hours after being contacted for a random pill count. I am aware that providing a fraudulent urine sample, inconsistent pill count or failing to appear for a random pill count (without a legitimate excuse) will result in my immediate discharge from the clinic.

11. I understand and agree that if I do not follow any of the above conditions or provisions, or if my urine/blood is found to **not** contain my medications as prescribed by my pain physician, or contains illegal substances, alcohol, or opioid medications not prescribed by my pain physician, that I will be discharged from this clinic and referred back to my primary care physician, and be referred for appropriate drug counseling/rehabilitation as determined by my pain physician. I understand that when I am discharged for testing negative for prescribed opioids, my pain physician **will not** provide me with any further opioid prescriptions.

I, _____, have read the above information, or it has been read to me, and all questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in opioid medication therapy.

_____ _____

Patient Signature Date

_____ _____

Physician or Designee Date

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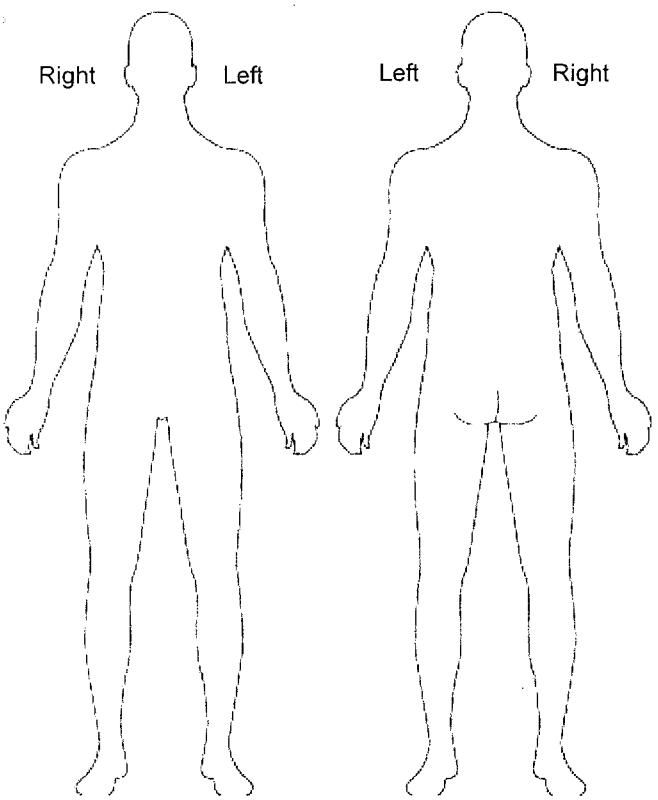
SOAPP

Patient Name:

	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
1. How often do you have mood swings?					
2 How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt things are just so overwhelming that you can't handle them?					
5. How often is there tension in the home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain pills than you were supposed to?					
10. How often have you been worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How oftenhave any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you have a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					

	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medication from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					



STUDY ID# _____ Hospital #_____

Do not write above this line

Brief Pain Inventory (short form)

Date: Time:

Name:

1. Throughout our lives most of us have had pain from time to time (such as minor headaches, spasms, and toothaches. Have you had pain other than these everyday kinds of pains today?

   1. Yes 2. No

2. On the diagram to the left shade in the areas where you feel pain. Put an X on the area that hurts the most

3. Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain — Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its least in the last 24 hours.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain — Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the average.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain — Pain as bad as you can imagine

---

6. Please rate your pain by circling the one number that tells how much pain you have right now.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain — Pain as bad as you can imagine

7. What treatments or medications are you receiving for your pain?

_____

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

   0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 10%

   No Relief — Complete Relief

9. Circle the one number that describes how, during the past 24 hours pain has interfered with your:

   A. General Activity

   0 1 2 3 4 5 6 7 8 9 10

   Does not Interfere — Completely Interferes

   B. Mood

   0 1 2 3 4 5 6 7 8 9 10

   Does not Interfere — Completely Interferes

   C. Walking Ability

   0 1 2 3 4 5 6 7 8 9 10

   Does not Interfere — Completely Interferes

   D. Normal Work (includes both work outside the home and housework)

   0 1 2 3 4 5 6 7 8 9 10

   Does not Interfere — Completely Interferes

   E. Relations with other people.

   0 1 2 3 4 5 6 7 8 9 10

   Does not Interfere — Completely Interferes

   F. Sleep

   0 1 2 3 4 5 6 7 8 9 10

   Does not Interfere — Completely Interferes

   G. Enjoyment of Life

   0 1 2 3 4 5 6 7 8 9 10

   Does not Interfere — Completely Interferes

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REVIEW OF SYMPTOMS

Patient Name: **Date:**

Have you experienced any of these symptoms in the last three (3) months? Check all **YES** answers, leave all **NO answers blank**, if you aren't sure make a ? (question mark).

SKIN
_____ Rash
_____ Lump or growth
_____ Skin cancers
_____ Jaw pain on chewing
_____ Swollen Lymph nodes

NOSE and THROAT
_____ Hoarseness
_____ Sinus problems
_____ Sores in mouth

EYES
_____ Glasses
_____ Glaucoma
_____ Change in vision
_____ Pain in eyes
_____ Halo around lights
_____ Conjunctivitis
_____ Iritis
_____ Red eyes

DIGESTIVE
_____ Loss of appetite
_____ Vomiting blood
_____ Passing blood in bowels
_____ Black stools
_____ Jaundice
_____ Frequent heartburn
_____ Frequent nausea/vomiting
_____ Stomach pain
_____ Constipation
_____ Stomach ulcers
_____ Hemorrhoids

NEUROLOGIC
_____ Convulsions/epilepsy
_____ Migraine headaches
_____ Frequent headaches
_____ Fainting
_____ Dizziness
_____ Depression
_____ Stroke/paralysis
_____ More nervous than the average person
_____ Difficulty sleeping most nights

HEART and LUNGS
_____ Chest Pain
_____ Shortness of breath
_____ Blood in sputum
_____ Wheezing
_____ Unusual heartbeat
_____ Heart attack
_____ Swollen ankles
_____ Murmer
_____ Rheumatic fever
_____ Pneumonia
_____ Emphysema

MUSCULOSKELETAL
_____ Broken bones
_____ Back pain
_____ Painful joints
_____ Sore muscles

ENDOCRINE
_____ Frequent urination
_____ Unusual thirst
_____ Thyroid problems or goiter

GENITOURINARY
_____ Difficulty starting urine stream
_____ Painful urination
_____ Blood or puss in urine
_____ Discharge (penile/vaginal)
_____ Unexpected vaginal bleeding after menopause
_____ Difficulty controlling urine

BREAST
_____ Lump
_____ Discharge
_____ Pain

GENERAL
_____ Unusual fatigue
_____ Unusual weakness
_____ Night sweats
_____ Anemia
_____ Cancer

Patient name: **Date:**

Circle the words that most describe your **PAIN:**

aching	throbbing	shooting	stabbing	gnawing	prickling	sharp
tender	burning	exhausting	tiring	penetrating	nagging	numb
miserable	unbearable	deep	cramping	radiating	squeezing	dull

How long have you had this Pain? CIrcle one

Less than a week 1-2 weeks 2-4 weeks more than a month

What kind of things make your pain feel better? (for example, heat, medicine, rest?)

1. _____
2. _____
3. _____
4. _____

What kind of things make your pain worse? (for example, walking, standing, lifting?)

1. _____
2. _____
3. _____
4. _____

Write down any questions or information you need to share with your doctor, nurse, or pharmacist about your pain.

_____
_____
_____
_____
_____
_____

PAIN SCORE

Please rate your pain as follows:

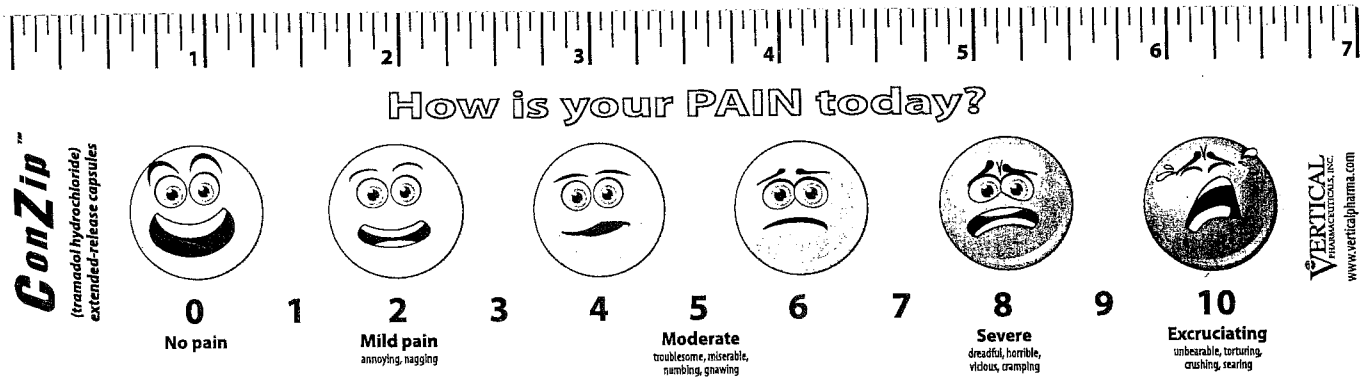
Circle one of each

NOW ☺no pain -**1-2-3-4-5-6-7-8-9-10**- worst possible pain☹

BEST ☺no pain -**1-2-3-4-5-6-7-8-9-10**- worst possible pain☹

AVERAGE ☺no pain -**1-2-3-4-5-6-7-8-9-10**- worst possible pain☹

WORST ☺**no pain -1-2-3-4-5-6-7-8-9-10**- worst possible pain☹



Florida Medical Clinic, P.A.
Authorization to Share Protected Health Information

Patient Name:	Second Form of Identification (SS#/DOB/Account#)

I authorize the physicians and staff of:

- ☐ All FMC Departments
- ☐ The following FMC Departments

Specify:

_____

_____

_____

to share protected health information with the following persons:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

This includes (please check all areas that apply)

- ☐ All Medical Information
- ☐ Lab Results
- ☐ X-ray Results
- ☐ Medication (RX Renewal and Pickup)
- ☐ Telephone Consults
- ☐ Hospital Information
- ☐ Insurance Information
- ☐ Dialysis Clinic Information
- ☐ Appointment Information
- ☐ Other (please specify)

This authorization will be in effect until authorization is revoked.

Patient's Signature_____ Date_____

Witness _____