NeuSpine Institute | Minimally Invasive Surgery

PATIENT INFORMATION

Today's Date: _____

Last Name: _____ First Name:_____Middle Initial: _____

Address: _____

STREET CITY STATE ZIP CODE

Gender: ☐Male ☐ Female Social Security #: _____ Date of Birth: _____

Home Phone: _____ Cell Phone _____ Work Phone: _____

E-mail: _____ Preferred Method of Contact: ☐ PHONE ☐ E-MAIL

Marital Status: ☐ Single ☐ Married Divorced ☐ Widowed

Race/Ethnicity: ☐ American Indian ☐ Hispanic/Latino ☐ Asian ☐African American ☐ White ☐ Other

Is your visit related to an Auto Accident? ☐ Yes ☐ No

Is your visit related to a Work Accident? ☐ Yes ☐ No

Is your visit related to a Slip & Fall? ☐ Yes ☐ No

How were you referred? ☐Primary ☐ Specialty ☐Friend/Family ☐ Advertising ☐Other (please specify)

Referring Physician (if applicable): _____

EMERGENCY CONTACT INFORMATION

1. Name: _____ Relationship: _____

Address: _____

STREET CITY STATE ZIP CODE

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

2. Name: _____ Relationship: _____

Address: _____

STREET CITY STATE ZIP CODE

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

PROVIDER HISTORY

Primary Care Physician:

Name: _____Phone Number: _____ Fax: _____

Address: _____

STREET CITY STATE ZIP CODE

Cardiologist:

Name: _____ Phone Number: _____

Address: _____

STREET CITY STATE ZIP CODE

Other:

Name: _____ Phone Number: _____

Address: _____

STREET CITY STATE ZIP CODE

INSURANCE INFORMATION

Primary Insurance

Person Responsible: ☐ Self ☐ Other Relationship to Patient: _____
Name: _____ DOB: _____ Social Security #: _____
Insurance Company: _____ ID Number: _____
Insurance Phone: _____ Group #: _____

Secondary Insurance

Person Responsible: ☐ Self ☐ Other Relationship to Patient: _____
Name: _____ DOB: _____ Social Security #: _____
Insurance Company: _____ ID Number: _____
Insurance Phone: _____ Group #: _____

PHARMACY INFORMATION

Local Pharmacy
Name: _____
Address: _____
_____
Phone Number: _____

Mail Order Pharmacy
Name: _____
Address: _____
_____
Phone Number: _____

FINANCIAL AND CONSENT AGREEMENT

ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

PATIENT INFORMATION FORM – FINANCIAL AGREEMENT

1) Services are rendered to the patient not the insurance company. Our office will file your insurance if proper information is received.
   a) You are responsible for Copays, Deductibles, Non-Covered Services, Co-Insurance and items considered "not medically necessary" by insurance.
   b) For unpaid claims, over 45 days,it is your responsibility to follow up with your insurance company and the balance may be considered due and payable.
2) It is your responsibility to notify our front desk of any insurance or address changes.
3) You will be responsible for any changes that occur if your current insurance is not communicated at the time of service.
4) Expenses incurred to collect patient-responsible debt may be charged to the patient or guarantor.

_____ _____ _____
Patient/Legal Guardian Printed Name Patient/Legal Guardian Signature Date

MEDICAL INFORMATION

Please circle:

Do you smoke cigarettes?	Yes	No	How many per day? _____
Are you a former smoker?	Yes	No	Last used? _____
Do you drink alcohol?	Yes	No	How often? _____
Do you participate in recreational drug use?	Yes	No	What kind? _____

LIST OF SURGERIES AND HOSPITALIZATIONS

Hospital Name	Reason	Date

MEDICATIONS

Please list all medications you are taking or provide a list
(Include all over the counter medications and medications taken within the last month)

Name	Dosage	Directions	Reason for Medication

Please list all allergies and symptoms if known:

_____

_____

Past Medical History: ***(check all that apply)***

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke or mini-stroke
- ☐ Aneurysm
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Abnormal Heart Rhythm
- ☐ Pacemaker or AICD
- ☐ Anemia
- ☐ Headaches
- ☐ Emphysema or COPD
- ☐ Acid Reflux
- ☐ Ulcerative colitis or Crohn's's Disease
- ☐ Kidney failure/problems
- ☐ HIV or AIDs
- ☐ Glaucoma
- ☐ Bleeding or Clotting problems
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Cancer
- ☐ Arthritis
- ☐ Anxiety
- ☐ Depression
- ☐ Epilepsy
- ☐ Osteoporosis
- ☐ Cataracts
- ☐ Pneumonia
- ☐ Hepatitis
- ☐ Asthma

ACKNOWLEDGEMENT AND CONSENT FOR NOTICE OF PRIVACY

Acknowledge of Receipt

I have reviewed NeuSpine Institute LLC Notice of Privacy, which explained how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at no cost to me.

Patient requested copy: ☐ Yes ☐ No

_____ _____ _____

Name of Patient *(Please Print* Signature of Patient of Legal Guardian Date

Consent to Release Medical Information to Personal Representative

I, _____, hereby consent to have my information released to the following individuals. This consent will remain in effect until otherwise notified by me in writing.

☐ Appointment times ☐ Medical Information ☐ Billing/Demographic Info

Do NOT release my information, except to health care providers and…

_____ _____ , _____ _____

Name Relationship Name Relationship

_____ _____ , _____ _____

Name Relationship Name Relationship

_____ _____

Signature of Patient of Legal Guardian Date

PATIENT AUTHORIZATION & CONSENT

I hereby voluntarily consent to medical treatment, including diagnostic procedures, surgical and other medical services, provided by NeuSpine Institute LLC or their authorized designees, as they may in their professional judgment be necessary to provide appropriate medical, surgical or emergency care. I agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, all costs, and expenses, including but not limited to reasonable attorney's fees that may incur in such collection efforts.

I authorize NeuSpine Institute LLC physicians to submit claims to my insurance for services rendered by my medical providers. I authorize the release of any medical information necessary to process this assignment on the claim. I authorize payment to be made to NeuSpine Institute LLC physicians for services provided by them.

TO ALL PATIENTS:

In order to provide you with good service, it is of great importance we have your current address and phone number on file. Please be sure to contact us if your phone number and/or address changes. This information will be utilized to remind you of your appointment date and time.

Cancellation/No Show Policy:

Any Follow-up appointment cancellation or no-show in which a 24-hour notice is not provided, will result in a $50 charge.

Any Injection appointment cancellation or no show in which a 24-hour notice is not provided, will result in a $75 charge.

After three occurrences you will be terminated from NeuSpine Institute. If we terminate our service with you, we will be happy to transfer a copy of your medical records to your new physician upon receipt of a signed authorization to release records.

Late Policy:

The clinic has limited waiting time for your appointment. If you are more than 15 minutes late your appointment will be rescheduled.

_____ _____

Patient/Legal Guardian Signature Date

NEUSPINE INSTITUTE

HIPAA Privacy Authorization Form

Authorization for Use of Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I Authorize **NEUSPINE INSTITUTE LLC.** to use and disclose the protected health information described below.

By signing,

1. I authorize the release of my complete health record (including records related to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
2. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
3. This authorization shall be in force and effect during my entire care at NeuSpine Institute LLC.
4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on the authorization or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
6. I may inspect and receive a copy of the information being used and disclosed pursuant to this Authorization form.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____	_____	_____
Printed Patient Name & DOB	Patient Signature	Date

NeuSpine Institute Minimally Invasive Surgery

Assignment of benefits, liens, direct payment authorization, authorization to release
insurance information, and authorization to escrow unpaid medical & PIP benefits
NEUSPINE ANCILLARY LLC

Insurance Carrier_____

For and consideration of NEUSPINE INSTITUTE LLC agreeing to pursue the responsible insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to NEUSPINE INSTITUTE LLC for Medical Payment Coverage, and other benefits which I may have accordance with Florida Statute § 627.736. This includes any benefits from my insurance company and any other entity may be responsible for medical expenses incurred. I further authorize NEUSPINE INSTITUTE LLC to collect payments & prosecute any necessary actions to collect payments for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

This assignment concerns only the bills for NEUSPINE INSTITUTE LLC and those costs including, but not limited to,attorney's fees other costs, and interest necessary in procuring payment from the above-names insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or copayment not covered by any policy of insurance cited above . I understand that as a benefit and convenience to me, NEUSPINE INSTITUTE LLC will bill any pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to NEUSPINE INSTITUTE LLC on the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to NEUSPINE INSTITUTE LLC at the address on the bill. NEUSPINE INSTITUTE LLC medical care is being provided for a reasonable fee for treatment that I have sought out for under my above mentioned insurance carrier and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part,my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by NEUSPINE INSTITUTE LLC. I further instruct my insurance company to make payment for charges submitted NEUSPINE INSTITUTE LLC in priority to any other request to escrow benefits,including a request by myself to reserve benefits for pending disability claims . I hereby give NEUSPINE INSTITUTE LLC limited power of attorney to endorse and sign my name on any draft for payment to either NEUSPINE INSTITUTE LLC or myself if said draft represents payment for charges related to services rendered by NEUSPINE INSTITUTE LLC.

I further direct my insurance carrier ir responsible other entity to provide information to NEUSPINE INSTITUTE LLC which is otherwise available to me including but not limited to a copay of any applicable insurance policy, declaration page,all applicable endorsements, transcripts and/or copies of any recorded statements,examinations under oath and request for same,independent medical evaluations and requests for same, and peer review reports, this request includes the name of other medical providers to whom payments have been under my policy of insurance in favor of NEUSPINE INSTITUTE LLC. If any language within this agreement has the effect of invalidating this agreement , that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original .

Patient Signature	Patient Name	Date

If patient is incapacitated or under the age of 18, please indicate the patient's name, guardian name and relation to patient and obtain guardian signature.

NeuSpine Institute | Minimally Invasive Surgery

NEW PATIENT INFORMATION

Please make sure that a response is written in EVERY SPACE

Name: _____

Previous SPINAL Surgeries:

WHERE: WHEN: WHO:

_____ _____ _____

_____ _____ _____

_____ _____ _____

When did it start? _____

Was there an event/injury that caused your pain to start?

_____

_____

What makes your pain worse? _____

_____

What makes your pain feel better? _____

_____

Previous Treatment (please answer yes/no and details as applicable)

Bracing therapy _____ When _____ How long _____ Did it help _____

Physical Therapy _____ When _____ How long _____ Did it help _____

Chiropractor _____ When _____ How long _____ Did it help _____

Acupuncture _____ When _____ How long _____ Did it help _____

Massage Therapy _____ When _____ How long _____ Did it help _____

Pain Management _____ Doctor's name: _____ When _____

How long _____ Did it help _____

What did they do? _____

Injections _____ What part of body _____What kind _____

When_____ How many _____ Did it help_____

Previous evaluated by spinal surgeon?(If so, who?) _____

Other tests/Doctors:

_____

_____

Are you on any blood thinners such as aspirin? _____

NeuSpine Institute | Minimally Invasive Surgery

Name: _____ Date: _____

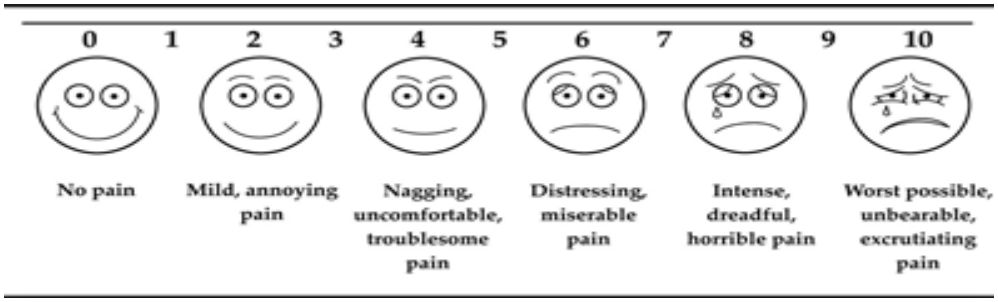
Please circle any symptoms you have experienced in the <u>last two weeks</u> :

Constitutional:	Fever	Night sweats	Chills	Appetite Change	Fatigue				
Skin:	Swollen glands	Rash	Ulcer	Laceration	Hives	Bruising	Sores	Hair loss	Itching
Ear, Nose, Throat:	Sore throat	Ear Ache	Sinus drainage	Hoarseness	Loss of hearing	Jaw pain	Neck Pain		
Eyes:	Double vision	Other visual changes	Pain from bright lights	Blind Spots					
Respiratory:	Shortness of breath	Wheezing	Chest pain	Sputum	Cough	Coughing up blood			
Cardiovascular:	Chest pain	Palpitations	Swelling	Fainting	Shortness of breath				
Gastrointestinal:	Nausea	Vomiting	Abdominal Pain	Acid Reflux	Difficulty Swallowing	Choking	Diarrhea		
Genital Urinary:	Painful Urination	Incontinence	Blood in urine	Frequent Urination					
Musculoskeletal:	Redness	Pain	Weakness	Joint Swelling	Prior Fractures				
Neurological:	Fainting	Seizure	Memory loss	Paralysis	Prior head injury	Numbness	Weakness		
Psychological:	Depression	Anxiety	Psychosis	Delirium	Fainting	Seizure	Paralysis		
Hematological:	Easy Bruising	Bleeding gums	History of blood clots	Nose bleed					
Endocrine:	Heat or cold intolerance	History of Diabetes	Thyroid Disease						

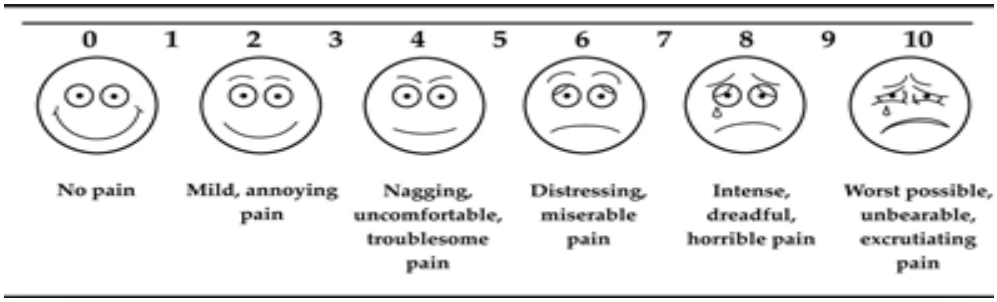
Visual Analogue Scale

Neck Pain

1) Mark your current NECK PAIN based on the scale below

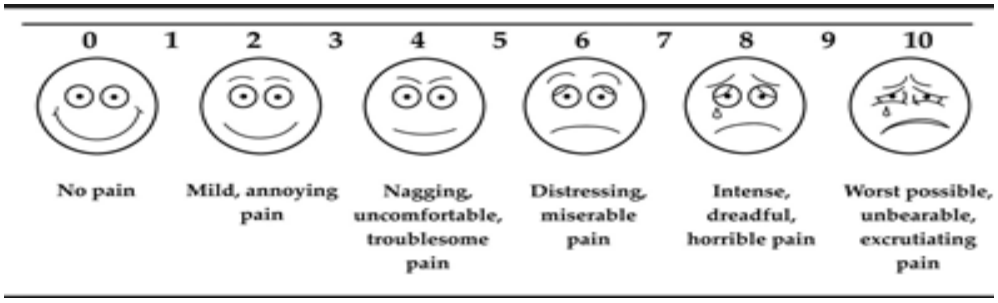


2) Mark your current ARM PAIN based on the scale below

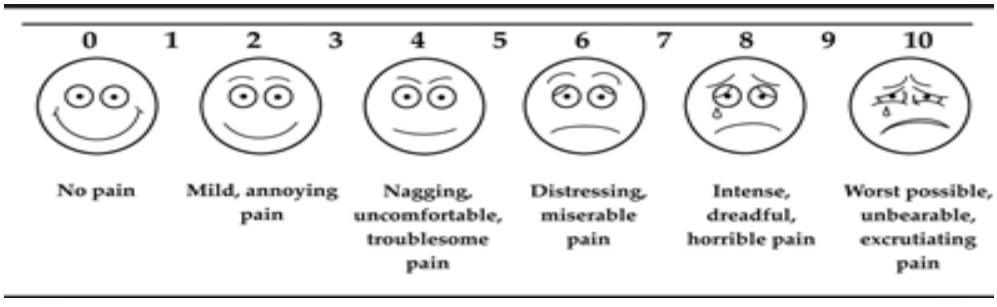


Back Pain

1) Mark your current BACK PAIN based on the scale below

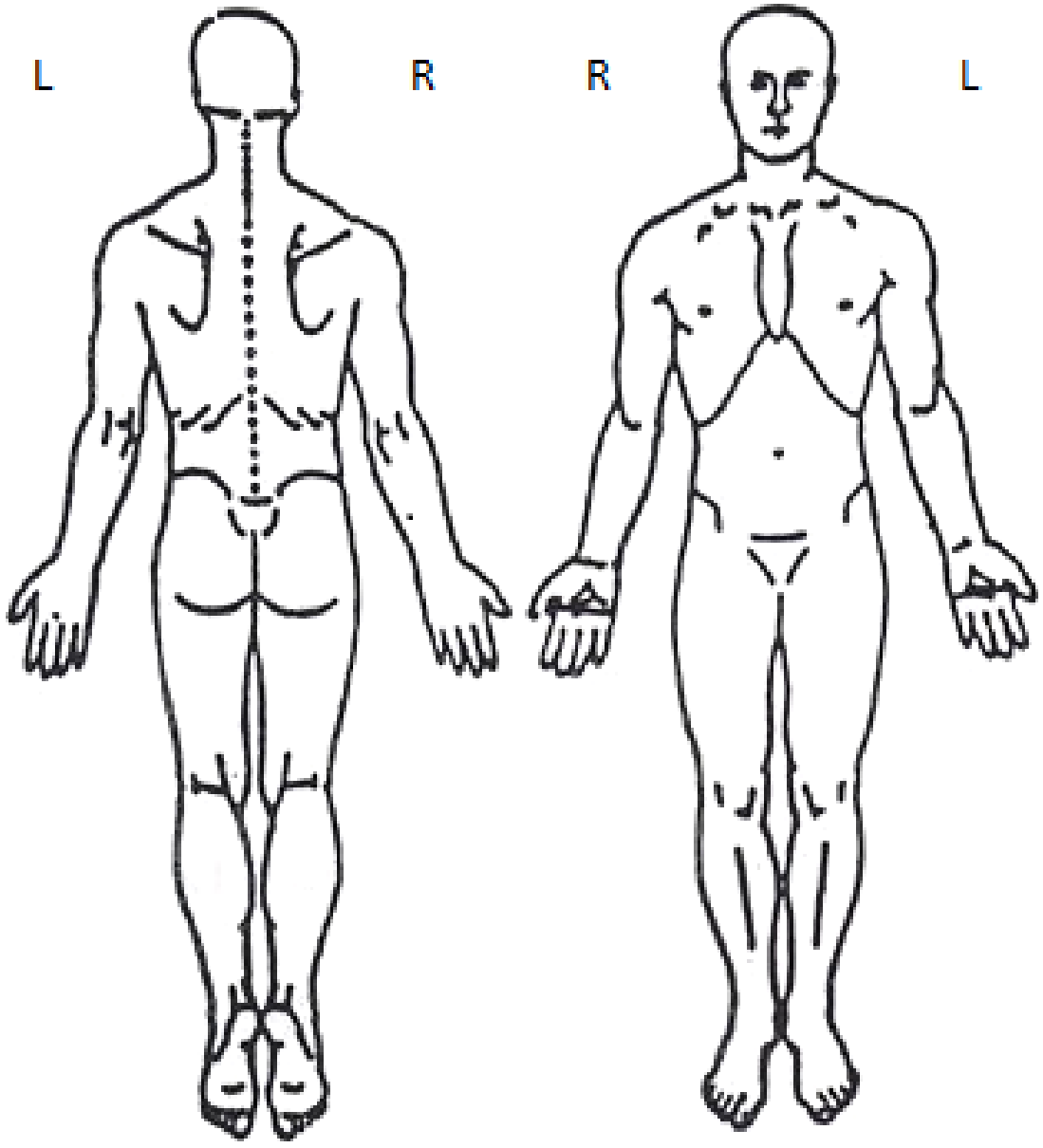


2) Mark your current LEG PAIN based on the scale below



What area is the most bothersome (neck, right arm, left arm, back, right leg, left leg): _____

Name: _____
Date: _____



Please color in the area with the following:
Red: Burning
Blue: Numbness
Yellow: Stabbing Pain
Green: Weakness
Brown: Aching