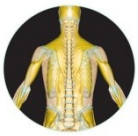


Invasive Pain Management

A Center of Excellence

Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

Dear Patient,

Thank you for choosing Invasive Pain Management Clinics, the offices of Dr. Edwin Colon, M.D., P.A. for your healthcare needs. The following are the addresses to our offices. We look forward to meeting your healthcare needs.

New Port Richey:	**Dade City**	**Wesley Chapel**
8819 River Crossing Blvd.	36739 S.R. 52	2407 Cypress Ridge Blvd.
New Port Richey, FL 34655	Suite 102	Wesley Chapel, FL 33543
	Dade City, FL 33525	
(727) 834-8833 Office	(352) 567-4117 Office	(813) 907-3300 Office
(727) 834-8842 Fax	(352) 567-4122 Fax	(813) 907-3311 Fax

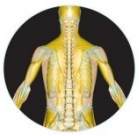
- Our **New Port Richey** office is located on the North East corner of Little Road and River Crossing Blvd's. We are behind the Hess gas station and the Auto Spa car wash.

- Our **Dade City** office is located in the old HRS building, right across the street from the
- Pasco County Fairgrounds and the Dade City MotoCross.

- Our **Wesley Chapel** office is located off State Road 56, behind the Synovus Bank and right next door to Tower Radiology. We're just 1.5 miles west of Wiregreass Mall.

Should you need additional information or directions, please don't hesitate to call us!

Sincerely,
Edwin Colon, M.D.,P.A.



Invasive Pain Management
A Center of Excellence
Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

I_____ Social Security # _____-_____-_____
(Print Patient's Name)
Date of Birth_____/_____/_____ Phone (_____) _____-_____
Address_____
Authorize_____
(Name of Doctor or person who is to release information)

To release information from my Medical Records, requested medical information, including:
___ Office Notes, Lab Work, Testing & X-rays
___ HIV Antibody test results / AIDS records ___ Communicable Diseases (Hepatitis, etc.)
___ Psychotherapy Notes / Drug and Alcohol ___Other_____

The information will be used for the following purpose(s):
Continued Medical Care _____ Insurance _____ Legal Follow-up_____
Personal Information _____ Disability _____ Other_____
I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by Federal privacy regulations
I understand that this consent shall be valid for a period of 1 year from the date of authorization and may be revoked at any time upon written notice, except to the extent that the information has already been released in reliance upon this authorization.
I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on any actions they took before they received the revocation.
I further understand that the confidentiality of this information may be protected by Federal regulations (42CFR, Part II), Prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated.

_____ _____
(Patient's signature) (Patient representative signature)

_____ _____
(Date signed) (Relationship to patient)

_____
(Witness)

New Port Richey:
8819 River Crossing Blvd.
New Port Richey, FL 3465

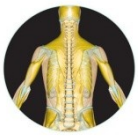
(727) 834-8833 Office
(727) 834-8842 Fax

Dade City
36739 S.R. 52
Suite 102
Dade City, FL 33525
(352) 567-4117 Office
(352) 567-4122 Fax

Wesley Chapel
2407 Cypress Ridge Blvd.
Wesley Chapel, FL 33543

(813) 907-3300 Office
(813) 907-3311 Fax

RELEASE OF CONFIDENTIAL INFORMATION

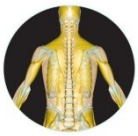


Invasive Pain Management
A Center of Excellence
Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

Attention All Patients

We are a specialist office that REQUIRES a referral BEFORE you can be seen by the physician. If you are on a HMO (health maintenance organization) or an insurance plan that requires a referral, you MUST obtain the referral from your PCP (primary care physician) before you can see our physicians. It is YOUR responsibility to obtain this referral and you WILL NOT be seen without it per your insurance company guidelines.

Your Insurance Company / HMO WILL NOT pay for your visit without the proper referral.



Invasive Pain Management
A Center of Excellence

Patient Last Name_____ **First**_____ **Middle Initial**_____

Address_____ **City, State, Zip**_____

Hm: (_____) _____-_____ Wk (_____) _____-_____ Cell (_____) _____-_____

D.O.B.____/____/_____ SSN_____-_____-_____ Marital Status_____

Employer_____ **Occupation**_____

Employer Address_____

Employer Phone (_____) _____-_____ ext._____

Spouse Last name_____ **First**_____ **Middle Initial**_____

D.O.B.--___/___/_____ SSN_____-_____-_____ Cell Phone# (_____) _____-_____

Spouse Employed By_____ **Business # (_____) _____-_____ ext**_____

Address_____ **Occupation**_____

Who is responsible for account? _____ **Relationship to patient**_____

Primary Insurance Co._____ **Phone (_____) _____-_____**

Address_____ **City, State, Zip**_____

Policy#_____ **Group#** _____

Name of Policy Holder_____ **D.O.B.____/____/_____ SSN____-____-_____**

Secondary Ins. Co. _____ **Phone (_____) _____-_____**

Address_____ City, State, Zip_____

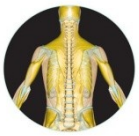
Policy#_____ **Group#** _____

Name of Policy Holder_____ **D.O.B.____/____/_____ SSN____-____-_____**

How did you hear about us? Who referred you?

_____

Please remember that insurance is considered a method of reimbursing the patient for fees paid/owed to the physician, but is usually not designed to pay the entire fee. Insurance companies vary in the amount they will pay for various services. It is ultimately your responsibility to pay the portion of the bill not paid by your insurance company restricted by law or agreement we might have made with the insurer.



Invasive Pain Management
A Center of Excellence
Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

Patient Privacy Rights

You Have the Right To:

- Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy of your record. We must respond within 30 days if the record is readily available and within 60 days if it is not readily available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days.
- Receive an accounting of any disclosures made from your record over the last six years starting April 14th, 2003. You can get this with a written request directed to our office. We must respond within 60 days.
- Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supersede the typical disclosures noted above. You may revoke or restrict consent.
- Request confidential communications. All communications in our office are confidential. You may specifically request that all communications be confidential with a written request directed to our office.
- Receive a copy of this notice by printing it or with a written request directed to this office and a copy of this notice will be given with all new patient packets.

We may contact you for appointment reminders and we may provide you with information about health related or product benefits and services.
Each patient is given a copy of the privacy notice & an opportunity to review and understand it.

Our responsibilities under HIPAA:

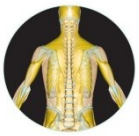
We are required by law to maintain the privacy of your personal health information and to provide you notice of our legal duties and privacy practices and adhere to this notice. We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change. Copies will be made available.

You can submit a complaint about our privacy policy or its execution either verbally or in writing to our PRIVACY OFFICER at:

Edwin Colon MD, PA
P.O. Box 99
Dade City, FL. 33525

(727) 834-8833 Office
(727) 834-8842 Fax

If you get no resolution to your complaint, you can send a written statement to this officer or the Secretary of Health and Human Services.



Invasive Pain Management
A Center of Excellence
Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

Dear Patient,

It is in everyone's best interest to take the time to read this notice.

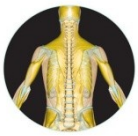
As a pain management practice, we have the responsibility of prescribing pain medications for our patients.

NARCOTICS in particular. As specialists in the field of pain management, we reserve the right to evaluate, asses and prescribe the appropriate medication for our patients. If you are placed on any narcotics, you ***MUST*** take the medications as prescribed. ***NARCOTICS MUST NOT BE CHEWED, CRUSHED, CUT IN HALF, DISSOLVED, OR INJECTED.*** Doing so will lead to very serious consequences resulting in death.

As a patient, you must fully understand the consequences mentioned above. By signing this notice, you acknowledge that you have read and understand this notice.

_____ _____
Edwin Colon, M.D., P.A. Rosemary Clanton, A.R.N.P.

_____ _____ _____
Patient Signature Please Print Date



Invasive Pain Management
A Center of Excellence
Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

Narcotic Agreement

The purpose of this agreement is to maintain a safe controlled treatment plan. I am asking for narcotic pain medication because other treatment and medications I have received have not given enough pain relief. It is unlikely that any medication will completely take away my pain. But humane reasons, narcotic pain medication will be given to me as long as my pain continues, provided I follow the terms of this agreement.

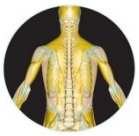
I understand that the possible complication of chronic narcotic therapy include but are not limited to Chemical Dependence (Addiction), Constipation, which could be severe enough to require medical treatment, difficulty with urination, drowsiness, nausea, itching, slowed respiration, and reduced sexual function. If I take more medication than what is prescribed, a dangerous situation could result, such as coma, organ damage or even death. I understand that if I run out of my medication too soon, or if my medication is stopped suddenly, I could have withdrawal symptoms, which can be very uncomfortable and dangerous. If I become pregnant, there are known and unknown risks to the unborn child, which include narcotic addiction and the possibility of the baby experiencing narcotic withdrawal at birth. I am obligated to let my doctor know if I am pregnant and they will help me find ways of controlling my pain without narcotics.

The terms of the agreement are as follows:

- Only **ONE** pharmacy will be used for filling narcotic prescriptions. That pharmacy's name address and phone number is:

  Name:_____
  Address:_____
  Phone#:_____

- If it is discovered that I received a prescription for narcotic medications from a source other than **Edwin Colon MD, PA (Invasive Pain Management Clinic),** I may be discharged from their care and any
- prescriptions of narcotics may be immediately discontinued.
- If it is necessary to call the office of **Edwin Colon MD, PA (Invasive Pain Management),** I will call on Monday through Friday (9:00 am – 4:30 pm) to refill medications. It is important to make sure that I have enough medications to get me through the weekend or after hours. I understand and agree that refills will only be given as I follow up in the office and keep my appointment maintenance.
- The physicians on call after hours and on weekends will **NOT** refill my medications. They do not have medical records available for review to make decisions regarding my medications.
- I agree ad will sign a release to allow **Edwin Colon MD, PA (Invasive Pain Management)**
- I will contract and communicate with **Edwin Colon MD, PA (Invasive Pain Management)** about
- narcotics and other pain related medications and side effects. I will **NOT** contract other physicians who do not work for **Edwin Colon MD, PA (Invasive Pain Management)**, regarding the above concerns, if I have a significant side effect that occurs after hours or during the weekend, it is appropriate to go to the emergency room or the nearest hospital.
- I agree to take the narcotic medication **EXACTLY** as instructed by **Edwin Colon MD, PA (Invasive Pain Management)** physicians. I am **NOT** allowed to change dosage amounts or alter the time schedule of
- taking the medication without talking to a staff member of **Edwin Colon MD, PA (Invasive Pain Management)**



Invasive Pain Management
A Center of Excellence
Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

- I agree that **Edwin Colon MD, PA (Invasive Pain Management)** will **NOT** replace lost, stolen or inaccessible narcotic medications or narcotic prescriptions for any reason.
- I **MUST** keep all regular follow up appointments as recommended by the physicians of **Edwin Colon MD, PA (Invasive Pain Management).** Failure to comply may cause discontinuation of narcotic prescriptions and possible discharge from the care of **Edwin Colon MD, PA (Invasive Pain Management).**
- **Edwin Colon MD, PA (Invasive Pain Management)** will **NOT** accept telephone requests for refills from anyone other than me
- All narcotic prescriptions must be picked up by me. If I am too disabled or sick, an exception may be allowed, at the discretion of **Edwin Colon MD, PA (Invasive Pain Management).**
- I understand that the benefits of narcotic medications will be evaluated regularly using the following criteria of pain relief: increase function and increase in life activities, improvement in pain intensity level, absence of unacceptable or intolerance adverse side effect, if appropriate progress in a rehabilitation program, and if appropriate possible return to work and maintenance of a job.
- I agree to periodic urine screens for other medications and drugs if the physicians of **Edwin Colon MD, PA (Invasive Pain Management)** deem appropriate.
- I have been given information about the use of narcotic medications and possible risks of side effects including development of tolerance, dependency, addiction and withdrawal problems due to the medications and I agree to undergo narcotic administration.
- I agree to **NOT** hoard medications or alter the narcotic prescription. These behaviors and other unacceptable behaviors will result in the discontinuation of narcotic prescriptions and possible discharge from the practice of **Edwin Colon MD, PA (Invasive Pain Management).**
- I agree to the following:
  - That I am **NOT** currently abusing illegal or prescription drugs and I am **NOT** undergoing treatment for substance dependence or abuse.
  - That I have **NEVER** been involved in sale, illegal possession or transport of any drugs.
  - **FOR WOMEN ONLY**: That I am not pregnant and that I will inform the physicians of **Edwin Colon MD, PA (Invasive Pain Management)** if I become pregnant.

This form has been fully explained to me. I have read it or have had it read to me, and I understand and agree to the terms of this agreement. If any part of this agreement as outlined above is broken, I understand that it may result in the immediate discharge from the care of **Edwin Colon MD, PA (Invasive Pain Management)** and discontinuation of narcotic prescriptions.

Print Patient Name: _____

Patient Signature: _____Date:_____

Witness Signature:_____Date: _____

Invasive Pain Management

A Center of Excellence

Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

Name:	Age:	Date: _____/_____/20_____	This Column for Office Staff Use Only. Summary Info
Primary Physician:	Referring Physician:		

Please list all Physicians (or Mental Health Professionals) you have consulted:

Name **Date last seen** **Office phone number**

_____
_____
_____
_____
_____
_____

How did your pain start? When did your pain start? _____

__ Auto accident __ Fall (not at work) __ Just started

__ After surgery __ Work related __Other (Describe what happened)

_____

_____

HPI—Pain

WHERE is your pain? Using the following color code on the drawing, color the areas where you feel pain as it has been for the last **2-3 weeks:**

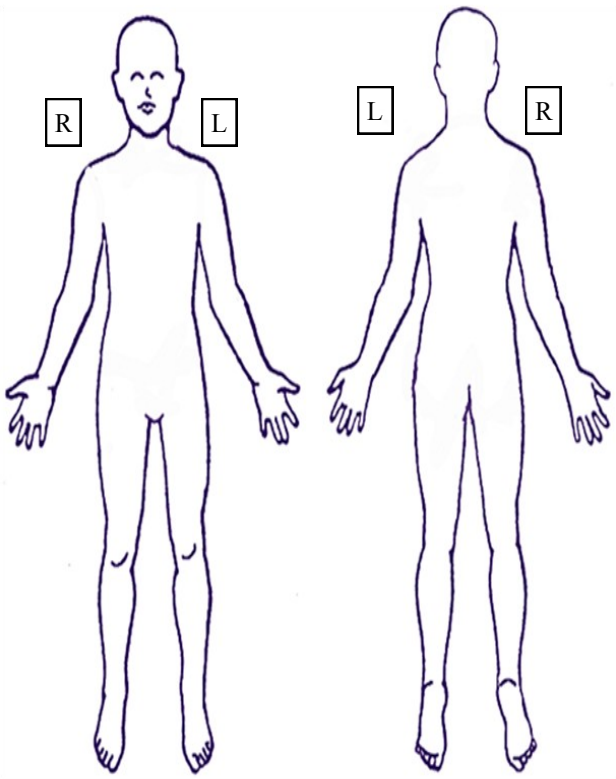
RED
Excruciating Pain

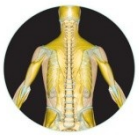
Blue
Severe Pain

Green
Moderate Pain

Black

Mild Pain





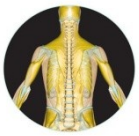
Invasive Pain Management

A Center of Excellence

Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

In the last 2-3 weeks, **WHEN** does your pain occur? __ Constant __ Intermittent (on and off) __ Less than 8 hours / day __ 8 - 16 Hours / day	***This column for office staff use only***
What does your pain feel like? (check all that apply) __ Mild __ Severe __ Burning __ Aching __ Sharp __ Other, Please describe: _____	
What **INCREASES** your pain? (check all that apply) __ Work __ Sitting __ Walking __ Standing __ Other, Please describe: _____	⇧
What **DECREASES** your pain? (check all that apply) __ Not working __ Drugs __ Rest __ Physical therapy __ Lying down __ Heat __ Cold __ Relaxation __ Injections __ Treatments in the Emergency Room __ Others, Please Describe: _____	⇩
What has been used to **TREAT** you pain? (check all that apply) __ Drugs __ Rest __ Physical therapy __ Surgery __ Counseling __ Chiropractic / Manual therapy __ Other. Please describe: _____	**Tx**
Does your pain keep you from falling asleep at night? __ Yes __ No	**Sleep**
Does your pain wake you up at night? __ Yes __ No	
What are your past or current medical problems? (check all that apply) __ Stroke __ Angina __ Hepatitis __ High blood pressure __ Epilepsy __ Heart Disease __ Arthritis __ Recent weight loss __ Migraines __ Asthma __ Cancer __ Lung disease __Diabetes __ Easy bleeding __ Heartburn / peptic ulcers __ Other, Please describe: _____	
Please list any surgeries and dates: _____ _____ _____ _____	**PSH**

Name:



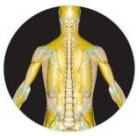
Invasive Pain Management

A Center of Excellence

Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

Do you use anticoagulants (such as Heparin or Coumadin)? __ Yes __ No	***This column for office staff use only.***
Do you use over the counter medications, recreational drugs or medications which were prescribed for someone else? __ Yes __ No If yes, Please describe: _____ _____	**Meds - Coag** **Meds-OTC**
Please list your current Medications: Dose: Frequency: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	**Meds-Rx**
Please list the medications you are allergic to or have had problems with in the past. Describe what happened when you used the medication. _____ _____ _____ _____ _____ _____	**Allergies**

Name:



Invasive Pain Management

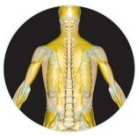
A Center of Excellence

Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

Have you had any of the following…			**Have you had any of the following?**			***This column for office staff use only.***
Heart trouble	__ Yes	__ No	High blood pressure	__ Yes	__ No	
Heart or chest pain	__ Yes	__ No	Shortness of breath at rest	__ Yes	__ No	**ROS**
Bleeding problems	__ Yes	__ No	Swollen ankles	__ Yes	__ No	**CV**
Breathing problems	__ Yes	__ No	Frequent pneumonias	__ Yes	__ No	**Pulm**
Frequent nausea/vomiting	__ Yes	__ No	Stomach ulcers	__ Yes	__ No	**GI/GU**
Frequent diarrhea	__ Yes	__ No	To use laxatives regularly	__ Yes	__ No	**Endo**
Loss of bowel control	__ Yes	__ No	To use stool softeners	__ Yes	__ No	**Skel**
Pain on urination	__ Yes	__ No	Loss of urinary control	__ Yes	__ No	**Imm**
Diabetes	__ Yes	__ No	Urinary tract infections	__ Yes	__ No	**Neuro**
Joint stiffness or swelling	__ Yes	__ No	Thyroid problems	__ Yes	__ No	
Frequent infections	__Yes	__ No	Joint pain	__ Yes	__ No	
Seizures	__ Yes	__ No	Skin problems	__ Yes	__ No	
Severe headaches	__ Yes	__ No	Fainting spells	__ Yes	__ No	
Strokes or TIA's	__ Yes	__ No	Weakness of arms/legs	__ Yes	__ No	

Have you gained or lost more than 10 pounds in the last year?	__ Yes	__ No	**Wt Chg**
For men only: Do you have any problems with erections?	__ Yes	__ No	**Men**
For women only: Are you pregnant?	__ Yes	__ No	**Preg**
Are you trying to get pregnant?	__ Yes	__ No	
If you smoke, how much do you smoke?			**Tob**
If you drink alcoholic beverages, how much do you drink?			**Alc**
Has anyone complained about your drinking?	__ Yes	__ No	
If yes, who has complained?			
If you drink beverages containing caffeine, how much do you consume?			**Caff**
Are you married?	__ Yes	__ No	**Social**
Do you have dependants at home?	__ Yes	__ No	
If yes, please list children's ages or describe other dependants:			
_____			
_____			
Current employer: _____			**Work**
Occupation: _____			
How long with this employer? ____ Years.			
If not working, date last worked? ____ / ____ / _____			**Off Work**
If not working, who took you off work? _____			
When will your off work slip expire? ____ / ____ / _____			

Name:



Invasive Pain Management

A Center of Excellence

Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

Are you on Worker's Comp? __ Yes __ No	Date W.C. started ____ / ____ / _____	***This Column for office staff use only***
Are you on Disability? __ Yes __ No	Date disability started ___ / ___ / ____	
If yes, which type of disability do you have?(check all that apply) __Short Term Disability __ Long Term Disability __ Social Security Disability __ Other: _____		**Disability**
What do you get disability for? _____		
Are you in a lawsuit with Worker's Comp? __ Yes __ No Are you involved in a lawsuit regarding an auto accident? __ Yes __ No Are you involved in a lawsuit regarding a disability claim? __ Yes __ No		**Litig**
If you are involved in a lawsuit, who is the lawsuit against? _____		
How has pain affected your personality? (circle all that apply)		**Psych**

No effect	Alert	Cheerful	Get along well
Slightly upset	Irritable	Disagreeable	Complaining
Moderately Upset	Unhappy	Anxious	Uncooperative
Severely Upset	Quite depressed	Bitter	Withdrawn
Totally incapacitated	Severely withdrawn	Panicked	Avoid everyone
Moody	Dull	Desperate	

Since the pain, what are you concerned about? (check all that apply)

__ Loss of recreational activities	__ Ability to earn income
__ Memory / Concentration difficulties	__ Poor sleep and daytime fatigue
__ Sexual desire, interest	__ Unidentified medical problems
__ The pain lasting forever	__ Other, please describe: _____

What stress has the pain caused you at home? _____

What stress has the pain caused you at work? _____

What stress has the pain caused you emotionally? _____

What stress has the pain caused you with relationships? _____

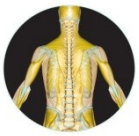
What stresses were you under before the pain? _____

Are you depressed now? __ Yes __ No

Have you ever seen a counselor, psychologist or psychiatrist? __ Yes __ No
If yes, please include their name, date last seen and office phone number on page 8.

Which treatments have you had for emotional problems? (check all that apply) __ ECT
__ Counseling __ Medication __ Group therapy __ Other, please describe:

Name:



Invasive Pain Management

A Center of Excellence

Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

Describe the stressful experience in your ***ENTIRE LIFE*** up to now:

_____
_____
_____
_____

In addition to decreased pain, what do you hope to get from treatment at our pain clinic?

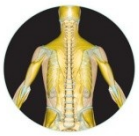
_____
_____
_____
_____

What diagnostic studies, such as X-rays, CT scans, MRI's, Myelograms, EMG (electromyelogram and/or nerve conduction study), or bone scans have been done within the last 5 years? Please give studied area and date.
Please have the reports of these studies available when you are first seen.

Type of study? (circle one)	**Date?**	**Do you have the report? (circle one)**	**Part of your body studied?**
X-ray MRI Myelo EMG CT Bone scan		Yes No	
X-ray MRI Myelo EMG CT Bone scan			
X-ray MRI Myelo EMG CT Bone scan			
X-ray MRI Myelo EMG CT Bone scan			
X-ray MRI Myelo EMG CT Bone scan			
X-ray MRI Myelo EMG CT Bone scan			
X-ray MRI Myelo EMG CT Bone scan			
X-ray MRI Myelo EMG CT Bone scan			
X-ray MRI Myelo EMG CT Bone scan			
X-ray MRI Myelo EMG CT Bone scan			
X-ray MRI Myelo EMG CT Bone scan			

Height: ____ Feet ____ Inches	Weight: _____ lbs

Name:



Invasive Pain Management

A Center of Excellence

Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

Dear Patient;

The completion of information / insurance forms represents an administrative service to our patients above and beyond the provision of medical care. Recent changes in health care have resulted in the tremendous increase in the volume of information requests to our practice. The time and effort involved in providing this detailed information results in significant costs, especially when multiplied over the large number of patients our practice services. The refusal of insurance companies and requesting agencies to cover the cost requires us to institute a policy of charges for the completion of forms as follows:

NO CHARGE INVOLVED:

- Mailing of records to a new physician or practice.
- Records or reports mailed to a primary physician .

$25.00 and up for completion of the following:

- Any dictated letter describing medical care and limitations
- Workers Compensation requested disability and work status forms
- Auto insurance carrier requests for work status and treatment plan
- Disabled parking applications
- Private disability insurance form
- School educational disability limitation form

$50.00 for the following:

- **No Show / No Cancellation fee for <u>OFFICE APPOINTMENT</u> that is not cancelled within 24 hours of your appointment time**

$100.00 for the following:

- **No Show / No Cancellation fee for <u>SURGERIES</u> that are not cancelled within 48 hours of your surgery time. <u>ALL SURGERIES</u> must be cancelled at the <u>OFFICE</u> in which you are seen. <u>NOT THE SURGERY CENTER OR HOSPITAL</u>** .

$100.00 and up for the following:

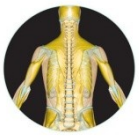
- Any narrative report detailing diagnosis, treatment and future medical care including work capacity statement. (Functional capacity evaluation testing necessary prior to or in addition to the narrative report).

In closing, thank you in advance for your cooperation and understanding.

_____ _____

Patient signature Date

Name:



Invasive Pain Management
A Center of Excellence
Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care / diagnostic treatment and or minor surgical treatment by the physicians of Invasive Pain Management Clinics (offices of Edwin Colon, M.D.,P.A.) deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment in the office. I authorize the release of any of my past/current medical records that are needed for my treatment from prior healthcare providers.

Signature: _____ Date: _____ / _____ / _____

AUTHORIZATION & ASSIGNMENT

Thank you for choosing us as your health care provider! We are committed to the excellent treatment of all our Patients and we will always do our best to provide excellent care both in the office and in the hospital. As in most practices, medical fee reimbursements continue to increase. We have implemented this **Patient Financial Policy** to help control costs so that we can always provide high-quality medical care. If you have any questions about this policy, please discuss them with the Office Manager. We are dedicated to providing care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

PRIVATE INSURANCE & SELF PAY

FULL PAYMENT is due at time of service, unless other arrangements have been made in advance by yourself or your health coverage. For your convenience, we accept Visa, MasterCard and Discover. We are happy to assist you by billing your insurance company for all office and surgical procedures and requesting the insurance companies to remit the payment to our office. ***YOU*** are responsible for the annual deductible and any co-insurance requirements at the time of treatment, as well as any differences between the amount of our fee and the amount received from your insurance company.

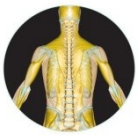
HMO, PPO, or WORKER'S COMPENSATION

If you are covered by an HMO, PPO or Worker's Compensation, please bring the referral/authorization form provided by the referring physician. Without this form, your insurance company may not pay for the treatment and you ***WILL*** be rescheduled for another appointment. We will bill the insurance company for all treatments except for any deductibles or co-pay.

Medicare & Medicaid

We participate with Medicare and Medicaid and fully cooperate with all the rules and regulations. However, you are responsible for the deductible and co-pay requirements at time of service.

I request that the payment of Authorized Medicare/Insurance Benefits be made either to me or on my behalf for any service furnished by **INVASIVE PAIN MANAGEMENT (the offices of EDWIN COLON, M.D.,P.A.)** I authorize any holder of medical information about me to release to CMS/Insurance Carriers and its agents any information needed to determine these benefits.



Invasive Pain Management

A Center of Excellence

Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

I hereby authorize **Edwin Colon M.D., P.A. (Invasive Pain Management)** to furnish information to Medicare/ Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my Insurance Carrier (s)/Medicare to make payments directly to **Edwin Colon MD, PA (Invasive Pain Management)** for medical, diagnostic or surgical benefits payable for services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status) that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or any other insurance carriers do not cover all office services /procedures . I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services.
I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you need to reschedule. There will be a **NO SHOW CHARGE OF $50.00** for all appointments not cancelled within a 24 hour notice. This charge will be your responsibility and not your insurance company's.
PLEASE NOTE YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. THE DOCTOR IS NOT INVOLVED.

I have read and understand the financial policy of Edwin Colon MD, PA (Invasive Pain Management) and I agree to be bound by its terms. I also understand that such terms may be amended from time-to-time by the practice as deemed necessary.

_____ _____ / _____ / 20_____
Signature Date

DESIGNATED RELATIVE

I authorize discussion of my general medical condition and diagnosis (including treatment, payment and health care operations) with ( ) Spouse ( ) Children ( ) Other _____
Please list the family members or significant others, if any, whom we may inform about your medical conditions and/ or in case of emergency.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

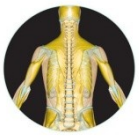
Name: _____ Relationship: _____ Phone: _____

_____ _____ / _____ / 20_____
Signature Date

PRIVACY NOTICE

I received a copy of **Edwin Colon MD, PA (Invasive Pain Management's)** privacy notice.

_____ _____ / _____ / 20_____
Signature Date
_____ _____-_____-_____
Print Name Social Security Number
_____ _____
Witness Relationship



Invasive Pain Management
A Center of Excellence
Edwin Colon MD, PA
Rosemary Clanton A.R.N.P.

NOTICE of PRIVACY PRACTICES for PROTECTED HEALTH INFORMATION (HIPPA)

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

We safeguard information about your health and person:
We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and are available only to designated staff and only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer but for service of computer operations.

Typical uses and disclosures of medical information:
We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities and agencies for whom you authorize disclosure such as other health-care providers (doctors, nurses, extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (deaths, child abuse, neglect, domestic violence, problems with products, re-actions to medications, product recalls, disease/infection exposure, disease/injury/disability control/ prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors
- Organ and tissue donation
- Research, provided authorization is IRB-approved or privacy board-approved
- Emergencies to avert serious threat to health or safety
- Specialized government functions (military, inmates)
- Worker's Compensation
- Disaster relief

We will not us or disclose your medical information for any purpose not listed without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.