KENNETH J. GALANG, M.D., P.A.

Patient Biographical Form

First Name | Middle Initial | Last Name | Social Security #

Date of Birth | Age | Male Female (Circle Gender) | Marital Status

Local Address | City

State | Zip Code | Student/Employer | Work Status

Home Phone | Work Phone | E-Mail Address | Race (Optional)

Emergency Contact | Emergency Phone # | Date First Visit | Cell Phone #

Are you a year round resident? YES NO

Northern Address | City | State/Zip

Responsible Party (If patient is Responsible Party please put SAME)

Insured First Name/Subscriber Name | Insured M.I. | Insured Last Name | Subscriber D.O.B.

Address | City | State/Zip

Relationship to Patient | Phone Number

Insurance Information

PRIMARY Insurance Company | Plan Name

Member ID#: _____ Plan #: _____ Group #: _____

Address: _____ City: _____ State/Zip: _____

Phone #: _____ Employer: _____

Coverage Start Date: _____ Coverage End Date: _____

Medigap Payer ID: _____ Co-Pay: _____

SECONDARY Insurance Company | Plan Name

Member ID#: _____ Plan#: _____ Group#: _____

Address: _____ City: _____ State/Zip: _____

Phone #: _____ Employer: _____

Coverage Start Date: _____ Coverage End Date: _____

KENNETH J. GALANG, M.D., P.A.

First Name _____ Middle Initial _____ Last Name _____

PAYMENT INFORMATION

How will you be paying for today's visit? ____Cash ____Check ____Charge ____Other

Is this a work-related injury? YES NO **Date of injury:** _____

Is this an auto accident? YES NO **Date of accident:** _____

Is an attorney involved? YES NO **Name:** _____

Address: _____

_____

Phone: _____

REFERRAL INFORMATION

Whom may we thank for referring you to our clinic?

_____ **My Family Physician** _____

_____ **Another Patient** _____

_____ **Yellow Pages**

_____ **Other** _____

I hereby authorize and consent to treatment by **Kenneth J. Galang, M.D., P.A.** as deemed reasonable and necessary by the physician at the time of my visit.

_____ _____

Signature of the Patient/Guardian **Date**

I, _____, hereby assign all medical and/or surgical benefits and rights to which I am entitled to **Kenneth J. Galang, M.D., P.A.** A photocopy or fax of this assignment is as valid as the original.

_____ _____

Signature of the Patient/Guardian **Date**

NAME: _____ DATE: _____
(LAST) (FIRST) (MI)
ADDRESS: _____ DOB: _____

MEDICAL HISTORY QUESTIONNAIRE

1) **Chief Complaint & HPI:** (Chief complaint for which you are seeing the physician today)

_____

_____

_____

Employment Related? YES NO **Auto Accident? YES NO** **Other Accident? YES NO**

Onset of pain: _____
_____
_____

Duration:
___ Constant
___ Intermittent
___ Daily
___ Day and night
___ Other
_____
_____

Quality:
___ Aching
___ Stabbing
___ Throbbing
___ Drilling
___ Burning
___ Builds up slowly
___ Builds up quickly

Location: _____
_____
_____

Intensity: ___ (0-10, 10 is worse pain ever)
_____

When is it worse?
___ With movement
___ Walking
___ Coughing
___ Sitting
___ Lying down
___ Night time
_____

Response to Treatment:

Therapy	worse	better
Medication	worse	better
Injections	worse	better
_____	worse	better

Associated symptoms:
___ Weakness
___ Tingling
___ Numbness
___ _____

2) **Current Medical History:** (Mark "**YES**" or "**NO**", if "**YES**" then describe problem)

Cardiovascular Problems	YES	NO	_____
Pulmonary Problems	YES	NO	_____
Gastrointestinal Problems	YES	NO	_____
Neurological Problems	YES	NO	_____
Blood related Problems	YES	NO	_____
Diabetes or Thyroid Problems	YES	NO	_____
Mental Disorder	YES	NO	_____
Musculoskeletal Problems	YES	NO	_____

3) **Preventive/Past History Screening:** (Mark "Yes" or "No" if you have had any of these conditions)

Polio	YES	NO	Mumps	YES	NO
AIDS/HIV	YES	NO	STD	YES	NO
Blood Transfusion	YES	NO	Hepatitis	YES	NO
Cancer	YES	NO	Depression	YES	NO
Chicken Pox	YES	NO	Arthritis	YES	NO
Epilepsy/Seizures	YES	NO	Skin Disease	YES	NO
Infectious Mono	YES	NO	Heart Problems	YES	NO

NAME: _____ DOB: _____

4) **Past Illness Screening:** (Other medical problems that you take medication for, ex: diabetes)

5) **Past Surgical History:** (List major surgeries have you had)

6) **Current Medication:** (List the prescription and non-prescription medication you take)

Name of Medicine	Dose	Frequency

7) **Drug/Food Allergies:** (List any medication or food allergies you have)

Name of Drug	Type of Reaction

8) **Family Medical/Social History:** (List the medical conditions that run in your family)

			(If "YES" list relationship to you, ex: mother)
Arthritis	YES	NO	
Auto Immune Disease	YES	NO	
Bleeding Disorder	YES	NO	
Blood Pressure	YES	NO	
Cancer	YES	NO	
Diabetes	YES	NO	
Heart Disease	YES	NO	
High Cholesterol	YES	NO	
Osteoporosis	YES	NO	
Other	YES	NO	

NAME: _____ DOB: _____

9) **Review of Systems (ROS):** Please mark each item "YES" or "NO" as they relate to your current health

GENERAL	YES	NO
Change in appetite	___	___
Change in weight	___	___
Chills, fever, sweats	___	___

EYES	YES	NO
Glasses/Contacts	___	___
Change in vision	___	___
Double vision	___	___

RESPIRATORY	YES	NO
Difficulty breathing	___	___
Cough	___	___
Shortness of breath	___	___
Coughing up blood	___	___
Wheezing/Asthma	___	___

DIGESTIVE SYSTEM	YES	NO
Abdominal pain	___	___
Nausea	___	___
Vomiting	___	___
Bloating	___	___
Diarrhea	___	___
Constipation	___	___
Blood in stool	___	___
Frequent belching	___	___
Acid reflux	___	___

URINARY SYSTEM-FEMALE	YES	NO
Irregular periods	___	___
Menopausal-no periods	___	___
Hysterectomy	___	___
Vaginal discharge	___	___
Difficulty urinating	___	___
Blood in urine	___	___

NERVOUS SYSTEM	YES	NO
Dizziness	___	___
Loss of consciousness	___	___
Seizures	___	___
Blackouts	___	___
Nervous exhaustion	___	___
Strokes	___	___

EMOTIONAL STATUS	YES	NO
Nervousness	___	___
Mood changes	___	___
Schizophrenia	___	___
Depression	___	___
Insomnia	___	___

BLOOD/LYMPH SYSTEM	YES	NO
Anemia	___	___
Easy bruising	___	___
Easy bleeding	___	___
AIDS/HIV	___	___
Swollen glands	___	___

HEAD	YES	NO
Frequent headaches	___	___
Recent trauma	___	___

EARS/NOSE/THROAT MOUTH	YES	NO
Loss of hearing	___	___
Ringing in ears	___	___
Gum problems	___	___
Bleeding	___	___
Nose bleeding	___	___
Hoarseness	___	___
Difficulty swallowing	___	___
Morning cough	___	___
Toothache	___	___
Vertigo	___	___

HEART	YES	NO
Chest pain	___	___
Heart beating fast	___	___
Difficulty breathing w/activity	___	___
Elevated cholesterol	___	___

URINARY SYSTEM-MALE	YES	NO
Penile discharge	___	___
Difficulty urinating	___	___
Blood in urine	___	___
Nighttime urination	___	___
Prostate trouble	___	___
Burning with urination	___	___

MUSCLES/BONES	YES	NO
Pain	___	___
Weakness	___	___
Joint swelling	___	___
Backache	___	___
Degenerative disc disease	___	___

SKIN	YES	NO
Skin cancer	___	___
Rash	___	___
Non-healing lesion	___	___

ENDOCRINE/GLANDS	YES	NO
Thyroid problems	___	___
Heat intolerance	___	___
Cold intolerance	___	___
Diabetes	___	___
Excessive thirst	___	___
Excessive hunger	___	___
Frequent urination	___	___

ALLERGIES	YES	NO
None/Normal	___	___
Hay fever	___	___
Environmental allergies	___	___

_____ _____

Patient Signature attests to the accuracy of this document **Date**

KENNETH J. GALANG, M.D., P.A.
13710 METROPOLIS AVENUE, SUITE 110
FORT MYERS, FLORIDA 33912

PAIN MANAGEMENT AGREEMENT (rev 10/1/10)

Pain Management Agreement Between_____(patient) and Kenneth J. Galang, M.D.

The purpose of this Agreement is to prevent misunderstandings about certain medicines the patient may be taking for pain management. This is to help both the patient and their provider comply with the laws regarding controlled medication.

This agreement relates to my use of controlled medication for chronic pain prescribed by Kenneth J. Galang, M.D., a physician at Rehabilitation Medicine and Pain Management Specialist. I have been informed and understand the policies regarding the use of controlled medication that are followed by the staff of Kenneth J. Galang, M.D. I understand that I may be provided controlled medication while actively participating in this program **ONLY** if I adhere to the following conditions:

1. I understand that Dr. Kenneth J. Galang and I will work together to find the most appropriate treatment for my chronic pain. I understand the goals of treatment are not to completely eliminate pain but to control my pain in order to improve my ability to function. Chronic Opioid therapy is only **ONE** part of my overall pain management plan.
2. I understand that Dr. Galang and I will **continually** evaluate the effect of opioids on achieving the treatment goals and make changes as needed. I agree to take the medication only at the **DOSE** and **FREQUENCY** prescribed by Dr. Galang. I agree not to increase the dose of opioids on my own and understand that doing so may lead to the discontinuation of opioid therapy.
3. I will attend all appointments, treatments and consultations as requested by my provider. I will attend all pain appointments and follow pain management recommendations. I understand that failure to keep appointments may lead to discontinuation of treatment.
4. I will tell my providers about the level and description of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve my pain.
5. I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, injections, psychotherapy, behavioral medicine, and other pain control strategies. I agree to cooperate and actively participate in **all** aspects of the pain management program to maximize functioning and improve coping with my condition.
If treatment for my condition is available, I agree I will not refuse the treatment just so the opiods will be continued. I understand that I have the right to refuse any procedure, but that does **not** mean that Dr. Galang must continue to prescribe narcotic or opioid medications.
6. The risks and benefits of taking opioid medications have been explained to me. I understand them. Opioids can cloud judgment and affect reflexes and motor skills. The patient will not participate in activities that would endanger themselves or others while using these medications.
7. I agree I will not use any illegal controlled substances, including marijuana, cocaine, Heroin, etc. I agree I will not use any prescription medications obtained illegally, or obtain them from friends or relatives.

PATIENT'S INITIALS: _____

8. I agree I will not abuse alcohol. If my provider advises, I will not use any alcohol.
9. I agree I will not share, sell or trade my medication with anyone.
10. I agree to protect my pain medicine from loss or theft. Lost or stolen medicines will not be replaced. I will report stolen medication to the police and to my provider and will produce a police report of this event.
11. I agree I will not attempt to obtain any opioid medicines from another doctor or provider without informing Dr. Galang first. I agree to have my opioid prescriptions filled only at_____ (List pharmacy name and number).
12. I agree that refills of my prescriptions for pain will be made only at the time of an office visit or during regular office hours. No routine refills will be available during evenings, after 4 pm, or on weekend, holidays, or through the emergency room. Medications will not be mailed or refilled without being seen at **monthly** pain clinic appointments (if patient is receiving his opioids from the pain clinic). **I understand that I can no longer pick up Scheduled narcotic medication without being seen, according to the law.**
13. I am responsible for keeping track of the amount of medications left and to plan ahead for arranging the refill of my prescriptions in a timely manner so I will not run out of medications.
14. I agree to bring in all unused pain medicine when requested.
15. As required by law, **I will submit urine for random drug testing twice a year to determine my compliance with their program of pain control.**
16. I authorize Dr. Kenneth J. Galang to cooperate fully with any official, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.
17. I will accept generic brands of my prescription medications.
18. I understand that I may become tolerant to, addicted to or have complications from the opioid medications. If this occurs, the medication may be changed or tapered and other methods of pain control may be used. If necessary, I will permit referral to addiction specialists.
19. If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled medication, I will agree to gradually taper my medication as directed by Dr. Galang.
20. I understand that if I violate any of the above conditions, Dr. Galang may choose to stop writing opioids prescribed for me. Discontinuation of the medications will be coordinated by Dr. Galang and may require specialist referrals.
21. I understand that if I am **verbally or physically abusive** to any staff member or engage in any illegal activity such as altering a prescription, that the incident may be reported to other physicians, local medical facilities, pharmacies and other authorities such a the local police department, Drug Enforcement Agency, etc. as deemed appropriate for the institution.
22. I Understand that suddenly stopping some pain medicines can cause problems such as: withdrawal symptoms, heart attack, stroke, seizures, permanent damage, disability or death.

PATIENT'S INITIALS: _____

KENNETH J. GALANG, M.D., P.A.
13710 METROPOLIS AVENUE, SUITE 110
FORT MYERS, FLORIDA 33912

Medication Refill Information:

1. Advance notice of 4 business days is required for all **non-opioids** refills of the prescriptions.
2. Requests for scheduled refills for **non-opioids** must be telephoned to the pharmacy only during regular office hours Monday-Friday (8:30 am – 4:00 pm). Refills will **not** be made at night, on holidays, or on weekends.
3. According to the law, **prescriptions for Schedule 2 narcotics may only be picked up when you are seen by the physician.**
4. According to the law, **if you are on a Schedule 2 narcotic, Schedule 3 narcotic, or Alprazolam (Xanax), you must be seen no later than every 3 months.**
5. You will be given a (30) thirty day supply each month, if indicated.
6. All hard copies of the opioids prescriptions must be hand delivered to the pharmacy by the patient.

- **This agreement will supersede all other agreements.**
- **By signing below I indicate that I understand AND agree to ALL the terms of the above agreement. I have received a copy of this for my own records.**

Patient _____Signature

Witness _____Signature

Provider _____Signature

Date _____

PATIENT'S INITIALS: _____

Kenneth J. Galang, M.D., P.A.

FINANCIAL POLICY

I **authorize financial information and reports** of my evaluation, treatments and any follow-up evaluations to be sent to or discussed with my referring doctor requesting consultation, my family physician, as well as any other healthcare providers, hospitals or outpatient facilities that I have or will identify to you.

I authorize any holder of medical or other information about me, to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, , or to the billing agents of my insurance companies or to my employer if this is a worker's compensation claim, any information needed for this or related insurance or Medicare claim. I permit a copy/fax of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment. If I have been tested for or have contracted Autoimmune Deficiency Syndrome (AIDS)/Human Immunodeficiency (HIV), I authorize the release of the fact and/or results of testing to any of the individuals, healthcare providers or third party payers related to my care. (This practice does not provide or perform testing for the virus.)

I understand that I am fully and legally responsible for all charges for services rendered which include all outstanding balances not covered by Medicare and/or insurance companies. In the event that I fail to pay any outstanding balance, I also agree to pay all billing fees, collection agency fees, and attorney fees and court costs, if any.

NO SHOW POLICY

I understand that I will be charged: **$50.00** if I miss a regular appointment or **$100.00** if I miss an appointment for a procedure **or** fail to cancel at least 24 hours before my scheduled appointment.

RETURNED CHECK POLICY

I understand that I will be charged the amount of **$40.00** for any returned check to cover bank fees and billing office processing.

Patient Signature _____ Date: _____

Guarantor Signature _____ Date: _____

MEDIGAP AUTHORIZATION

I request that the payment of authorized Medigap benefits be made on my behalf to KENNETH J. GALANG, M.D., P.A., for any services furnished me by the physician. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or MEDIGAP INSURANCE COMPANY NAME the benefits payable for related services. This authorization applies to all occasions of service until it is revoked.

Beneficiary Name _____ Account # _____

Medicare # _____ Medigap Policy # _____

Beneficiary Signature _____ Date _____

KENNETH J. GALANG M.D. P.A.
13710 Metropolis Avenue
Suite 110
Fort Myers, FL 33912
Office (239) 225-0129
Fax (239) 225-0575

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF MEDICAL INFORMATION PRIVACY NOTICE

I hereby acknowledge that I received the Dr. Kenneth J. Galang M.D., P. A. Medical information Privacy Notice for my review prior to receiving services through Dr. Kenneth J. Galang M.D., P.A.

_____ _____

Signature of Witness

(If Patient Signs with an "X")

Signature of Patient or

Patient's Representative

_____ _____

Print Name of Witness

Print Name of Patient or

Patient's Representative

_____

Relationship of Patient's

Representative To Patient

_____

Date

KENNETH J. GALANG, M.D., P.A.
13710 Metropolis Ave, Suite 110
Fort Myers, FL 33912
Office: (239) 225-0129
Fax: (239) 225-0575

Authorization for the Use and Disclosure of Protected Health Information (PHI)

This form is used to authorize Kenneth J. Galang, M.D., P.A. to disclose protected health information to the person/entity designated below. Please complete the following information. All sections must be completed or the form will be considered incomplete and returned to you.

SECTION 1: DEMOGRAPHIC INFORMATION:

Patient Name: _____ **Phone Number:** _____
Street/PO Box: _____
City: _____ **State:** _____ **Zip:** _____

SECTION 2: PURPOSE OF THE AUTHORIZATION:

Please note that by signing this form, you will authorize Kenneth J. Galang, M.D., P.A. to disclose your protected health information for the following purpose. Describe the purpose of the authorization.

_____
_____

SECTION 3: PROTECTED HEALTH INFORMATION TO BE DISCLOSED:

Please indicate the specified protected health information you authorize us to disclose for the purposes stated above. (What Document):

_____
_____

SECTION 4: PERSON/ENTITY AUTHORIZED TO RECEIVE:

Please indicate the person and/or entity name and address to which you are authorizing Kenneth J. Galang, M.D., P.A. to disclose the protected health information described above.

Name/Entity: _____
Relationship to Patient: _____ **Phone Number:** _____

Name/Entity: _____
Relationship to Patient: _____ **Phone Number:** _____

SECTION 5: EXPIRATION:

This authorization will expire in one year from the date of signature unless you indicate another date below.

On: _____ /_____ /_____

_____
Patient Date of Birth

_____
Date

_____
Signature of Patient or Legal Representative