Marla D. Golden, D.O., PA
6817 Southpoint Parkway, Suite 1404
Jacksonville, FL 32216
(904) 260-1070 Office | (904) 260-1170 Fax

Patient Demographic and Insurance Intake Form

Last Name: _____ First Name: _____ MI: _____

DOB: _____ SS#: _____ Sex: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____@_____ Referred by: _____

Primary Care Physician Name and Phone: _____

Pharmacy Name and Phone: _____

Insurance Information

Primary Insurance Co: _____ ID #: _____ Grp #: _____

Secondary Insurance Co: _____ ID #: _____ Grp #: _____

Policy Holder name: _____ ID #: _____

Policy Holder DOB: _____ Policy Holder Address: _____

Policy Holder SS #: _____ Policy Holder Sex: _____ Copay Amount: _____

Patient Authorization

I authorize the release of any medical information necessary to process any claim. I authorize payment of medical benefits to the physician for services rendered.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if minor): _____ Date: _____

Managed Care / HMO Patients

I understand that it is my responsibility to obtain a valid referral from my primary care physician. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if minor): _____ Date: _____

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Today's Date: _____

Dear New Patient:

Welcome to the practice! I am looking forward to seeing you and working with you to relieve your pain. We are one of the only practices worldwide targeting the brain as an organ of treatment to combat and relieve pain.

The treatment plan at Marla D. Golden, D.O., PA features the Neuroplastic Transformation program created by me and Dr. Michael Moskowitz. It is based on the core concept of neuroplasticity and the body's ability to change in response to the input it receives. You will be guided through phases of care designed to restore function and allow you to return to a pleasurable life. The emphasis of treatment options will change as you move through the phases.

Please read this letter carefully and be sure you are willing to comply with the following requests:

Please arrive 30 minutes prior to your appointment time and plan to be here an additional 75-90 minutes. Please be considerate of my time and that of other scheduled patients. A 48 to 74 hour notice of cancellation or rescheduling of a new patient appointment is required. A 24 hour notice is required for a follow up visit. A message left on the voicemail the night before does not constitute a 24 hour notice of cancellation.

Please have your medical records sent to us prior to your first visit. Your treating physician can forward your records at your request. These include copies of recent office visit notes of treating physicians, reports of diagnostic studies, x-rays, CT scans, MRI's, ultrasounds and any pertinent lab work prior to your first visit.

You are required to have a primary care physician to manage your basic medical care. I will be providing your pain care. It is my preference to send office visit notes to your primary care physician to keep them informed of your progress. Many patients have additional members of their Pain Care Team. These may include psychiatrists, physical therapists, as well as other types of practitioners in addition to your primary care physician. You have the right to decide who is kept informed; however, a team approach is always beneficial. We can discuss this further at your first visit. Please submit the names and phone numbers of all treating physicians or health care professionals that are part of your pain care team with this paperwork.

Medication regimens will be reviewed at the first visit and throughout treatment. As a general rule, controlled substances are not prescribed at the first visit. We will discuss the role of medications in the different phases of care and use N.O.R.M.A.L., the Neuroplastic Optimization and Reduction of Medications for Adaptive Living.

Urine drug screening may be done at my discretion. The purpose is to monitor medication changes, disconcerting signs or symptoms associated with medications, and to determine how medications are being taken.

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Please bring all of your pain-related medications, and medication list to each appointment. Please bring insurance card(s), a picture ID, and any applicable copayment with you to your initial appointment and to any appointment after a change of information has been made.

If you have any questions or concerns prior to your first appointment, please feel free to call the office. My staff will be happy to answer questions of any kind. If you have any further concerns, I will be happy to discuss them at your initial visit. I am hopeful that we will enjoy an open and honest physician-patient relationship. This is critical to the success of your overall pain care program.

Once again, I am happy to welcome you to the practice and look forward to meeting you.

Sincerely,

Marla D. Golden, D.O. FACEP
Director
Electronically reviewed and signed

Your appointment has been scheduled for _____ at _____.

Please be sure to call the office with your insurance information prior to your first appointment.

Thank you!

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Marla D. Golden, D.O., PA Office Policies & Procedures

Please read the following statements, initial by each and sign the sheet after you have gone over each of them.

BILLING AND INSURANCE

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize; however, that your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

Most insurance companies consider our fees usual, customary, and reasonable. If your insurance company does not cover the whole fee, the balance becomes your responsibility.

_____ Payment for office services is due at the time services are rendered unless we participate with your insurance plan or payment arrangements have been approved in advance by our staff. We accept cash, checks, Visa and Master Card. If we participate with your insurance carrier, we expect applicable co-payment and deductibles at the time of service.

_____ A $30.00 fee will be charged for returned checks. Repayment of original fee plus returned check fee is due prior to the next office visit by cash, credit card, money order or cashier's check.

_____ I understand all services are not covered by all contracts and I am responsible for uncovered services.

_____ If you have health insurance that has a timely filing limit and you do not provide this information prior to that deadline, the responsibility for the medical debt is yours, regardless of what your insurance tells you.

_____ **I understand it is my responsibility to provide the correct insurance information, whether it be a change in insurance carrier or policy, *prior to my next scheduled appointment*. Failure to inform the office of any changes can result in denial of payment by my insurance company and any charges will be my responsibility.**

_____ If your health insurance sends you their payment, you are required to remit the payment to Dr. Golden immediately.

_____ If you are being seen for a work related injury, we must have the date of injury, W/C carrier name and address, the claim number assigned to your case and the adjusters name and phone number. The office will verify this information with the carrier. If the carrier says your employer did not report your injury, you will not be seen by Dr. Golden under workers compensation insurance.

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BILLING AND INSURANCE (CONTINUED)

_____ If you are being seen for injuries related to an auto accident, we will need the date of the accident, the claim number assigned by your auto insurance company, the adjusters name and phone number assigned to your claim and the address where claims should be mailed. If you are unable to furnish this information, you may reschedule your appointment or pay for the charges at the time of service. It is the responsibility of the patient to provide all insurance information. The office will verify the information given. If you have a high deductible and it has not been met, you will be required to pay that amount prior to being seen. Dr. Golden DOES NOT accept Letters of Protection.

_____ If you are being seen for an injury that is a result of a fall or injury that is a liability case, you must inform us prior to being seen and you must pay the medical debt in full. Dr. Golden does not file liability claims. You can take the receipt for the medical treatment and give that receipt to the person handling your liability case and they will reimburse you.

_____ If you do not have health insurance, payment is due in full at the time of service.

_____ Patients will not be able to carry a balance on their account over 30 days. Once your insurance carrier has processed the claim, and determined that the patient has a financial responsibility, you will receive a statement from our office. Statements are mailed once a month and payment is due upon receipt or by your next office visit, whichever comes first. Delinquent accounts over 90 days and 3 statements with failed attempts to collect unpaid balances will be turned over to a collection agency. You will be responsible for any administrative/collection fees and legal costs that are incurred.

APPOINTMENTS

_____ You are expected to arrive for your appointment on time. It is even advisable to be a few minutes early to update any necessary information and address any payment issues prior to being seen.

_____ Monday appointments must be cancelled by 2 PM on Friday **PRIOR** to the weekend or a $50.00 late cancellation fee will be charged.

_____ Tuesday through Friday appointments require a 24-hour notice of **CANCELLATION** to avoid a $35.00 late cancellation fee.

_____ Stand-alone NMT appointment cancellations or no shows will be charged in the same fashion as the above.

_____ Cancellations sent via text message, or email will not be accepted and will be considered a No-Show, and a No Show fee will be charged.

_____ New patient’s that do not show for scheduled appointments will be rescheduled once.

_____ More than 2 late cancellations or no shows may result in discharge from the practice.

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MESSAGES/EMERGENCIES/AFTER HOURS CALLS

_____ If you have concerns after hours, call the office, you will be able to leave a message that will be checked the next business day. If there is an emergency, call 911. My cell phone is available for **URGENT** telephone communication **AFTER HOURS**. It should not be used for non-urgent matters. It should not be used during normal business hours. Scheduling and rescheduling requests or clinical communication is done by phone conversation via office phone during normal business hours. **DO NOT** text or e-mail me clinical questions or information or scheduling requests.

_____ I am available by cell phone if you are being treated in the emergency department or are hospitalized. Please feel free to give my number to treating physicians should they need to coordinate care.

_____ **DO NOT** e-mail or fax the office about clinical concerns, appointments or medications. Email is not protected for privacy. Fax communications can be unreliable. They may not get through or may be delayed on either end. *(All such e-mails or faxes that were previously acknowledged will be no longer).*

_____ Voicemail is checked hourly on workdays, when the office is open. You will have **PLENTY of** advance notice of any office closures. All calls are returned to patients in order of clinical acuity. When you leave a message, please specify whether or not you require a return phone call. Expect telephone conversations to be brief and to the point.

_____ You will be charged a $50.00 fee per 15 minutes for non-urgent phone conversations with Dr. Golden.

_____ Urgent matters should be able to be resolved in 15 minutes. Extended conversations will be charged $50.00 per 15 minutes after the 1st 15 minutes.

_____ Dr. Golden does not answer the office phone. Please direct all questions and concerns to the office personnel, they will communicate with me and get back to you. If necessary, Dr. Golden will call you directly.

PRESCRIPTIONS AND MEDICATIONS

_____ State law requires patients on controlled substances to be seen every 3 months. **NO** medications will be prescribed if you have not been seen in SIX months. Your chart will be closed and in order to reopen it you will need to schedule an extended time visit and interim medical records will be required.

_____ Medications are prescribed and refilled at office visits. Please know what is needed when you come in for your appointment.

_____ If you send someone else to pick up your prescription, this person must be listed on the Release of Information form you signed. This person also must show valid proof of identification in order to pick up your prescription.

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PRESCRIPTIONS AND MEDICATIONS (CONTINUED)

_____ If refills are necessary at times other than office visits, please allow **THREE** business days for refills to be processed. Remember, we try to avoid this as much as possible and refill medications at office visits.

_____ There is **NO** guarantee urgent demands for refills that are made inside this three-day window will be met.

_____ **ALL** fees must be paid, or payment plans must have been set up through our office prior to any prescription(s) being called in, refilled or provided.

_____ Patients who misuse or overuse medications will be referred to the appropriate practitioner or law enforcement agency at Dr. Golden's discretion and per controlled substance agreement.

MISCELLANEOUS

_____ Please make sure your contact information is current and correct. It is your responsibility to notify us of any changes.

_____ If someone calls our office to inquire about you and this person is not listed on your Release of Information form, **NO** information will be released regardless of your relationship to this person. We will neither confirm nor deny that you are a patient in this practice.

_____ Office staff must be treated with courtesy and respect. Failure to do so will most likely result in discharge from the practice.

If you have a complaint about our office, please provide me/us with specific date, time, employee or service in question. I cannot operate on generalities.

I hereby attest that I have read and understand the information provided to me regarding the Policies and Procedures of Marla D. Golden, D.O., PA and agree to abide by these terms and conditions.

Signature: _____ Date: _____

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Controlled Substance Policy Information Consent

As part of your treatment with Dr. Golden, you may need a prescription to control your pain. These medications can include narcotics (painkillers) and sedative/hypnotic (anti-anxiety/sleeping pills). These medications are called controlled substances. They are monitored closely by the Drug Enforcement Agency in Washington, D.C.

Therefore, we have a strict set of rules you must follow while under our care using these medications.

Please read the following statements, initial by each and sign the sheet after you have gone over each of them.

_____ I agree to bring in all of my medications to every visit. This includes all pill bottles, pills, daily dose packs, and pill containers of any kind. This policy is to ensure your safety when prescribing medications.

_____ I agree to never share or sell any of my medications.

_____ I understand and agree that I am fully responsible for all my medications.

_____ I agree never to obtain additional pain medications from any other Healthcare Provider including my Primary Care Provider unless I get approval from Dr. Golden.

_____ I agree to fill my prescriptions with only one pharmacy, if possible. I will make Dr. Golden or Marla D. Golden, DO staff aware of pharmacy issues.

_____ I agree never to increase my dose prior to discussing this with Dr. Golden. I understand no early refills will be provided if I escalate my medication use without prior approval.

_____ I understand that there exists a risk of developing an addictive behavior with many of these drugs, although this behavior is a rare occurrence, it still can happen. I agree to discuss any craving or compulsive use of medications with Dr. Golden as soon as it occurs.

_____ I understand that if my medications are stolen, I will report to my local police department within 24 hours and prior to Dr. Golden prescribing another refill. I agree to obtain a stolen/missing item report from the police. More than one lost or stolen medication occurrence is considered irresponsible behavior and will result in discharge from our practice.

_____ I understand that Marla D. Golden, D.O., PA may conduct random quarterly drug screens on all patients. Drug screens may also be conducted with medication changes, disconcerting signs or symptoms associated with medications, or at Dr. Golden's discretion.

_____ I understand and agree that due to the seriousness of these medications, Dr. Golden will **NEVER** be able to phone in any refills. All prescriptions will be given out at office visits only. **NO EXCEPTIONS**.

_____ I understand that I waive all rights to HIPAA regulations if found in violation of any controlled substance act with respect to illicit or prescription drug use, abuse or diversion.

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Controlled Substance Policy Information Consent

_____ I understand that any and all violations of the controlled substance acts with respect to illicit or prescription drug use, abuse or diversion will be handed over to law enforcement to take the necessary and proper steps to investigate.

_____ I have read and understand the above policy and by signing this form, I agree to follow these rules.

_____ I understand that any breech in any rule are grounds to be discharged from the practice formally by a written letter; as well as, personally contacting your primary care physician or referring physician.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Pharmacy: _____ Phone: _____

Name: _____ Date: _____

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Marla D. Golden, D.O., PA, for purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Marla D. Golden, D.O., PA.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. However, if Marla D. Golden, D.O., PA agrees to the restrictions that I request, the restriction is binding on Marla D. Golden, D.O., PA. I have the right to revoke this consent, in writing, at any time, except to the extent that Marla D. Golden, D.O., PA have taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider or hospital (including all departments of such), a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have reviewed Marla D. Golden, D.O., PA Notice of Privacy Practices prior to signing this document. The Marla D. Golden, D.O., PA Notice of Privacy Practices was provided to me. It is also posted in the waiting room for my information. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Marla D. Golden, D.O., PA. The Notice of Privacy Practices also describes my and Marla D. Golden, D.O., PA duties with respect to my protected health information. Marla D. Golden, D.O., PA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Description of Personal Rep. Auth.

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ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT

Necessary forms will be completed to help expedite insurance reimbursement. However, unless we participate with your insurance company, the patient is responsible for all fees regardless of insurance coverage. Patients with insurance with which we participate are responsible for all co-insurance, co-pays, deductibles and non-covered services. Co-pays are due at the time of service, unless other arrangements have been made in advance with our office.

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: _____/_____/_____

RELEASE OF INFORMATION

☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Other: _____

☐ Information is **not** to be released to anyone other than the patient.

This ***Release of Information*** will remain in effect until terminated by me in writing.

MESSAGES

Please call ☐ my home ☐ my work ☐ my cell Telephone Number: _____

If unable to reach me:

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) _____ between (time) _____.

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Insurance Authorization and Assignment of Benefits

I request that payment or authorized Medicare/Other insurance company benefits be made on my behalf to Marla D. Golden, D.O. for any services furnished to me by Marla D. Golden, D.O. I authorize any holder of medical information about me to release to the Centers of Medicare & Medicaid services (CMS) and its agents/Other insurance companies any information needed to determine the benefits payable to related services.

I understand my signature requests that payments be made and authorize release of medical information necessary to pay any claims.

Signature: _____ Date: _____

Witness: _____ Date: _____

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Patient History

PATIENT NAME: _____ DATE: _____

PLEASE CHECK ALL THAT APPLY

____ Stroke
____ Hypertension
____ Arrhythmia
____ Heart Attack/MI

____ Mitral Valve Prolapse
____ Pacemaker
____ Emphysema/COPD
____ Pneumonia
____ Seizures
____ Depression
____ Meningitis/Encephalitis
____ Bipolar Disorder
____ Hepatitis Type: _____
____ Cirrhosis
____ Cancer: _____
____ Ulcer Disease
____ GERD (acid reflux/heartburn)

____ Hiatal Hernia
____ Inflammatory Bowel Disorder
____ Crohn's Disease
____ Osteoarthritis
____ Rheumatoid Arthritis
____ Diabetes
____ Lupus/Scleroderma
____ Hypothyroid/Graves
____ Crohn's Disease

PREVIOUS PAIN MANAGEMENT
____ Massage
____ Biofeedback
____ Injections
____ Physical Therapy
____ Chiropractor
____ Acupuncture

Prostate Problems ____
Interstitial Cystitis ____
Endometriosis ____
Peripheral Vascular Disease ____
Blood Clots/Location: _____ ____
Fibromyalgia ____
Kidney Disease ____
Neuropathy ____
CRPS/(RSD) ____
Other: _____ ____

SOCIAL HISTORY
Tobacco ____PPD ____Years ____
Alcohol ___Type _____Amt____Yrs___
Recreational Drugs ____Type___Yrs__

Current Occupation _____
Partially Disabled_____%_____
Totally Disabled_____
Pre-Disability Occupation_____
Living Situation_____

FAMILY HISTORY
_____
_____
_____
_____

PERTINENT SURGICAL HISTORY
_____
_____
_____
_____

ALLERGIES: _____
_____

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Review of Systems

PATIENT NAME: _____ DATE: _____

Please circle what applies:

Constitutional
No constitutional symptoms Fever night sweats weight loss fatigue poor appetite

Respiratory
No respiratory symptoms Shortness of breath cough wheezing bloody sputum

Female Reproductive
No female reproductive symptoms abnormal periods vaginal bleeding vaginal discharge pain with intercourse decreased libido

Psychiatric
No psychiatric symptoms depression anxiety nervousness agitation

Eyes
No eye symptoms blurry vision eye pain itchy eyes redness

Allergy
No allergy symptoms excessive sneezing frequent infections frequent colds

Constitutional
No constitutional symptoms Fever night sweats weight loss fatigue poor appetite

Male Reproductive
No male reproductive symptoms penile discharge testicular pain or mass erectile dysfunction decreased libido

Endocrine
No endocrine symptoms excessive urination excessive thirst cold intolerance heat intolerance

Cardiovascular
No cardiovascular symptoms chest pain “smothering” at night irregular heartbeat racing heart exercise intolerance

Urinary
No urinary symptoms frequent urination difficulty initiating dribbling reduction in flow pain with urination

Musculoskeletal
No musculoskeletal symptoms muscle pain joint pain joint swelling joint deformity

Blood
No blood symptoms enlarged lymph nodes easy bruising prolonged bleeding

ENT
No ENT symptoms hearing loss ear pain ringing nosebleeds runny nose facial pain sore throat hoarseness difficulty speaking

Neurologic
No neurologic symptoms weakness numbness frequent headache confusion fainting spells seizures tremor

Gastrointestinal
No GI symptoms indigestion bloating abdominal pain difficulty swallowing nausea or vomiting vomiting blood
constipation diarrhea rectal bleeding dark, tar-like stool light, clay-like stool

Skin
No skin symptoms rash fingernail changes toenail changes itching abnormal pigment edema (fluid)

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Patient Comfort Assessment Guide

PATIENT NAME: _____ DATE: _____

1. **Where is your pain?** _____
2. **Circle the words that describe your pain.**

aching	sharp	penetrating	throbbing	tender
nagging	shooting	burning	numb	stabbing
exhausting	miserable	gnawing	tiring	unbearable

Circle one. Occasional Continuous

What time of day is your pain the worst? Circle one.

morning afternoon evening nighttime

3. **Rate your pain by circling the number that best describes your pain at its <u>worst</u> in the last month.**

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

4. **Rate your pain by circling the number that best describes your pain at its <u>least</u> in the last month.**

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

5. **Rate your pain by circling the number that best describes your pain at its <u>average</u> in the last month.**

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

6. **Rate your pain by circling the number that best describes your pain <u>right now</u>.**

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

7. **What makes your pain <u>better</u>?** _____
8. **What makes your pain worse?** _____
9. **What <u>treatments</u> or <u>medicines</u> are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.**

a) _____ No Relief 0 1 2 3 4 5 6 7 8 9 10 Complete Relief
Treatment or Medicine (include dose)

b) _____ No Relief 0 1 2 3 4 5 6 7 8 9 10 Complete Relief
Treatment or Medicine (include dose)

c) _____ No Relief 0 1 2 3 4 5 6 7 8 9 10 Complete Relief
Treatment or Medicine (include dose)

d) _____ No Relief 0 1 2 3 4 5 6 7 8 9 10 Complete Relief
Treatment or Medicine (include dose)

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PATIENT NAME: _____ DATE: _____

10. **What <u>side effects</u> or <u>symptoms</u> are you having? Circle the number that best describes your experience during the past week.**

a)	Nausea	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
b)	Vomiting	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
c)	Constipation	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
d)	Lack of Appetite	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
e)	Tired	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
f)	Itching	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
g)	Nightmares	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
h)	Sweating	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
i)	Difficulty Thinking	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
j)	Insomnia	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine

11. **Circle the one number that describes how during the past week <u>pain has interfered</u> with your:**

a)	General Activity	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
b)	Mood	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
c)	Normal Work	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
d)	Sleep	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
e)	Enjoyment of Life	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
f)	Ability to Concentrate	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
g)	Relations with Other People	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes

Where is the location of the pain?

_____

_____

Does the pain radiate or move to other areas? If so, where?

_____

_____

How long have you had this problem?

_____

_____

Do you experience emotional distress when you **<u>think</u>** about the pain?

_____

_____

Marla D. Golden, D.O., PA

6817 Southpoint Parkway, Suite 1404
Jacksonville, FL 32216
(904) 260-1070 Office | (904) 260-1170 Fax

PATIENT NAME: _____ DATE: _____

Do you experience emotional distress when you **talk** about the pain?

_____

On a scale of 0-10 with 10 being the worst, what is your pain level at its **best**?

_____

How would you describe the pain? (sharp, dull, aching, stabbing, burning, etc.)

_____

_____

If you imagined your pain to be a person, what type of person would it be?

_____

Besides the pain, what is the #1 stressor in your life right now?

_____

_____

Is there anything in your life that you would consider painful to think about or talk about?

_____

_____

Place a check mark by **any** feelings listed below that you are currently experiencing in your life. Circle the **one** that is the strongest.

Anxiety_____	Fear_____	Rage_____	Anger_____	Loss/Grief_____	Sadness_____
Doom_____	Despair_____	Nervous_____	Restless_____	Guilt_____	Cravings_____
Panic_____	Rejected_____	Shame_____	Frustration_____	Jealous_____	Confused_____

What do you do to relieve stress in your life?

_____

_____

Have you ever learned or practiced any type of relaxation technique? What type?

_____

_____

List any other health problems or illness that you are currently experiencing.

_____

_____

_____

Do you smoke? _____ How long? _____

Are you currently seeing a mental health counselor, psychologist or psychiatrist? _____

Signature: _____ Date: _____

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PATIENT NAME: _____ DATE: _____

During the past six months, how often have you used each of the following methods to reduce your physical and emotional tension?

N – Never R – Rarely S – Sometimes O – Often

_____ 1. Drink alcoholic beverage

_____ 2. Smoke

_____ 3. Take a prescription medication

_____ 4. Blame someone

_____ 5. Take an over-the-counter relaxant

_____ 6. Drink coffee, cola, or tea

_____ 7. Eat

_____ 8. Yell, hurt or otherwise take it out on someone else

_____ 9. Forget about it and keep going

_____ 10. Used TV, books, or movies to “escape”

_____ 11. Grin and bear it

_____ 12. Redefine the situation more positively in your mind

_____ 13. Take a leisurely walk

_____ 14. Change your approach to the person or stress

_____ 15. Exercise or stretch

_____ 16. Practiced deep relaxation with meditation or visualization

_____ 17. Practiced deep breathing or other relaxation technique

_____ 18. Listened to soothing music

_____ 19. Talked it over with someone

_____ 20. Pray

_____ 21. Use humor

_____ 22. Practiced a hobby

_____ 23. Took a hot bath

_____ 24. Had a massage

_____ 25. Other_____

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PATIENT NAME: _____ DATE: _____

Circle any of the statements below that you believe are true for you.

1. I don't believe I can ever be pain free…
2. I'm destined to always be in pain…
3. The health care system has let me down…
4. I don't trust any doctors/surgeons…
5. I'm convinced the pain will always be there…
6. I don't believe there's anything that can help me get rid of the pain…
7. I'm in pain because of the injury/accident…
8. I'm in pain because of the surgery…
9. I believe I'll have to be on pain medicine the rest of my life…
10. I'm afraid of the pain…
11. I feel like no one understands the pain…
12. I feel like no one is listening to me…
13. I don't deserve to be pain free…
14. Even if the pain is gone I think I'll still feel overwhelmed and unhappy…
15. My body is too damaged to ever be pain free…
16. It's not safe for me to be pain free…
17. I've had this pain for so long it must be permanent…
18. I would have to change too much in my life if I were pain free…
19. The doctors told me I would always have pain…
20. The doctors told me there was nothing more that could be done…
21. I believe this pain is a punishment…
22. I think I inherited this pain problem…
23. I believe no one will find the answer to this pain…
24. I know I'll have to take pain medicine forever…
25. The only treatment option that exists for me is medication…
26. I feel like no one understands me…

Add anything else that may come to your mind to describe how you feel.

_____
_____
_____
_____
_____
_____

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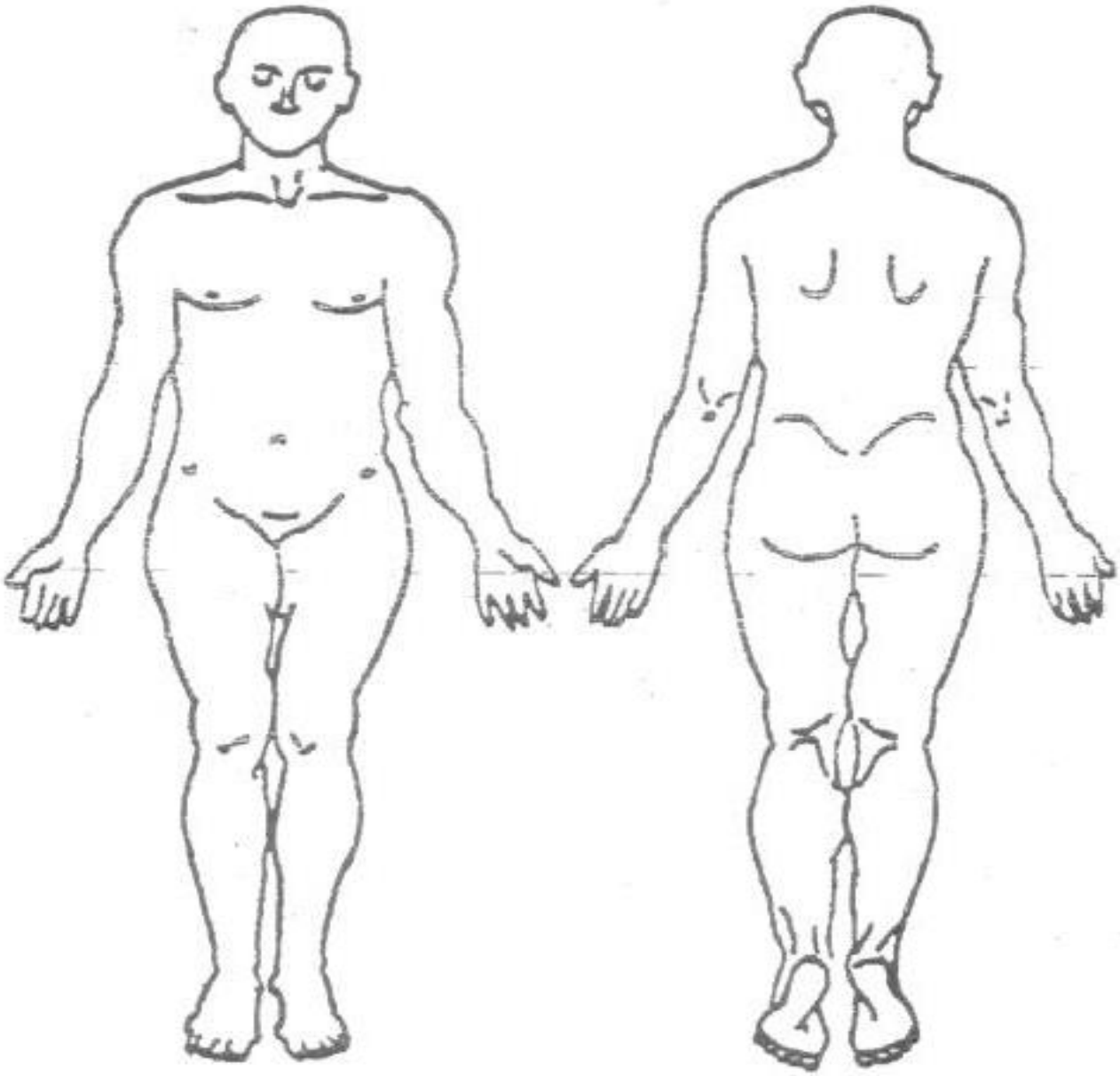
PATIENT NAME: _____ DATE: _____

Draw or color area of pain or discomfort.



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HIPAA Notice of Privacy Practices

Marla D. Golden, D.O., PA has a policy of complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our objective is to be 100% compliant at all times. The following method of operations will be used to insure privacy of a patient's Protected Health Information (PHI). The HITECH Act provides further protection for the privacy and security of PHI used and disclosed through health information technology. The Privacy, Security, Breach Notification, and Enforcement Rules are collectively referred to herein as the "HIPAA Rules."

1. Based on HIPAA guidelines a patient's medical records may be transferred to another care provider upon your signed authorization. Records will not be transferred without your or your guardian's signed authorization.
2. If a referral of your specimen to another medical provider is required, only the necessary information to refer the specimen will be provided.
3. If you elect to not allow any other member of your family access to your records you have the right to notify Marla D. Golden, D.O., PA as they are the owner of records. That notice must be in writing. If you wish to provide access to your records to a designated individual you may also provide that notice in writing.
4. Our office will not provide any information about you or your medical condition to any other party other than other medical providers to whom you have been referred for treatment and your insurance carrier without your specific authorization.
5. If you are chosen to be part of any research program you will be required to sign additional authorizations and releases, so that your PHI May be used in the program.
6. Under HIPAA rules, we may use the necessary PHI from your medical records to file Insurance claims on your behalf. Your authorization and insurance assignment allows the practice to file insurance on your behalf.
7. Under HIPAA guidelines you have the right to review your records by scheduling a time with Marla D. Golden, D.O., PA.
8. After review of your records if you disagree with any of the documentation in the records you have the option of writing your own documentation to be placed in the chart.
9. There will be certain circumstances where public health authorities and health oversight agencies may require a copy of your records. They are authorized under law to collect that information and we are required to furnish a copy of your PHI.
10. All efforts will be taken to ensure that your PHI will not be shared with any unauthorized persons.
11. If you are on active military or are called to active military, under federal law we are required to supply a copy of your record.

If you should have any questions concerning any of the above please contact the staff at Marla D. Golden, D.O., PA.

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

NOTICE OF PRIVACY POLICY
Effective August, 2009

The following is the privacy policy ("Privacy Policy") of Marla D. Golden, D.O., PA ("Covered Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy policies with respect to your person health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain healthcare entities, including healthcare providers, such as physicians and hospitals, as well as health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number and other information that could be used to identify you as the patient associated with that information.

Uses or Disclosure of your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained we must use or disclose your personal health information in accordance with the specific terms of that permission. The following are the circumstances under which we are permitted by law to disclose your personal health information:

Without your consent: Without your consent we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related healthcare operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission we are still required to limit such disclosures to the minimal amount of personal health information that is required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health providers; (b) consultation between health care providers relating to patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include: (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; (f) general administrative activities such as customer service and data analysis.

As Required By Law: We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your personal health information include:* (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purpose for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious

threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization: Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right to Request Restrictions On Use or Disclosure: You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures:* (a) to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergence circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Right to Receive Confidential Communications: You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means for at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right to Inspect and Copy Your Personal Health Information: Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy of your personal health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing and explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right to Amend Your Personal Health Information: You have the right to request that we amend your personal health information or record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us; (c) the

information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to **Marla D. Golden, D.O., PA, Care of Office Manager, 6817 Southpoint Parkway, Suite 1404, Jacksonville, FL 32216.**

Right to Receive an Accounting of Disclosures of Your Personal Health Information: Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings for disclosures for the following purposes:* (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosure to you, (d) for a facility directory or to personas involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for accounting shall be sent to **Marla D. Golden, D.O., PA, Care of Office Manager, 6817 Southpoint Parkway, Suite 1404, Jacksonville, FL 32216.**

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail to our privacy officer, **Marla D. Golden, D.O., PA, Care of Office Manager, 6817 Southpoint Parkway, Suite 1404, Jacksonville, FL 32216.** A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you know or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request to **Marla D. Golden, D.O., PA, Care of Office Manager, 6817 Southpoint Parkway, Suite 1404, Jacksonville, FL 32216.** For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our privacy officer at the address listed above.

Marla D. Golden, D.O., PA
6817 Southpoint Parkway, Suite 1404
Jacksonville, FL 32216
(904) 260-1070 Office | (904) 260-1170 Fax

Notice of Privacy Practices Acknowledgement Form

I acknowledge that Marla D. Golden, D.O., PA has provided me with a copy of its Notice of Privacy Practices.

I understand this acknowledgement means only that I have received the notice, and in no way affects the care I receive.

Please sign this form and return it to the front desk staff.

_____ _____
Signature Date

_____
Relationship to patient (if not patient)

Marla D. Golden, D.O., PA
6817 Southpoint Parkway, Suite 1404
Jacksonville, FL 32216
(904) 260-1070 Office | (904) 260-1170 Fax

Authorization for Request of Medical Records

Marla D. Golden, D.O.

TO: _____ _____
Physician Date

_____
Address

_____
City and State Zip Code

_____
Telephone

_____
Fax

I, the undersigned, request all medical records be sent to the address identified below:

Marla D. Golden, D.O., PA
6817 Southpoint Parkway, Suite 1404
Jacksonville, FL 32216

Phone: (904) 260-1070
Fax: (904) 260-1170

_____ _____
Patient's Printed Name Patient's Signature

_____
Social Security Number

_____
Date of Birth