Omni Spine & Joint - Clearwater

Interventional Diagnostics and Treatment

Sid Panchamia, MD
Terry Gribbin, PA
1811 N Belcher Rd, Ste H2
Clearwater, FL 33765
P:727-724-6373 F:727-724-6377

Patient Information

Date_____ Home Phone_____ Email_____

Name_____ SS#_____

Address_____ Cell Phone_____

City_____ State_____ Zip_____

Sex |M |F DOB_____ |Married |Widow |Single |Divorced/Separated |Minor

Patient Employer/School_____ Occupation_____

Employer/School Address_____ Phone_____

Emergency Contact_____ Phone_____

Family/Referring Dr_____ Phone_____ Fax_____

Auto (PIP) Insurance

Insured Name_____ DOB_____

Address (if different than above)_____ Phone_____

City_____ State_____ Zip_____ SS#_____

Insured Employer_____ Wk Phone_____

Insurance Company_____

Policy ID #_____ Claim #_____

Insurance Address_____ Phone_____

City_____ State_____ Zip_____ Fax #_____

Worker's Compensation Insurance

Claim #_____ Date of Injury_____

WC Co. Name_____ Phone_____

Address for Claims_____

Adjuster Name_____ Phone_____ Fax_____

Attorney Name_____ Phone_____ Fax_____

The above information is true to the best of my knowledge. I authorize my PIP and or Work Comp benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Omni Spine & Joint or insurance company to release any information required to process my claims.

_____

Patient/Guardian Signature Date

OMNI SPINE & JOINT - CLEARWATER

Patient: _____ **Age:** _____ **DOB:** _____

Date of Accident: _____ **Type of Accident: Slip & Fall** _____ **or MVA** _____

How accident happened: Rear ended _____ **Side-swiped** _____ **T-Boned** _____ **Head on** _____

Did your head hit anything? _____ **Did you lose consciousness?** _____

Did you go to the hospital? _____ **Where?** _____ **What was done?** _____

What doctors have you seen for this injury? _____

Please describe your painful areas:

Low Back Pain: Ache / Burning / Sharp Does the pain radiate down your leg? _____ Right / Left / Both

Numbness, tingling or weakness in your legs? _____ Right / Left / Both

What lessens the pain? _____ What makes it worse? _____

Neck Pain: Ache / Burning / Sharp Does the pain radiate down your arm? _____ Right / Left / Both

Numbness or tingling or weakness in your arms? _____ Right / Left / Both

What lessens the pain? _____ What makes it worse? _____

Headaches: _____ Front / Back / Sides Do you have: nausea / vomiting / dizziness / blurry vision

Other problems: _____

Past Medical History: _____

Past Surgical History: _____

_____

Meds: _____

_____

Allergies: _____

Social History: Tobacco use: yes / no Alcohol use yes /no Other: _____

Family History: _____

----------FOR PHYSICIAN----------

Review of Systems

Cardiovascular: chest pain Gastrointestinal: Abdominal pain /rectal bleeding / nausea, vomiting

Respiratory: Frequent cough /shortness of breath / wheezing Hematologic: History of blood clots

Genitourinary: Loss of bladder control / urine retention Neurological: Tremors / dizzy spells

Psychologic: Depression / anxiety / bipolar disorder General: Fever / unexplained weight loss

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NOTICE OF PRIVACY PRACTICES

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

It is the policy at Omni Spine & Joint – Clearwater to keep your health information secure and confidential. The Health Insurance Portability and Accountability Act (HIPAA) requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist or doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you, such as in newsletters, appointment reminders, and patient portal communications. We may also attempt to contact you by phone for appointment reminders and for medication management purposes. If you are not home or do not respond, we may leave this information on your voicemail or with the person who answers the phone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose health information without your prior written authorization. You may request in writing that we do not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your health information to another practice. We will transmit your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied; however, there may be a charge to you as deemed reasonable and customary by the Florida Statutes.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing If you wish to include a statement in your file, please provide it to us in writing. We may or may not fulfill your request, but we will be happy to include your statement in your file. If we agree to an amendment or change, we will neither remove nor alter earlier documentation, but will add new information.

You have the right to receive a copy of this notice at any time upon request.

If we change any details of this notice, we will notify you in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independent Avenue SW, Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office manager at (813) 533-5522. This notice went into effective on January 1, 2020.

Acknowledgement: I have read and understand and agree with the above Notice of Privacy Practice.

Patient/Guardian (Please Print Name) Patient/Guardian (Signature) Date

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Medical Records Release Authorization

To avoid a delay, this form must be completed in its entirety.
PLEASE PRINT CLEARLY

Patient Name: _____ Maiden Name: _____

D.O.B. **(Required)**_____ SS#**(Required)**_____

Home Phone: _____ Work Phone: _____

Permission is hereby granted to Omni Spine & Joint to request medical information to the individual / organization as noted below or to have records released to Omni Spine & Joint:

Mail to ☐ Name: _____

Address: _____

City/State/Zip: _____

☐ Fax to another medical entity (___)_____ ☐ call when ready for pick up (___)_____ ☐ Person picking up records

Please check information to be released:

☐ All records, excluding records from other physicians.
☐ Surgical Records
☐ Therapy reports
☐ Diagnostic test results
☐ Other _____
☐ Office Notes only
☐ X-ray/MRI films
☐ X-ray/MRI reports
☐ Patient information

This authorization will be valid for two years after the date of the patient's signature as it appears below, or by whichever comes sooner.

_____
Signature of Patient / Legal Guardian Date

I understand I have the right to refuse this authorization, in writing, and Omni Spine & Joint is released from all legal liability that may arise from the released information requested.

_____ _____
Signature of patient/Legal Guardian Date

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DEFERRED PAYMENT AGREEMENT (DPA):

1. Omni Spine & Joint - Clearwater (hereinafter "Practice") hereby agrees to provide medically necessary care and treatment to the above patient based upon the terms and conditions of this agreement.

2. I _____, (hereinafter referred to as "Patient") understand that the Practice is not in network with any private health insurances and does not participate with Medicare. As a result, I agree to be seen and treated under this payment arrangement with the Practice.

3. The Practice agrees to provide the medically necessary medical care and treatment and to bill me at their usual and customary rate.

4. Based upon this agreement the Practice will defer collection of these medical bills as set out below.

5. I understand and agree that I am personally responsible for any and all medical charges billed by the Practice for my treatment and that if at any time, I default on this obligation, I am subject to a collection action and/or civil litigation instituted by the Practice to recover the above medical debt. My obligations under this Agreement stand alone and are not subject to any other contingency or occurrence.

6. I understand that I have the right to request, in writing (the form will be provided by the practice upon request), an estimate of medical charges to be incurred prior to undergoing any treatment or procedure at the Practice.

7. If I have retained an attorney, I request and direct the Practice to follow my direction that any and all cost estimates for medical care and treatment and/or the actual medical billings for services provided be sent directly to his/her office so that I may consult and seek their counsel throughout my medical care and treatment.

8. The Practice agrees to defer the collection on any billings provided to me for 24 months from the date of my first medical treatment without interest.

   If my medical debt remains due and owing at the conclusion of that time period, I agree to pay 5% Annual Percentage Rate (hereinafter referred to as "APR") on the incurred medical debt for the third year the debt is due and owing.

   I further agree to pay an additional 5% APR for each additional year the debt remains outstanding up to five years from the date of my first treatment at the Practice or a maximum of 15% interest APR. The above interest shall be compounded annually.

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At the conclusion of the five-year period, unless I have negotiated a payment agreement with the Practice, collection proceedings and/or civil litigation shall begin for the recovery of the entirety of the medical debt and associated interest that remains outstanding.

9. I, the Patient, enter into this Agreement freely and voluntarily. I have had an opportunity to ask any and all questions of the Practice and I have been provided with satisfactory responses to those questions.

10. Additionally, I have had an opportunity to have this Agreement reviewed by an attorney of my choice prior to signing it.

Patient/Legal Guardian (if patient is a minor):

_____
Signature

Date: _____

Practice Representative:

_____
Signature

Date: _____

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PIP AUTHORIZATION

Patient: _____ Date of Loss: _____

Insurance Carrier: _____ Claim #: _____

I authorize my auto insurance companies Personal Injury Protection (PIP) benefits to pay directly to OMNI SPINE & JOINT - CLEARWATER any sums that may be due and owing them for medical services rendered, as same are reasonable, necessary, and related to the motor vehicle incident. The responsible liability carrier will not make interim settlement payments; therefore, I understand that until all reasonable efforts have been made to collect the contractually obligated sums due from my auto insurance PIP benefits OMNI SPINE & JOINT - CLEARWATER will refrain from attempts and efforts to collect the amount owed directly from me. I understand that I am responsible for the amounts that my auto insurance company PIP benefits are not obligated or has failed to pay pursuant to Florida PIP laws. I understand that OMNI SPINE & JOINT - CLEARWATER will not be filing claims to my health insurance for any services related to this motor vehicle incident. I understand OMNI SPINE & JOINT - CLEARWATER will not accept anything less than what is owed for my medical services rendered to me, as same are customary, reasonable, and medically necessary without a case-by-case analysis and mutual agreement being reached. I understand I am responsible for my medical services at OMNI SPINE & JOINT - CLEARWATER and agree to these conditions. I consent to treatment at OMNI SPINE & JOINT - CLEARWATER and fully understand my financial obligation.

_____ _____ _____
Patient/Guardian (Please Print Name) Patient/Guardian (Signature) Date

"No Show" Agreement

The following represents a mutual agreement between Omni Spine & Joint and the patient, _____.

I understand that by making an appointment for either a follow up or in-office injection procedure, I agree to be present at the arranged time for this appointment. I understand that Omni Spine & Joint is reserving this time specifically for my care.

In addition to the above, failure to follow pre-procedure instructions may result in cancellation of the procedure by the doctor. Such cancellation, based upon my own failure to follow instructions, will be deemed a failure to be present for my appointment and will be handled as below.

After reading the above, I understand that failure to be present for my appointment without 24-hour notice OR failure to follow pre-procedure instructions resulting in procedure cancellation on the day of procedure, will result in a charge to be billed to my account for which I am financially responsible.

Charges for missed appointments as indicated above are as follows:

- Office Visit $100
- In-Office Procedure $150

_____ _____
Patient/Guardian (Please Print Name) Patient/Guardian (Signature) Date