Our mission at Deuk Joint Institute is to fix back, neck and joint pain through a continuum of care philosophy in state-of-the-art facilities with world class Surgeons and Physicians. We want you to have exceptional service and the best medical care available anywhere, and we pledge to put the Patient first.

Please remember…

- ✓ Bring your completed packet to your appointment.
- ✓ Bring your most current insurance card(s), including secondary insurance and a photo ID.
- ✓ Bring CDs with reports pertinent to your visit that were done in the last six months. (MRIs, X-Rays, CT Scans.) You may need to go to the facility to pick them up.
- ✓ Bring a current list of medications including dosage.

Please arrive 15 minutes prior to your Scheduled appointment time.

7955 Spyglass Hill Road Suite A, Melbourne, FL 32940
Phone: (321)751-3389 Fax: (321)775-1363

office hours are Monday through Friday, 8:00am to 5:00pm.

Things to Know About Our Office

We collect insurance deductibles, co-pays, and coinsurances upon checking in.
Check or Credit Card Only. **No cash**, **please.**

Please allow 48-72 hours for all prescription refill requests.
Some prescriptions cannot be called into the pharmacy.
You will be notified if it must be picked up at our office.

DEUK JOINT INSTITUTE

Patient Label

PATIENT INFORMATION

First Name: _____ **Last** :_____

Date of Birth: _____ **Gender**: ☐ Male ☐ Female ☐ Other:_____

Address: _____ **City**: _____ **State**: _____ **ZIP Code**: _____

Phone: _____ **Alt. Phone**: _____

Social Security: _____ **Email**:_____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Occupation: _____ **Highest Education**: _____

EMERGENCY CONTACT

Emergency Contact Name: _____

Relationship: _____ **Phone**: _____

PHYSICIANS

Primary Care Physician: _____ **Phone**: _____ **Fax**:_____

Address: _____ **City**: _____ **State**: _____ **ZIP Code**: _____

Do you have a Pain Management Provider? ☐ NO ☐ YES If **Yes**, please provide the following information:

Physician: _____ **Phone**: _____ **Fax**:_____

Address: _____ **City**: _____ **State**: _____ **ZIP Code**: _____

PREFERRED PHARMACY

Pharmacy Name: _____ **Phone**: _____ **Fax**:_____

Address: _____ **City**: _____ **State**: _____ **ZIP Code**: _____

INSURANCE

Primary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other:_____

Insurance Company: _____ **Policyholder**: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Group #: _____ ID #: _____

*Complete the following if you are **not** the policyholder for your primary insurance:*

Policyholder Name: _____ Date of Birth: _____

Policyholder Social Security Number: _____

Secondary Insurance (if any): _____

Group #: _____ ID #: _____

DEUK JOINT INSTITUTE

Patient Label

MEDICAL RECORDS RELEASE

Patient Name: _____

Date of Birth: _____ Phone #: _____

I hereby authorize:

Deuk Joint Institute
7955 Spyglass Hill Rd Ste A
Melbourne, FL 32940
Phone: 321.775.1324
Fax: 321.775.1327

☐ To **Send** ☐ To **Receive**

☐ **Facility Information**

_____
Provider, Facility, Person

_____
Address, City, State, Zip Code

_____
Phone Fax

☐ **Pick up** *(payment due at the time of pick up)*

---

the following information on my behalf:

☐ Millennium Medical Management (**MMM**) ☐ Surgery Center of Viera (**SCV**)

☐ Medical Record: from: _____ to: _____ ☐ Demographic information/Insurance Information

☐ Dictated Notes/Reports ☐ Radiology reports ☐ XRAY CD (DOS) _____ ☐ MRI CD (DOS) _____

☐ Other _____

FEES FOR COPIES – ALL RECORDS AND CD'S PLEASE ALLOW 7-10 BUSINESS DAYS

For Personal Use (records released directly to patient): **$1.00 per page up to 25 pages. Over 25 Pages $.25 cents per page (per Florida law)**
For Continuing Care (doctor to doctor): **No charge**
For Work Comp: **$.50 cents per page**
For Personal Injury: **$1.00 per page up to 25 pages. Over 25 pages $.25 cents per page (per Florida law)**
Copy for CD - **1st one free – Additional copy $10.00**

I understand these records may contain information from other health care providers, as well as information which is administrative in nature. This information will be given only to those specified on this form and only through the expiration date stated below. I also understand I have the right to revoke this authorization at any time through written notice and that written notice must include 1) the patient's name, social security number and date of birth, 2) make reference to this specific authorization and the name so those authorized by this form to receive information, 3) a statement that the patient wants to revoke this authorization, the effective date of revocation, and the signature of the patient or a legal guardian.
I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and the information may not be protected by federal privacy laws or regulations.

This authorization will expire 1 year from the date specified below

_____ _____
Patient/Legal Representative Signature *Date*

_____ _____
Witness Signature *Date*

If not signed by the patient, list title of legal representative: (Validation of legal representative must be in patient chart)

DEUK JOINT INSTITUTE

Patient Label

HEALTH HISTORY

Height: _____ft _____in **Weight: _____lbs.**
What is the main reason for your visit today? ☐ Back Pain ☐ Leg Pain ☐ Neck Pain ☐ Arm Pain ☐ Other**:**
How long has this been a problem? ☐ Less than ☐ 2 months ☐ 2-6 months ☐ 6-12 months ☐ greater than
Is your problem related to: ☐ **Auto Accident** ☐ **Work Injury** ☐ **Other:** **Date of Injury:**

WORK STATUS

☐ Full Duty	☐ Light Duty	☐ Off Duty **(per physician)**	☐ Unemployed	☐ Retired
If you are not working full duty, how long have you been off work?				
Have you had a work capacity assessment? ☐ YES ☐ NO		**Are you disabled through Social Security?** ☐ YES ☐ NO		

DIAGNOSTIC TEST

Please list any diagnostic tests you have had for your neck or back, along with the dates (e.g., MRI, CT scan, X-ray, EMG).

TREATMENT

Have you received any of the following treatments for your neck or back pain? ***(check all that apply)***

☐ **Physical Therapy** ☐ **Chiropractic Care** ☐ **Medication Management** ☐ **Home Exercise**

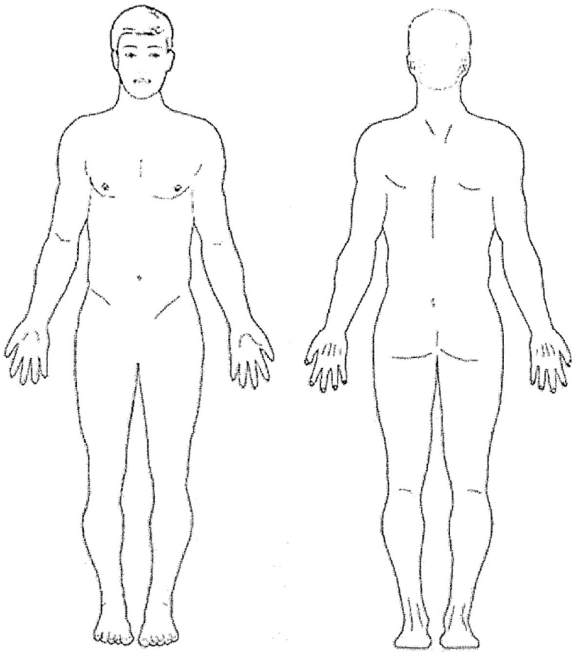
☐ **Injections** (*Please specify*)_____

☐ **Other Treatments** (*Please specify*)_____

HISTORY AND PAIN MAP

Using the following symbols, please draw in the location of your symptoms on the diagram

X*= pain* ***O*** *= numbness* */ = weakness* ******* *= pins & needles*



If you have NECK PAIN, what percentage is Neck _____% and _____Arm (total 100%)

If you have BACK PAIN, what percentage is Back _____% and _____ Leg (total 100%)

Mark an ***X*** *on the line indicating your usual amount of pain*

0 1 2 3 4 5 6 7 8 9 10

no pain worse pain

DEUK JOINT INSTITUTE

Patient Label

REVIEW OF SYSTEMS

*Please mark the box any **persistent** symptoms you have had in the **past few months.** Check "no problems" if none of the symptoms apply to you.*

GENERAL
- ☐ Unexplained weight loss/gain
- ☐ Unexplained fatigue/weakness
- ☐ Fall asleep during day when sitting
- ☐ Fever, Chills
- ☐ No problems

GASTROINTESTINAL
- ☐ Heartburn / reflux/ indigestion
- ☐ Blood or change in bowels
- ☐ Constipation
- ☐ No Problems

GENITOURINARY
- ☐ Leaking urine
- ☐ Blood in urine
- ☐ Nighttime urination or increased frequency
- ☐ Discharge: penis or vaginal
- ☐ Concern with sexual functions
- ☐ No Problem

ENDOCRINE
- ☐ Heat or cold sensitivity
- ☐ No Problems

RESPIRATORY
- ☐ Cough/ wheeze
- ☐ Loud snoring/ altered breathing during sleep fatigue/weakness
- ☐ Fall asleep during day when sitting
- ☐ Fever, Chills
- ☐ No problems

NEUROLOGICAL
- ☐ Headache
- ☐ Memory loss
- ☐ Fainting
- ☐ Dizziness
- ☐ Numbness/ tingling
- ☐ Unsteady gait
- ☐ Frequent infections
- ☐ No Problems

PSYCHIATRIC
- ☐ Anxiety / stress / irritability
- ☐ Sleep problems
- ☐ Lack of concentration
- ☐ No Problems

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations
- ☐ No Problems

EYES
- ☐ Change in vision/ eye pain/ redness
- ☐ No Problems

ALLERGIC/ IMMUNE
- ☐ Hay
- ☐ Frequent infections
- ☐ No Problems

HEMATOLOGIC/ LYMPHATIC
- ☐ Swollen glands
- ☐ Easy Bruising
- ☐ No Problems

SKIN
- ☐ New or change in mole
- ☐ Rash/ itching
- ☐ No Problems

MUSCULOSKELETAL
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Muscle/ Joint pain
- ☐ No Problems

WOMEN ONLY
- ☐ PMS symptoms (bloating, cramps. Irritable)
- ☐ Problems with menstrual periods
- ☐ No Problems

BREAST
- ☐ Breast lump/pain/nipple discharge
- ☐ No Problems

CURRENT MEDICATION

Please list all prescriptions, dosage, over-the-counter, and supplements you are currently taking

Do you take Blood Thinners? (Coumadin, Plavix, Aggrenox, Ticlid, Pletal) ☐ **YES** ☐ **NO**

If **YES**, prescriber physician**:** _____

Have you had any changes to your medications or dosages in the last 7 days made by a physician or prescribing provider?

☐ **NO** ☐ **YES** If **YES,** please list all recent changes below

Medication Changed: _____

Previous Dosage: _____**New Dosage:**_____ **Date of Change:** ____ / ____ / _____

Prescribing Provider: **Reason for Change** (if known)**:**

IMMUNIZATIONS

Have you ever received a dose of COVID-19 vaccine? ☐ **YES** ☐ **NO**

If YES, which vaccine product? ☐ **Pfizer** ☐ **Moderna** ☐ **Other:** _____

ALLERGIES

Drug Allergies ☐ **NO** known drug allergies ☐ **YES**-Please list drug and reaction:

Food Allergies ☐ **NONE** ☐ **YES**-Please list:

Other Allergies (e.g., latex, environmental) ☐ **NONE** ☐ **YES**-Please list:

DEUK JOINT INSTITUTE

Patient Label

PERSONAL MEDICAL HISTORY

Diabetes	☐ YES ☐ NO	Emphysema/ COPD	☐ YES ☐ NO	**Other:**
High Blood Pressure	☐ YES ☐ NO	Pneumonia	☐ YES ☐ NO	
Stroke	☐ YES ☐ NO	Depression/ Bipolar	☐ YES ☐ NO	
Heart Disease/ Heart Attack/Stents/Implants	☐ YES ☐ NO	Mental Illness	☐ YES ☐ NO	
Kidney Stones	☐ YES ☐ NO	Dementia (Alzeimer's etc)	☐ YES ☐ NO	
Thyroid Disease	☐ YES ☐ NO	Ulcers	☐ YES ☐ NO	
Seizures	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO	
Bleeding Disorder	☐ YES ☐ NO	High Cholestrol	☐ YES ☐ NO	
Sexually Transmitted Disease	☐ YES ☐ NO	Irritable Bowel Syndrome	☐ YES ☐ NO	
Tuberculosis	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO	
Rheumatic Fever	☐ YES ☐ NO	Osteoporosis	☐ YES ☐ NO	
Asthma	☐ YES ☐ NO	Cancer	☐ YES ☐ NO **If yes, type:**	

SURGICAL HISTORY

Please list any hospitalizations and surgeries *year*

FAMILY HISTORY

Adopted? ☐YES ☐ NO

If yes and you do not know your family history, please skip the following section.

	Living	Age	Deceased	Age at death	Medical History (ex: diabetes stroke, heart attack)
Father					
Mother					

Siblings	**_____sister(s)_____brother(s)**		**Healthy**	
Children	**_____son(s)_____daughter(s)**		**Healthy**	

SOCIAL HISTORY

Have you ever been treated for a drug or alcohol addiction? ☐ YES ☐ NO
Do you currently consume alcoholic beverages? ☐ YES ☐ NO **Quantity per day?** Beer: Wine: Spirits: Have you ever felt you needed to cut down on your drinking? ☐ YES ☐ NO
Have people annoyed you by criticizing your drinking? ☐ YES ☐ NO
Have you ever felt guilty about drinking? ☐ YES ☐ NO
Have you ever felt you needed a drink first thing in the morning to steady your nerves, or to get rid of a hangover? ☐ YES ☐ NO
Do you currently use tobacco products? ☐ YES ☐ NO Age/Year Started: Age/Year Quit:
If **yes**, please indicate the quantity per day: **Cigarettes:** **Cigars:** **Chewing Tobacco:**

DEUK JOINT INSTITUTE

Patient Label

INFORMED CONSENT AND CONTROLLED SUBSTANCE AGREEMENT

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent to the drug(s) recommended to you by me, as your physician.

CONSENT TO TREATMENT AND/OR DRUG THERAPY voluntarily request Dr. Ara J. Deukmedjian, Dr. DeMola, as my physician, and such associates, technical assistants, nurses and other health care providers as it may deem necessary or advisable, to treat my condition, which has been explained to me as: chronic pain. I hereby authorize and give my voluntary consent to administer or follow prescribed prescription(s), controlled substance(s), or narcotic medication(s) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) are addictive and may, like other drugs used in the practice of medicine, produce adverse effects or results. (See attached Narcotic Information Sheet.) The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

I understand that I will undergo medical tests and examinations before and during my treatment at Deuk Joint Institute. Those tests include random unannounced urine and/or blood test for drugs, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment with controlled substances. Presence of unauthorized substances may result in my discharge from Deuk Joint Institute.

For Female patients only: To the best of my knowledge,

☐ I am pregnant ☐ I am not pregnant

If I am not pregnant, I will use appropriate contraception during my course of treatment. I promise to inform my doctor and/or his/her appropriately authorized assistant(s) immediately if I become pregnant during the course of treatment.

If I am pregnant, in addition to the possible risks involved with the long-term use of narcotic(s) and controlled substance(s), I further understand that information on the effects of narcotic(s) and controlled substance(s) on pregnant women and their unborn children is at present inadequate to guarantee that I may not produce significant or serious side effect(s) to my unborn child.

It has been explained to me and I understand that narcotic(s) and controlled substance(s) are transmitted to the unborn child and will cause physical dependence. Thus, if I am pregnant and suddenly stop taking narcotic(s) and controlled substance(s), I or the unborn child may show signs of withdrawal, which may adversely affect my pregnancy or the child. I shall use no other drugs without approval, since these drugs particularly as they might interact with narcotic(s) and controlled substance(s), may harm me or my unborn child.

I shall inform any other doctor who sees me during my present or any future pregnancy or who sees the child after birth, of my current or past participation in a chronic, intractable pain program in order that he may properly care of my child and me.

It has been explained to me that after the birth of my child I should not nurse the baby because narcotic(s) and controlled substance(s) are transmitted through the milk to the baby and this may cause physical dependence on narcotic(s) and controlled substance(s) in the child. I understand that for a brief period following birth, the child may show temporary irritability or other ill effects due to my use of narcotic(s) and controlled substance(s). It is essential for the child's physician to know of my participation in a narcotic(s) and controlled substance(s) treatment program so that he may provide appropriate medical treatment for the child.

Patient Initials _____

All the above possible effects of narcotic(s) and controlled substance(s) have been fully explained to me, and I understand that at present, there have not been enough studies conducted on the long-term use of the drug to assure complete safety to my child. With full knowledge of this, I consent to its use and hold Deuk Joint Institute and its physicians and all staff harmless for injuries to the embryo / fetus / baby.

MOST COMMON SIDE EFFECTS: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention, insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive narcotic(s) for the treatment of my chronic, intractable pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that the goal of taking narcotic(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. An appropriate treatment goal may even mean the eventual withdrawal from the use of all narcotic(s). I realize that the treatment for some will require prolonged or continuous use of controlled medication(s) and that my condition will be evaluated on an individual basis.

I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time, and I will be afforded detoxification under medical supervision.

The drug therapy that my physician may prescribe for me may involve using a drug that the Federal Food and Drug Administration may not have been asked by the manufacturer to review for safety or effectiveness for your condition. Current medical literature shows that such “off label” use may be beneficial to some patients and I understand that recommended dosages for treating intractable pain are often exceeded to balance the benefit and risk to the patient.

I understand that no warranty or guarantee has been made to me as to result of any drug therapy or cure of any condition. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

I am aware that certain other medicines such as nalbuphine (Nubain), pantazocine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of these medicines listed above.

I am aware that addiction is defined as the use of medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low, if I follow the assigned protocol. I am aware that the development of addiction has been rarely noted in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware that physical dependence means that is my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any of all the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

Patient’s Initials _____

DEUK JOINT INSTITUTE

Patient Label

CONTROLLED SUBSTANCES AGREEMENT

This informed consent also contains the following important requirements that I must fulfill in order to participate in the Chronic Pain Treatment Program.

This agreement relates to my use of any controlled substance(s) (i.e., Narcotics, painkillers, prescription medications) for chronic pain prescribed by Deuk Joint Institute's Doctors and/or any appropriately authorized ancillary personnel at its office(s). I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). The Florida Department of Health has specific requirements for the use of controlled substance(s) for the treatment of chronic pain.

Therefore, controlled substance(s) will only be provided so long as I am actively participating in Deuk Joint Institute Treatment Program and adhere to the rules specified in this Agreement.

My doctor and/or any appropriately authorized ancillary personnel may at any time discontinue the narcotic prescription(s) at his/her discretion. My progress will be periodically reviewed and, if the narcotics are not improving my quality of life, the narcotics will be discontinued. I will disclose to Deuk Joint Institute drugs I take at any time, prescribed by any physician.

In the event that my doctor and/or any appropriately authorized ancillary personnel discontinue my medication and start me on another medication, the discontinued medication will need to be turned into my local police department and a copy of the receipt from the police department will need to be turned into Deuk Joint Institute prior to receiving any new medications.

The therapies necessary to treat my chronic pain have been explained to me and I understand that the therapies will involve my taking daily dosage(s) or narcotic(s), which will help to control my chronic, intractable pain.

I will use the medication(s) exactly as directed by my doctor and/or his appropriately authorized ancillary personnel. I agree not to share, sell or otherwise permit others, including my family and friends, to have access to these medications. I will not participate in the diversion of my medications for illegal use; nor will I give or sell them to anyone else.

All controlled substances must be obtained at the same pharmacy, when possible. Should the need arise to change pharmacies, I agree to inform Deuk Joint Institute I will use only one pharmacy and I will provide my pharmacist a copy of this agreement.

I authorize my doctor, and his/her appropriately authorized ancillary personnel to release my medical records to my pharmacist at his/her discretion. I also authorize any pharmacy that I am receiving medications from to release my medical records to Deuk Joint Institute.

Pharmacy Name:_____ Pharmacy Phone: _____

Pharmacy Address: _____ **Patient's Initials** _____

I understand that my medication(s) will be refilled on a regular basis. **I understand that my prescription(s) and my medication(s) are exactly like money. If either are lost or stolen, they WILL NOT BE REPLACED. I FURTHER UNDERSTAND THAT ANY REPLACEMENT OF LOST OR STOLEN MEDICATIONS IS COMPLETELY AT THE DISCRETION OF MY TREATING PHYSICIAN.** Otherwise, I will need to wait until my next scheduled refill. I will not seek the same or similar medications from any other source, whether professional or otherwise and if I am prescribed them by another practitioner, I will notify the physician here. In the event that I am arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given.

Refill(s) will not be ordered before the scheduled refill date. I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out. I agree that refills of my prescription(s) for pain medicine will be given only at the time of an office visit or during regular office hours. No refills will be available during evening hours and/or weekends. The patient or authorized person must be present in person at the office in order to be able to pick up medication script(s). I am aware of the fact that my physician will not call in any pain medication(s) to the pharmacy by phone and/or fax.

I will receive controlled substance(s) or medication(s) **only** from Deuk Joint Institute Doctors and/or their appropriately authorized ancillary personnel unless it is for an emergency or the controlled substance(s) that are being prescribed by another physician are approved by Deuk Joint Institute Doctors.

Information that I have been receiving medication(s) prescribed by other doctors, that has not been approved previously by Deuk Joint Institute doctors may lead to a discontinuation of medication(s) and treatment.

Until Deuk Joint Institute and/or their appropriately authorized ancillary personnel have gotten to know me and my medical history well, I understand that prescription(s) for larger quantities of medication(s) to cover me while I am out of town will not be given. Later, depending on my compliance, *Deuk Joint Institute* and/or their appropriately authorized ancillary personnel may modify this, at the sole discretion of the physicians.

If it appears to my doctor and/or his appropriately authorized ancillary personnel that there are no demonstrable benefits to my daily function or quality of life from the controlled substance(s), then my doctor and/or his appropriately authorized ancillary personnel may try alternative medication(s) and/or his appropriately authorized ancillary personnel, may taper me off of all narcotic(s). I will not hold my doctor and/or any other member of Deuk Joint Institute staff liable for problems caused by the discontinuance of controlled substance(s).

I agree to submit to urine and blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), treatment for chronic pain will be terminated and can only be restarted if I am evaluated and treated by an Addictionologist and the Addictionologist recommends continued treatment for chronic pain.

I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, behavioral medicine strategies, and surgery. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program to secure increased function and improved coping with my condition.

I agree that I shall inform any doctor who may treat me for any medical problem that I am enrolled in a narcotic(s) and controlled substance(s) treatment program, since the use of other drug(s) in conjunction with same may cause me harm.

I hereby give my doctor and/or his appropriately authorized assistant(s) permission to communicate with the referring physician(s) and any pharmacist(s) regarding my use of controlled substance(s).

I must take the narcotic medication(s) as instructed by my doctor and/or his appropriately authorized assistant(s) or in smaller doses. Any unauthorized **increase** in the dose of narcotic medication(s) may be viewed as a cause for discontinuation of the treatment with narcotic medication (s).

All opiate medications prescribed must be brought to each visit. This means you must bring your opiate medication bottles with you to each visit in order for the physician to refill your medication. The medication will then be counted by an authorized Deuk Joint Institute staff member in a sterile manner to ensure that medications are being taken as prescribed and will document those finding in your chart.

If I demonstrate unacceptable behavior patterns, my doctor and /or his appropriately authorized assistant(s) may discontinue prescribing the narcotic medication(s) for me.

I must keep all regular follow up appointments as recommended by my doctor and/or his appropriately authorized assistant(s).

I agree to be seen/re-evaluated every month, while receiving controlled substances prescriptions from Deuk Joint Institute.

Evidence of medication hoarding; increasing the amount of medication without communication to my doctor and/or his/her appropriately authorized assistant(s); refilling my prescription too frequently; getting the medication from multiple physicians; increasing the amount of the medication despite significant side effects; altering prescriptions; selling, trading, or giving away medication; un-approved use of other drugs (alcohol, sedatives, or using non-prescription medications inconsistent with drug labeling) during narcotic analgesic treatment; or other unacceptable behavior will result in tapering and discontinuing of narcotic maintenance therapy.

Patient's Initials _____

DEUK JOINT INSTITUTE

Patient Label

Failure to comply with any of the foregoing conditions may cause discontinuation of narcotic prescription(s) and/or your discharge from the care and treatment by Deuk Joint Institute. Discharge may be immediate for alleged criminal behavior.

I certify and agree to the following:

I am not currently abusing illicit or prescription drug(s) and I am not undergoing treatment for substance dependence or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

I have never been involved in the sale, illegal possession, diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.). No guarantee or assurance has been made as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that I would otherwise continue to have chronic pain.

I have reviewed the Narcotic Side Effect Information, on pages 1, 2, 3 and 4 that may be used in the treatment of my chronic pain. I fully understand the explanations regarding the benefits and the risks of this method. I agree to the use of narcotic medication(s) in the treatment of my chronic pain.

_____

Patient Signature Patient Full Name

ARA J. DEUKMEDJIAN, M.D.

PHILIP DeMOLA, D.O.

HANS BERNDES M.D.

_____

Physician(or Appropriately Authorized Ancillary Personnel) Signature

DEUK JOINT INSTITUTE

Patient Label

ASSIGNMENT OF INSURANCE BENEFITS; APPOINTMENT OF AUTHORIZED REPRESENTATION; PRIVACY; PAYMENTS; APPOINTMENT

Assignment of Insurance Benefits -- Appointment as Legal Authorized Representative: I (i) assign all applicable health insurance payments and benefits, and all rights and obligations that I and my dependents have under my health plan to the Deuk Spine Instiute ("Provider"); (ii) authorize payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Provider; and (iii) appoint Provider as my authorized representative ("Authorized Representative") with the power to (i) file medical claims, appeals and grievances with the health plan; (ii) file appeals and grievances with the health plan; (iii) institute any necessary litigation and/or complaints against my health plan ***naming me as plaintiff in such lawsuits and actions if necessary*** (or me as guardian of the patient if the patient is a minor); and (iv) discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan. I also understand that Provider is not responsible for the terms of the contracts which I have with my health benefit plan or insurance companies. I certify that the health insurance and coverage information I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated. I am fully aware that having health insurance and/or Medicare coverage does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that (i) I am responsible for all amounts not covered by my health insurance and/or Medicare, including co-payments, co-insurance, and deductibles; and (ii) with respect to Medigap/Secondary Insurance, should my insurance or not pay all or part of the secondary balance, I am responsible for all remaining allowed charges.

Authorization to Release Information: I authorize my Authorized Representative and any holder of medical or other information about me to (i) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments (including the Social Security Administration or its Medicare Administrative Contractors if I am a Medicare beneficiary); (ii) process insurance and other payment claims generated in the course of examination or treatment; and (iii) allow a photocopy of my signature to be used to process insurance and other payment claims. This authorization will remain in effect until revoked by me in writing. I authorize Provider to discuss my **medical/health care** with the following family members or close friends:

Full Name:_____ Relation:_____ Phone:_____

Full Name:_____ Relation:_____ Phone:_____

Full Name:_____ Relation:_____ Phone:_____

I authorize Provider to discuss my **account finances** with the following family members or close friends:

Full Name:_____ Relation:_____ Phone:_____

Full Name:_____ Relation:_____ Phone:_____

Full Name:_____ Relation:_____ Phone:_____

ERISA Authorization: I designate, authorize, and convey to my Authorized Representative to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (i) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance police and/or benefit plan; and (ii) the right and ability to act as my Authorized Representative to pursue such claim, right or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.503-1(b)(4) with respect to any health care expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. This authorization will remain in effect until revoked by me in writing. A photocopy of this Authorization shall be as effective and valid as the original.

Payment Policy; Out-of-Network Disclosure/Patient Acknowledgment of Responsibility: I understand that (i) Provider accepts most forms of payment including checks, debit cards, credit cards and credit facilities like CareCredit (ii) Provider reserves the right to charge 1.5% interest per month, compounded daily, after 90 days of non-payment on all outstanding balances; (iii) credit cards and other revolving credit programs have chargeback provisions to allow, for example, return of purchased goods, but that such chargeback features are not appropriate at Provider, such that I waive my rights for chargebacks; (iv) if a chargeback occurs, Provider may initiate legal action to recoup the charges and I will be responsible for all resulting legal fees and other appropriate expenses to recoup those charges; and (v) Provider will assess a $50 fee on all checks that are returned as unpaid. I understand that Provider is an out-of-network provider and that, consequently: (i) I am responsible for the difference between charges and payments made by my health plan and any coinsurance and deductible required by my health plan; and (ii) Provider cannot waive any such patient responsibility.

Notice of Privacy Practices: I have reviewed the posted copy of Provider's Notice of Privacy Practices, which describes how my medical information may be used and disclosed and how I can obtain access to this information, and I understand that a copy for my records is available upon request.

Patient Name:_____ **Patient Signature:**_____

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CANCELLATION / NO SHOW POLICY

At Deuk Joint Institute our goal is to provide quality medical care to you and the rest of our patients. In an attempt to be fair to all patients seeking our care, we have implemented a Cancellation and No-Show Policy. We understand that there are times when you may miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If you must cancel an appointment, we ask you please call at least 24 hours prior to the appointment, or earlier if possible.

To cancel an appointment, call Patient Services at 321-751-3389 or 1-800-349-6922 (1-800-FIX-MY-BACK). Each cancellation or "no show" is tracked in our system and you will receive a cancellation number. Excessive cancellations and 'no shows may require us to discharge you from the practice.

1. Cancellation/No Show Policy for Doctor Appointment

We understand that there are times when you miss and appointment due to emergencies or obligations for work or family; however, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a forty ($40) dollar fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen; however, we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time, we will either fit you in or give you the option to reschedule the appointment.

3. Cancellation/No Show Policy for Procedures/Surgery

Due to the large block of time needed for surgery/procedures, last minute cancellations will not allow time needed to schedule another patient in need of our services.

If surgery/procedure is not cancelled at least 48 hours in advance you will be charged and eight ($80) dollar fee; this will not be covered by your insurance company.

4. Account Balances

We require that patients with no show/cancellation fees pay their account balances to zero ($0) prior to receiving further services by our practice. Patients who have questions or would like to discuss the charges may call Clinic M

Patient Signature: _____ Date: _____

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MUTUAL AGREEMENT, CONSENTS AND RESOLUTION OF CONCERNS

1. Privacy and Ratings

Deuk Joint Institute agrees not to provide medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Deuk Joint Institute will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Deuk Joint Institute has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about Deuk Joint Institute- our practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Deuk Joint Institute, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Deuk Joint Institute for any written, pictorial, and/or electronic commentary. This assignment shall be effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be for a period of five years from Deuk Joint Institute last date of service to Patient. Deuk Joint Institute requires all patients in its practice to sign the Mutual Agreement to establish that any anonymous publishing or airing of commentary will be covered by this agreement. Further, this Agreement will survive for a minimum of three years beyond any termination of the Deuk Joint Institute - Patient relationship.

Patient and Deuk Joint Institute acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Deuk Joint Institute agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this provision result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

2. Surgical Consent Modification

We recognize that you have a choice in receiving care. We take great pride in our reputation for providing the highest levels of quality medical care to our patients. However, we realize there are times when some patients might not be satisfied with the outcomes of their treatments.

Every patient has a right to file a complaint with the Division of Medical Quality Assurance, Board of Medicine. But, that right is not unlimited. For example, those who file complaints in bad faith can be subject to civil liability (Florida Statutes§ 456.073 (11)). In the context of balancing your rights with those of the physician, I, the patient, agree to the following:

1. If a complaint related to my care is ever filed (by my agent or me) with the Division of Medical Quality Assurance, I will only do so in good faith, addressing matters only related to my health and welfare.
2. In particular, I understand that there are risks inherent to any surgical procedure and these risks have been explained to me prior to the procedure. I have signed that consent voluntarily and with my free will. And I have had an opportunity to ask questions and have them answered to my satisfaction. In that context, a complaint to the Division of Medical Quality Assurance, founded on any such realized risks, unless there is clear and convincing evidence to the contrary, will be construed as bad faith.
3. Next, should a complaint be filed with the Division of Medical Quality Assurance related to standard of care, I, the patient, will explicitly request that the complaint be reviewed by a member of my specialty; that specialty being Neurosurgery, Spinal Surgery, Orthopedic Surgery, Pain Management or Neurology.
4. Finally, should the complaint allege facts that can be disrupted by the clear medical record, I, the patient, will voluntarily withdraw my complaint if that portion of the medical record is drawn to my attention. I will have the right to inspect and review the medical record to correct any perceived error in the medical history. Such corrections must be performed within two weeks of the treatment received

3. Resolution of Concerns

I understand that I am entering into a contractual relationship with Physician(s) of Deuk Joint Institute for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative, agree not to initiate or advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Medical Specialties ("ABMS") board-certified expert medical witness (es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the

American Board of Neurosurgery, American Board of Interventional Pain Management, American Academy of Pain Management, American Board of Electrodiagnostic Medicine, American Board of Physical Medicine and Rehabilitation, American Board of Orthopedic Surgery and American Board of Psychiatry and Neurology.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach
may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

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4. Waiver

Article 1, Section 21 of the Florida Constitution reads as follows: Access to court – The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay. The Undersigned patient understands and acknowledges that: I have been advised that signing this waiver releases an important constitutional right; and I have been advised that I may consult with counsel before signing this waiver; and by signing this waiver I agree that if any controversy arises out of or in any way relating to the current, future or past diagnosis, treatment, or care that I have or will receive from Deuk Joint Institute, it's physicians, agents or employees, the maximum amount of any non-economic damages that can be awarded in any such action will be $250,000. This limit applies regardless of the number of claimants or defendants in the proceeding. There is no limit on the amount of economic damages that a jury may award; and I have three (3) business days following execution of this waiver in which to cancel this waiver; and I wish to engage the medical services of Deuk Joint Institute, but I am unable to do so because of the provisions of the constitutional limitation set forth above. In consideration of the physician or group of physicians' agreements to provide medical services to me and my desire to receive medical services from the physician or group of physicians listed below, I hereby knowingly, willingly, and voluntarily waive the right, in an action in a court of law for any controversy, including any malpractice claim, arising out of or in any way relating to the diagnosis, treatment, or care of the patient by Deuk Joint Institute, including any partners, agents, or employees of the physician, to recover non-economic damages in excess of $250,000; and I have selected Deuk Joint Institute as my physician group of choice in this matter and would not be able to retain their medical services without this waiver; and I expressly state that this waiver is made freely and voluntarily, with full knowledge of its terms, and that all questions have been answered to my satisfaction. I understand that this waiver will remain in effect for one year from the date that I have signed this form.

ACKNOWLEDGEMENT BY PATIENT FOR PRESENTATION TO THE COURT

The undersigned patient hereby acknowledges, under oath, the following:

I have read and understand this entire waiver of my right under the constitutional provision set forth above. I am not under the influence of any substance, drug, or condition (physical, mental, or emotional) that interferes with my understanding of this entire waiver in which I am entering and all the consequences thereof. I have entered and signed this waiver freely and voluntarily.

I authorize Deuk Joint Institute to present this waiver to the appropriate court, if required. Unless the court requires my attendance at a hearing for that purpose Deuk Joint Institute is authorized to provide this waiver to the court for its consideration without my presence.

DATED this _____day of _____, 20____ By: _____

Patient Signature

Sworn to and subscribed before me this _____ day of _____, 20_____by_____, who is

personally known to me or has produced the following identification: _____.

_____

Notary Public Signature

My Commission Expires:

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Financial Guidelines

Form Of Pay	You are responsible for…	We will…
Medicare	If you have standard Medicare, and have not met your $140 deductible, we ask that it be paid at the time of service. For any services not covered by Medicare, payment is also requested at the time of the visit. If you have regular Medicare as your primary insurance and also have a secondary insurance or Medigap coverage: No payment is required at the time of the visit after your Medicare deductible has been met. If your secondary insurance does not send payment within 45 days, a bill for the balance will be sent to you. If you have regular Medicare as your primary insurance and no secondary insurance: Be prepared to pay your 20% co-insurance at the time of the visit	Accept your Medicare deductible payment (if applicable), any co-insurance amount, file the claim on your behalf including any claims to your secondary insurance.
Medicare HMO Fee-For-Service	All applicable co-payments and deductibles at the time of the visit.	Accept your payment and file a claim to your insurance.
In Network HMO/PPO Plans	If the services you received are covered by your plan: All applicable co-payments and deductibles apply and are due at the time of the visit. If authorization is required by your insurance, you must verify with provider's office before your visit.	Accept your payment and file a claim to your insurance.
Limited Plans	Full payment for services provided at the time of service.	Accept your payment and file a claim to your insurance without accepting assignment.
Commercial Insurance	All applicable co-payments and deductibles at the time of the visit.	Accept your payment and file a claim to your insurance.
Out of Network	Payment in full at the time of service for office visit, injections, and for any other service provided. You may be asked to make a deposit at the time of registration.	Accept your payment and courtesy file a claim to your insurance.
Self Pay	Payment in FULL at time of service is expected. For patients scheduled to see our specialists, the deposit amount is $250-$500 (New Patients) and $150-$300 (Established Patients) and any additional fees will be settled at time of visit. Credit, debit, check are accepted methods of payment. If you are a NEW patient please come prepared to pay by credit or debit.	Accept your payment.
HSA Plans	You must return to the Registration area to pay with your HSA Debit Card.	Accept your HSA card payment.
Workers Comp or MVA	If an authorization to treat has been obtained from your carrier, no payment will be required at time of visit. If an Authorization is not in place, your appointment will be re-scheduled.	Schedule your appointment after services have been authorized by your carrier.