NEW PATIENT PACKET

Please print, fill out & bring with you to your appointment
Dear New Patient:

Thank you for choosing Pain Treatment Center!

You are scheduled for an initial consultation on _____________________ At __________ AM PM. (Please arrive 10 minutes before this time to allow for copying of any documents and insurance cards you bring with you.)

Attached is the paperwork you will need to fill out prior to this appointment. Please remember to bring this paperwork with you, in ADDITION to the following:

- FLORIDA PICTURE ID
- INSURANCE CARDS
- COPIES OF ANY IMAGING REPORTS (MRI’S CT SCANS, X-RAYS) THAT YOU’VE HAD DONE-PERTAINING TO THE PAIN WE ARE SEEING YOU FOR.**
- BRING ANY & ALL MEDICATIONS YOU ARE TAKING IN THEIR CURRENT PRESCRIPTION BOTTLES WITH ALL REMAINING PILLS TO YOUR APPOINTMENT. IF YOU DON’T HAVE THESE AT THE TIME YOU CHECK IN FOR YOUR APPOINTMENT YOU WILL BE RESCHEDULED & CHARGED A $35 FEE.**

**If you do not have the reports, but know the facility that does have them, please contact them prior to your appointment and authorize them to fax the reports to us.

- YOUR CO-PAY/CO-INSURANCE

We accept cash, personal checks, VISA, MasterCard & Debit Cards. Copays/co-insurance will be collected at Check-in for your initial and every subsequent visit. If you do not have your copay, your appointment will need to be rescheduled.

- MEDICATION BOTTLES/BRING TO EVERY OFFICE VISIT

This is to verify date of last prescription & pharmacy. If you do not bring in your medication in their current bottles with any pills remaining to your appointment, you will NOT receive your refill or prescription and you will be rescheduled to our next available appointment and charged a $35 fee.

If you have any questions, please give us a call. Please allow yourself enough travel time to arrive on time for your appointment. We reserve the right to reschedule the appointment of any patient that arrives 15 minutes later than their scheduled time.

Cordially,   Stephen T. Pyles, MD
Chief Complaint:

- Abdominal Pain
- Hand Pain
- Leg Pain
- Ankle Pain
- Headache
- Neck Pain
- Back Pain
- Hip Pain
- Nerve Pain
- Elbow Pain
- Joint Pain
- Shoulder Pain
- Facial Pain
- Knee Pain
- Wrist Pain

**History of Present Illness: Without medication:**

<table>
<thead>
<tr>
<th>Pain level at best:</th>
<th>Pain level at worst:</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ am ___ pm</td>
<td>___ am ___ pm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

Pain level at present: Please Circle

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

**History of Present Illness: With medication:**

<table>
<thead>
<tr>
<th>Pain level at best:</th>
<th>Pain level at worst:</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ am ___ pm</td>
<td>___ am ___ pm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

Pain level at present: Please Circle

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>
Name: ________________________________________    Date of Birth _________________________

<table>
<thead>
<tr>
<th>Current Medications:</th>
<th>Medication Allergies:</th>
<th>Supplements:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Additional Medications:
______________________________________________________________________________

Are you allergic to any metals?   ___ yes   ___ no    Are you pregnant? ___ yes   ___ no

Diabetes   ___ yes   ___ no    Heart Disease:   ___ yes   ___ no    High Blood Pressure:   ___ yes   ___ no

Do you smoke:   ___ yes   ___ no    Do you drink alcohol:   ___ no   ___ socially   ___ 1 or 2 daily   ___ 3 or more daily

Surgeries:

<table>
<thead>
<tr>
<th>Type/Description</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Current MRI’s, CT’s or Xrays:

<table>
<thead>
<tr>
<th>Where</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
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</tr>
</tbody>
</table>

Did you ever attend Physical Therapy and if so where/when: ____________________________________________

Did you ever have a nerve Conduction Study and if so where/when: ______________________________________

Did you ever have Chiropractic Treatment and if so where/when: ______________________________________

Did you ever receive care by another pain specialist, where/when: ______________________________________
Patient Name: __________________________  DOB: _______________ Age: ____________
Address: ___________________________City: __________________State: ______
Home Phone #: _______________________ Cell Phone #: ___________________ Gender: M F
Email address: ___________________________________________________________
Social Security Number: ______________________ Driver’s License #: ______________________
Employer Name: ___________________________Work #: ______________________
Marital Status: ______ Married ______ Single _______ Widowed _______
Name of Spouse: ___________________________ Home #: ___________________ Cell #: ______________________
Emergency Contact: __________________________ Relationship: ______________________
Home #: _______________________________ Cell #: _______________________________
Winter Address (If applies): ______________________________ Phone # _______________
Primary Physician: ___________________________ Referring Physician: ______________________
Pharmacy Information: ___________________________ Phone #: ______________________
## INSURANCE INFORMATION

### Primary Insurance:

<table>
<thead>
<tr>
<th>Insurance Company</th>
<th>Subscriber</th>
<th>Policy #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Secondary Insurance:

<table>
<thead>
<tr>
<th>Insurance Company</th>
<th>Subscriber</th>
<th>Policy #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Third Insurance:

<table>
<thead>
<tr>
<th>Insurance Company</th>
<th>Subscriber</th>
<th>Policy #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name: ____________________________  Date of Birth ____________________________
PLEASE MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS:

*Use the following symbols. Mark areas of radiation. Include all affected areas.*

<table>
<thead>
<tr>
<th>Sensation</th>
<th>Marking</th>
<th>Marking</th>
<th>Marking</th>
<th>Marking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbness</td>
<td>&lt;&lt;&lt;&lt;&lt;</td>
<td>0000</td>
<td>XXXX</td>
<td>/////</td>
</tr>
<tr>
<td>Pins &amp; Needles</td>
<td>&lt;&lt;&lt;&lt;&lt;</td>
<td>0000</td>
<td>XXXX</td>
<td>/////</td>
</tr>
<tr>
<td>Stabbing</td>
<td></td>
<td>XXXX</td>
<td>XXXX</td>
<td>/////</td>
</tr>
</tbody>
</table>

PLEASE USE ANY OTHER MARKINGS FOR OTHER TYPES OF PAIN

How often does your pain interfere with:

<table>
<thead>
<tr>
<th>Work</th>
<th>Family</th>
<th>Chores</th>
<th>Continuously</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Continuously</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Several times a day</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Once a day</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Several times a week</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Once a month</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Less frequent:</td>
</tr>
</tbody>
</table>

COMMENTS:

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________
MAP TO THE OFFICE:
2300 S. Pine Ave. Suite A, Ocala, FL 34471
NOTICE OF PRIVACY PRACTICES
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. You have the right to obtain a paper copy of this Notice upon request.

Effective Date: The effective date of this notice is 4/14/2003

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION
For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Title: Privacy Officer
Kelli C. Frederick
Telephone: 352-873-6868 ext. 27
Fax: 352-872-9726
Email: kfrederick@flpain.ecoxmail.com
Address: 2300 South Pine Avenue, Suite A, Ocala, Florida 34471

OUR LEGAL DUTY
We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page, and will remain in effect unless we replace it.

We reserve the right to make changes to our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION
Treatment: We may disclose your medical information, without your prior approval, for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;

any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorized, you may opt out of any of these communications.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you identify in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.
We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has had a relationship with you and the medical information is for that provider's or plan's health care quality assessment and improvement activities, competence and qualifications evaluation and review activities, or fraud and abuse detection and prevention.

**Your Authorization:** You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services, and treatment alternatives.

**Reminders:** We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders.

**Plan Sponsors:** If your dental insurance coverage is through an employer’s sponsored group dental plan, we may share summary health information with the plan sponsor.

**Public Health and Benefit Activities:** We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker’s compensation laws.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

**Business Associates:** We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

**Data Breach Notification Purposes:** We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.

**Additional Restrictions on Use and Disclosure:** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information. Including highly confidential information about you. “Highly confidential information” may include information about criminal activities under federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

- HIV/AIDS;
- Mental health;
- Genetic tests;
- Alcohol and drug abuse;
- Sexually transmitted diseases and reproductive health information; and
- Child or adult abuse or neglect, including sexual assault.

**YOUR RIGHTS**

**Access:** You have the right to examine and receive a copy of your medical information, with limited exceptions. We will use the format you request unless we cannot practically do so. You should submit your request in writing to our Privacy Officer.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Officer for information about our fees.

**Disclosure Accounting:** You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to our Privacy Officer. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

**Amendment:** You have the right to request that we amend your medical information. You should submit your request in writing to our Privacy Officer.

We may deny your request only for certain reasons. If we deny your request, we will provide you with a written explanation. If we deny your request, you may have a statement of your disagreement added to your medical information. If we accept your request, we will make the amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the amended information to your detriment, as well as persons you want to receive the amendment.

**Restrictions:** You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. Except in limited circumstances, we are not required to agree to your request. But if we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to our Privacy Officer. Except as otherwise required by law, we must agree to a restriction request if:

1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and
2. the medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the patient.

**Confidential Communication:** You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should submit your request in writing to our Privacy Officer.

**Breach Notification:** You have the right to receive notice of a breach of your unsecured medical information. Breach may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are discussed and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if we know the identity and address of such individual(s).

**Electronic Notice:** If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Privacy Officer to obtain this notice in written form.
COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact our Privacy Officer.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, DC 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, _________________________________ hereby acknowledge receipt of the Notice of Privacy Practices given to me by the Pain Treatment Center.

Signed: __________________________________________ Date: ________________

For Office Use Only:

If not signed, reason why acknowledgement was not obtained:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Person seeking acknowledgement: __________________________ Date: ________________
AUTHORIZATION TO TREAT: I hereby grant permission to the physicians and staff of Pain Treatment Center to perform any necessary procedures to treat the medical conditions for which I am seeking assistance. I understand that, except in an emergency situation, the staff will discuss with me my treatment options and that I will have the opportunity to accept or refuse specific treatments at that time.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any holder of medical information about me to send to my insurance carrier or sponsoring agency or to the Social Security Administration or its intermediaries or carriers, when relevant, any such information that is requested by them needed for the processing of insurance benefit claims.

ASSIGNMENT OF BENEFITS: I certify that the information I have given is correct, and I hereby authorize payment to Pain Treatment Center of the benefits payable to me and to my physicians. In applying for payment under Title XVIII of the Social Security Act, I request payment of authorized benefits be made on my behalf to those who accept this assignment. I further understand that I am responsible for any charges not covered or payable by the assignment, even though Pain Treatment Center accepts assignment of services rendered by the physician. I agree to forward any such payments I receive to Pain Treatment Center as soon as I receive them.

CHARGES FOR SERVICES: The charges for Pain Treatment Center are for the physician’s professional fees and services. These charges do not include Surgery Center or Hospital facility fees. The facility fees will be billed separately by the facility.

PAYMENT FOR SERVICES: As a courtesy to you, we will file claims with your insurance company. Monthly statements are mailed to patients only if they are responsible for some portion of the bill. Patients, who have no insurance coverage, should be aware that payment for services is due on the day they are seen. We accept payment by Visa and MasterCard. Once the insurance payment is received, if necessary, depending on your payment history a monthly payment arrangement can be made on any open balances.

PATIENT RESPONSIBILITY FOR PAYMENT: I understand that my insurance coverage is a contract between my insurance carrier and me. NOT between the insurance carrier and Pain Treatment Center. Ultimately, all fees are my responsibility. Should timely payments not be made on my account, I authorize Pain Treatment Center to retain the services of an attorney or collection agency to assist with the collection. Any expenses incurred by Pain Treatment Center for such action become an additional liability for which I assume responsibility.

____________________________
DATE

____________________________
PATIENT’S SIGNATURE
AUTHORIZATION TO RELEASE/OBTAIN HEALTH INFORMATION

1. Patient Name: __________________ DOB: __________________
   Address: __________________________________________________________
   Home Phone #: _________________________________________________

2. I Authorize: ________________________________________________
                   To release to: ________________________________________
                   ________________________________________________
                   ________________________________________________

3. Information to be disclosed includes only those items checked below:

   - [ ] Discharge Summary
   - [ ] Progress notes
   - [ ] Lab Results
   - [ ] Photographs, videotapes or other images
   - [ ] History & Physical Exam
   - [ ] Psychotherapy notes
   - [ ] Consultation Reports
   - [ ] Genetic test results
   - [ ] X-Ray Reports
   - [ ] Entire Medical Records
   - [ ] UA Drug Testing Results
   - [ ] Summary of Treatment
   - [ ] Other:

   [ ] Additional Comment:

4. Release the following Billing and Payment Information for dates of services:

   ________________________________

5. Revocation: I understand that I may revoke this authorization at any time by sending a written notice to
   the Practice. However, the revocation will not have any effect on any uses or disclosures the Practice may
   have made before the revocation was received.

6. Expiration: I understand that unless I revoke the authorization earlier, this authorization will expire (1)
   year after the date this authorization is signed.

7. Redisclosure: I understand that information used or disclosed in accordance with this authorization may
   no longer be protected by federal law and could be redisclosed by the receiving party.

   *Certification: I certify that I am (Check which applies):
   - [ ] Patient and the identification that I have provided is true and correct.
   - [ ] The patient’s authorized representative and that the identification and proof of authority that I have
     provided are true and correct.

SIGNATURE OF PATIENT OR GUARDIAN: __________________________________________

RELATIONSHIP TO PATIENT IF UNABLE TO SIGN: _________________________________

DATE: ________________________________

WITNESS: ________________________________ DATE: __________________________
POLICY FOR CANCELLATION AND NO-SHOWS

The following are our policies regarding cancellations and no show appointments. We take this subject seriously at our clinic because it can make the difference between pain and pain free. Usually your doctor has prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you have to do is follow your given instructions and hopefully we will be able to help you with your pain.

We require **24 hours’ notice** in the event of cancellation. It is your responsibility to notify the clinic. Coming in more than 15 minutes late for an appointment is considered a cancellation.

There is a **$35.00 charge** for a cancellation without proper notice. This charge will not be covered by insurance and will have to be paid by you personally.

For Worker’s Compensation and personal injury patients, documentation of any missed appointments is forwarded to your case manager and primary physician. This may jeopardize your claim.

Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally resolved. Either of these conditions can seem to be a reason not to come in: You are feeling worse and think the treatment is not working or you are feeling better and have something else to do. Neither of these conditions is a legitimate reason not to come. If you have a scheduled appointment, please keep it.

When you don’t show as scheduled, two people are hurt. You, because you don’t get the treatment you need as prescribed by the doctor and another patient who would have been scheduled for treatment if you had given proper notice. Please co-operate with us in this regard.

_________________________________________________________  __________________________
Patient Signature                                                                                         Date

_________________________________________________________  __________________________
Witness                                                                                                   Date
When you are coming to our office for a New Patient Visit and/or a Medication Refill appointment you must bring any and all pain medications prescribed by Dr. Pyles or any other physician to your appointment. They must be in their current bottle with your remaining pills. If you do NOT have these items with you at the check in point of your visit you will be rescheduled and charged a reschedule fee of $35.00.

Patient signature: ________________________________ Date: ________________

When you come to your appointments at Dr. Pyles office, children are NOT permitted to accompany you past the door. You must have someone that can watch them in the waiting area at all times. If you do not have someone that can supervise your children while you are being seen by Dr. Pyles your appointment will be rescheduled at that time and a rescheduling fee of $35.00 will be charged.

Patient signature: ________________________________ Date: ________________
The undersigned does hereby authorize The Pain Treatment Center in Ocala, Florida to take a photograph of patient: ____________________________________________________________

And place the photo in the client’s chart/electronic record while under the care of the Physician(s). We do this for the sole purpose of making sure that the patient’s name matches the photo. This photo is kept in your chart and electronic record only.

______________________________________________________________
Patient Name

______________________________________________________________   ___________________
Patient Signature   Date

______________________________________________________________
Witness Signature   Date
Date: ___________________________  

I, ___________________________________________ give my permission for the following individuals to discuss my medical care and or schedule appointments for me with the Pain Treatment Centers, Dr. Stephen T. Pyles.

Name:                                                                                             Relationship:

___________________________                                                                 ________

___________________________                                                                 ________

___________________________                                                                 ________

___________________________                                                                 ________

___________________________                                                                 ________

Patient Signature: ___________________________ Date: ______________________

Witness Signature: ___________________________ Date: ______________________