Dr. Stephen T. Pyles
2300 South Pine Avenue, Suite A
Ocala, FL 34471
Phone (352)861-4600 Fax (352)237-5437

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 #** _________________

Living Will/Advanced Directive? ___ **yes** ___ **no** **Name of Directive:** ____________________________

Primary Physician: __________________________ **Referring Physician:** ________________________

Pharmacy Information: ____________________________ **Phone #:** ____________________________

Name: ______________________________ **Date of Birth** ____________________

Current Medications:	Medication Allergies:	Supplements:

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:

Type/Description	Year

Current MRI's, CT's or Xrays:

Where	Year

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:

____

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.

Numbness	<<<<<	Pins & Needles	0000	Burning	XXXX	Stabbing	////
	<<<<<		0000		XXXX		////
	<<<<<		0000		XXXX		////

PLEASE USE ANY OTHER MARKINGS FOR OTHER TYPES OF PAIN

COMMENTS: ______________________________

____

____

____

____

____

____

____

____

____

How often does your pain interfere with:

Work	Family	Chores	
☐	☐	☐	**Continuously**
☐	☐	☐	**Several times a day**
☐	☐	☐	**Once a day**
☐	☐	☐	**Several times a week**
☐	☐	☐	**Once a month**
☐	☐	☐	**Less frequent:**

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 retian 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**

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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**

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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: ______________

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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: ______________