New Patient Registration Form

Patient Name : _____ Date of Birth: _____

Sex (Circle One): Male Female Other Social Sec #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Preferred Pharmacy Information:

Name: _____ Location: _____ Phone: _____

Marital Status (Circle One): Single Married Divorced Widowed

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Who is financially responsible for payment for these services? (Circle One)

Self Spouse Parent/Guardian Workers Comp Other

Responsible Party of Bill Information: (If other than yourself)

Full Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Sec #. _____

Employer: _____

If your primary insurance is an HMO plan, please provide the name of your Primary Care Provider below.

Dr.: _____ Phone: (_____) _____

Assignment of Benefits and Authorization to Release Medical Information

I request that payment of authorized benefits Medicare, Medicaid and/or any Insurance Carrier listed, be made to me or on my behalf to the provider on this form, for any services furnished to me, my physician/supplier. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, listed insurer(s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits for other related services.

Name: _____ Date of Birth: _____

Allergies: _____ _____
_____ _____
_____ _____
_____ _____

Medications: _____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Family History: (Please check all that apply and write which family member has condition and any other specifics)

Medical Conditions:	Family member(s):	Medical Condition:	Family member(s):
__ Diabetes	_____	__ Cancer	_____
__ High blood pressure	_____	__ Stroke/CVA	_____
__ High cholesterol	_____	__ Bleeding problems	_____
__ Heart problems	_____	__ Blood clot formation/DVT	_____
__ Asthma	_____	__ Anesthesia problems	_____
__ Other	_____	__ Other	_____

Social History:

Smoking (Check One): ___ Never ___ Former Smoker (How long did you smoke? _____ yrs)
___ Current everyday smoker ___ Social smoker (How often _____)

If yes to the above, please specify: ___ Loose tobacco ___ Cigarettes ___ Vape

If applicable, how much do you smoke regularly? (Circle One): 1ppw 2ppw ¼ ppd ½ ppd 2 ppd+

Alcohol consumption: ___ No ___ Yes

If yes, how much? (Circle One): Occasional Moderate Heavy

History of drug abuse: ____ No ___ Yes

If yes, please specify the type(s) of drug used: _____

Occupation: _____ Employer: _____

Current work status (Circle One): Full time Part time Light/Limited duty Disabled

Name: _____ Date of Birth: _____

Surgical History:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Past Medical History:

___ None
___ Aids/HIV
___ Anemia
___ Aneurysm
___ Anxiety Disorder/Depression
___ Asthma
___ Bleeding Disorder
___ Blood Clot(s)/DVT(s)
___ Blood Transfusion
___ Brain Tumor
___ COPD
___ Cancer
___ Cerebral Palsy
___ Cardiac Catheterization/Stents
___ Coronary Artery Disease
___ Dementia
___ Diabetes Type I/II
___ Epilepsy/Seizures
___ Gout
___ Headaches/Migraines
___ Head Trauma/Injury
___ Heart Problems/History of Heart Attack
___ Hepatitis A, B, C
___ High Cholesterol
___ Hyperlipidemia
___ Hypertension/High Blood Pressure
___ Kidney Problems
___ Liver Problems
___ Lupus
___ Prior/Current MRSA/Staph Infection
___ Pacemaker
___ Multiple Sclerosis
___ Osteoporosis
___ Rheumatoid Arthritis
___ Tuberculosis
___ Sleep Apnea/Use of C-PAP
___ Stroke

If yes to any above or need to add, please explain: _____
_____
_____
_____
_____

I attest that all the above is complete and is a correct reflection of my medical history.

_____ _____
Patient Signature Date

Pain Assessment Sheet

I have pain in my:
(Please check all that apply)

___ Upper Back (Cervical)
___ Mid-Back (Thoracic)
___ Low Back (Lumbar)
___ Neck & R. Shoulder
___ Low Back & R. Buttock
___ Neck & L. Shoulder
___ Knee Left/Right
___ Elbow Left/Right
___ Low Back & L. Buttock
___ Hip Left/Right
___ Foot/Ankle Left/Right
___ Hand/Wrist Left/Right
___ Leg Left/Right
___ Neck
___ Between Shoulder Blades

My pain is best described as:
(Please check all that apply)

___ Sharp
___ Cramping
___ Throbbing
___ Dull
___ Aching
___ Tingling
___ Mild
___ Moderate
___ Severe
___ Burning
___ Shooting
___ Numb

My pain on a scale of 1 to 10: (10 being the worst pain)

0 1 2 3 4 5 6 7 8 9 10

My pain is:	Better	Worse	No Change
In the morning	____	____	____
Bending forward	____	____	____
Sitting in the car	____	____	____
During mid-day	____	____	____
Lying on my stomach	____	____	____
Coughing/sneezing	____	____	____
Prolonged standing/walking	____	____	____
Prolonged sitting	____	____	____

Patient Name: _____ DOB: _____ Date: _____

Patient Consent to Treatment, Assignment of Benefits, and Guarantee of Payment

As a condition of myself and/or my dependent's treatment by Brevard Spine & Joints, I hereby agree to the following:

Authorization to Treat:
I hereby authorize Dr. S. Farhan Zaidi and/or Amanda Folkers, PA to perform any and all medical examinations and treatments which may now, or during the course of my care, as physician(s) deem advisable and medically necessary. I understand that under the direction of my treating physician(s), Physician Assistants, and/or Advanced Registered Nurse Practitioners may be used in my care. All possible risk and/or side effects, as well as probability of success with such procedures shall be disclosed by his/her physician. The patient shall not be subjected to any procedure without his/her voluntary, competent and understanding consent or consent of his/her legally authorized representative. If the physician recommends diagnostic x-rays or injections:

1. The female patient shall affirmatively and, on a continuous basis, inform the doctor or members of Brevard Spine & Joints' staff if she may be pregnant.
2. Patient consents and authorizes use and release of photographs or scanned identification cards, x-rays, videos, photographic, electronic or another image for use medically appropriate.
3. These images shall be maintained as a permanent part of the Patient's medical record.

Patient understands that the healthcare professionals involved in his/her care will rely on his/her documented medical history as well as other information provided by him/her, and his/her immediate family determining whether to perform or recommend procedures. **Initials: _____**

General office visits, testing and procedures:
I acknowledge that I am responsible for all co-payments, deductibles, and all subsequent financial responsibilities for medical services. All co-payments are due at the time of service. As a patient, I understand it is my responsibility to contact my insurance company regarding what services are covered under my individual policy and to ensure all visits are authorized by my primary care physician as directed by my policy. I acknowledge that if I owe a balance for services previously rendered, Dr. S. Farhan Zaidi may refuse to provide additional services until the balance is paid in full. Returned checks are subject to a $25.00 return check fee. In addition, I will lose the privilege to use a check as a form of payment.
Initials: _____

Medicare/Managed Care:
Our physicians participate with the Medicare Program and several managed care programs. You will be expected to pay any deductible and/or co-payment as outlined in your policy at the time of service. As a courtesy to our patients, we will file to most secondary insurances for you. **Initials: _____**

Assignment of Benefits:
I hereby assign, grant and transfer to Brevard Spine & Joints, now and in the future, all of my rights and interest in the following: a) any and all benefits now or in the future owed or receivable by me or on my behalf from my insurer, health maintenance organization (HMO), preferred provider organization (PPO), employer health benefit plan, or other third party payer for those cost I incur in receiving services from Dr. Zaidi. The

insurance policies and insurer include but are not limited to health, auto, uninsured motorist (UM), and personal injury protection (PIP); and b) any and all monies or other benefits paid or payable to me and/or my attorneys from any settlement, judgment or verdict which is obtained as a result of the injury or medical condition for which my debt to Brevard Spine & Joints was or is to be incurred. I further authorize, request and direct any and all assigned insurers to pay directly to Brevard Spine & Joints the amount due me in any potential or pending claim for benefits under the respective policies, expressly including all PIP policies. I agree that, should the amount received by Brevard Spine & Joints be insufficient to cover the entire expense of service, including the co-payment and the deductible, I will be personally responsible for covering the difference. I also understand and agree if the nature of services rendered by Dr. Zaidi and/or Amanda Folkers is not covered by said insurance policy, I am responsible for the payment of the bill entirety.

Initials: _____

Guarantee of Payment:

For value received, including but not limited to the services rendered, I agree to guarantee and promise to pay Brevard Spine & Joints all charges and expenses incurred during my treatment, including those expenses not covered by any insurance policy presently in force, including co-payment and/or deductible. Treatment includes, but is not limited to, physician office visits, diagnostic testing, injections, supplies, medications and any and all services rendered by Dr. Zaidi, Amanda Folkers PA, and staff. Unless specifically agreed in writing, all charges shall be paid at time of service or upon presentation of the first bill from Brevard Spine & Joints. I understand and agree that if Brevard Spine & Joints is required to bring a claim or file an action to enforce the agreement, Brevard Spine & Joints shall be entitled to recover from me any reasonable attorney's fees, expert fees, court costs, and any other costs of collections, in addition to the amount owed to Brevard Spine & Joints for its visit.

Initials: _____

By signing below, I agree that I have read this agreement and understand it entirely.

_____ _____

Patient Signature Date

_____ _____

Signature & Relationship of Patient's Authorized Rep Date

_____ _____

Witness Signature Date

Waiver of Insurance Benefits & Self Pay

Thank you for choosing Brevard Spine & Joints as your healthcare provider. We value your business and are committed to providing exemplary patient care.

Healthcare Insurance - Non-Participating:

Brevard Spine & Joints unfortunately does not participate with your healthcare insurance plan. If you elect to see our physicians, you will be eligible for the self-pay discount. **This will strictly be a cash or charge transaction and payment must be received at the time of service.** You should file your claim with your insurance company, and they should direct any reimbursement payments for covered services directly to you. These services do not include specimens (sent to labs), pathology, blood work, etc. You may receive a separate laboratory bill for specimens. It is your responsibility to provide any lab with your information.

By signing below, you have elected to waive your assignment of benefits and become private pay for the healthcare services provided today. **Payment is required in full at the time of service.**

_____ _____ _____

Patient Name (Printed) Patient Signature Date

_____ _____

Witness Signature Date

SELF-PAY - No Insurance Coverage:

Self-pay patients, if you elect to see our physicians, you will be eligible for the self-pay discount. **This will strictly be a cash or charge transaction and payment must be received at the time of service.** These services do not include specimens (sent to labs), pathology, blood work, etc. You may receive a separate laboratory bill for specimens. It is your responsibility to provide any lab with your information.

By signing below, you have elected to waive your assignment of benefits and become private pay for the healthcare services provided today. **Payment is required in full at the time of service.**

_____ _____

Patient Name (Printed) Patient Signature

_____ _____

Witness Signature Date

Controlled Substance Agreement Form

Patient Name: _____ Date of Birth: _____

I understand that, in order to receive care for the treatment of pain or the use of controlled medications, I must agree and comply with the following:

MENTAL HEALTH AND/OR PAIN MANAGEMENT CONSULTANT:
A mental health assessment and/or continuing psychological therapy may be required. If I am currently involved in mental therapy, or if I enter such therapy, I will authorize my mental health practitioner to exchange unrestricted information regarding my condition and treatment with the undersigned physician. If you are on any mental health prescriptions you must have a recent (within 3 months) psychological evaluation done before any narcotics are given.

USE OF MEDICATIONS:
I will take all medications as prescribed. I will speak with the undersigned physician before making any change in either the dose or frequency of my medications. **There will be no early refills of controlled medications due to overuse or not taking your medication as prescribed.** I understand that I may be subjected to random pill counts and/or office visits in accordance with DEA guidelines, and failure to appear or comply for such may result in termination of care. **I understand that I must bring in all prescription bottles that are prescribed by our physicians, with however much medication is left in them, to every office visit.**

PHARMACY:
I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, I will inform one of the providers and/or office staff before the next prescription is sent.

SEEKING PRESCRIPTIONS:
I will neither seek nor fill prescriptions for any controlled medications from any other health care provider unless authorized by the undersigned physician. I will not harass or repeatedly speak with the pharmacist about refills which may be early. I will not call the physician after hours about my controlled substance prescription refills. I will treat the staff in the office with respect at all times. **I understand that if I am disrespectful or rude to staff, or disrupt the care of other patients, my treatment is subject to termination.**

MEDICAL RECORDS RELEASES:
I will inform all of my health care providers that I received pain management care and will maintain an unrestricted, and current, medical records release form on file.

DRUG SCREENING:
I will participate in drug screening as a part of my treatment plan. I understand that urine drug screening will be conducted on my first visit before any controlled substances will be prescribed, and thereafter on a random basis when requested by the treating physician. Screening may include urinalysis, blood testing, mouth swab or pill counts. I agree to pay all costs associated with drug testing not covered by my insurance. Specimens will

be sent to an outside lab for final results and additional charges may occur from the Lab Facility. **Refusal to submit to screening at the time specified may result in termination of services.**

ILLEGAL/ILLICIT AND NON-PRESCRIBED DRUG USE:
I understand that the use of any controlled medications not prescribed by the undersigned physician, as well as alcohol and any other illicit/illegal substances, may result in termination of care. I also authorize the practice to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of controlled medicines.

PRESENCE & USE OF WEAPONRY:
I understand that the presence of weaponry of any kind, including but not limited to guns and knives, are forbidden from entering the office building. I agree that I absolutely will not, under any circumstances, bring such weaponry into the building or office. I also understand that failure to comply with such guidelines may result in termination of care.

LOST OR STOLEN MEDICATIONS:
I agree to safeguard all medications prescribed by the undersigned physician and understand that **lost, stolen or damaged medications will not be replaced.** This includes paper form prescriptions as well as pills in bottles. I agree to keep all **medications safe, secure, and out of the reach of children.**

DRIVING & OPERATING EQUIPMENT:
Many medications can cause drowsiness and/or very relaxed state of mind, causing operation of equipment or vehicles to be dangerous. I agree to refrain from driving or operating dangerous equipment for 72 hours after any change in medication dosage and whenever I feel drowsy. I am aware that I am not to drive while under the influence of narcotics, even if prescribed by a physician.

TERMINATION:
I will no longer be eligible for care if I am in possession of illicit drugs or substances, trafficking in controlled or illegal substances, intoxicated or if arrested for DUI. If I alter my prescription in any way, sell or share my medications, I will no longer be eligible for care. **Non-compliance with ANY clinic policy or procedure may result in the termination of your care from our clinic.**

I understand and agree to the conditions of care described above and will comply with them. All of my questions about the terms of this agreement have been answered to my satisfaction. Failure to comply with any of the terms of this agreement may result in termination of this contract and discharge from the physician and/or practice.

_____	_____	_____
Patient Signature	Patient Name (printed)	Date
_____	Dr. S. Zaidi	_____
Provider Signature	Provider Name (printed)	Date

Financial Policy and Agreement

Release of Information:
We understand people are concerned about the exposure of sensitive information that may be asked during your visit(s) and we have policies and procedures in place to protect all your information. Brevard Spine & Joints may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation which is or may be liable or under contract for reimbursement to Brevard Spine & Joints for services rendered, and any health care provider for continued patient care.

Payment:
I agree that in return for the services provided by Brevard Spine & Joints, **payment is due at the time the service is rendered**. Any unpaid balances must be paid up to date before the next scheduled appointment. We accept cash, personal checks, MasterCard, Visa, and Discover. Returned checks are subject to the following service charge starting at $25.00 but will not exceed 5% of the face value. In addition, you will lose your privilege to write a check to our office.

Insurance:
Our services are provided directly to you, not to an insurance company. Therefore, we cannot render services on the assumption that charges will be paid for you by the insurance company. As a courtesy to our patients, we submit medical claims to primary, secondary, and tertiary carriers with whom we are contracted. We do not bill carriers that we are not contracted with or third-party carriers, this is the responsibility of the patient. You will be expected to pay any copay, deductible, co-insurance and non-covered amounts determined by your policy at the time of service. **If your insurance company has failed to pay within a 60-day period, we will expect you to pay the balance of your bill in full.** You must then collect from your insurance company. We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. All charges are your responsibility from the date services are rendered. I understand my vision and/or dental insurance cannot, and will not, be used for any services rendered in office.

Medicare/Managed Care:
I request that payment of authorized Medicare benefits be made on my behalf to Brevard Spine & Joints for services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare, and its agents, any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

Print Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____

Request for Release of Confidential Information

Brevard Spine & Joints is requesting medical records to be sent to our office regarding the patient listed below:

Information being requested: (Check Selection)

___ General Medical Record ___ History and Physical Results ___ UTOX Results

___ Progress Notes ___ Consultations/Referral ___ Imaging (MRI, CT, X-Ray)

From: _____
Physician's name/Facility Phone # Fax #

Patient Info: _____
Patient DOB

_____
Address City State Zip

Purpose of Disclosure: Continuity of care

Expiration Date: This authorization will expire when the patient revokes it.

Redisclosure: 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 and regulations.

Conditioning: I understand that completing this authorization form is voluntary. Treatment may not be denied if I refuse to sign this form.

Revocation: I understand that I have the right to revoke this authorization at any time. If I revoke authorization I must do so in writing and forwarded to the medical record department. This revocation only applies to this authorization to release medical information from a facility to our healthcare agency.

Print Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____

HIPAA Authorization for Use or Disclosure of Protected Health Information

It is the office policy of Brevard Spine & Joints not to release confidential medical information regarding your treatment to anyone, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from your circumstances, i.e. if you bring a family member or friend into the examination room, we will assume unless you object, that person is entitled to receive information regarding your treatment, (iv) emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996, as amended in 2013. **If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers, please indicate that below so that we may best serve you.**

I authorize the person(s) listed below to have access to any/all of my protected health information. Brevard Spine & Joints is permitted to share any medical and/or billing information with them, including but not limited to test results, information disclosed during office visits, and any other information contained in my health record. For copies of medical records, I understand that I will need to sign a separate authorization.

List below those individuals that you wish to receive your protected health information:
(If you do not want any of your medical information provided to anyone, please check the box marked "None")

Patient Name: _____ Relationship: _____Self_____ Phone: _____

Full Name: _____ Relationship: _____ Phone: _____

Full Name: _____ Relationship: _____ Phone: _____

Full Name: _____ Relationship: _____ Phone: _____

None _____

In addition to the individual(s) listed above, I allow you to notify me of test results, appointment reminders, and other information related to my health in the following manner:

___ Calling/Leaving voicemails (Check all that apply: ___ Cell ___ Home ___ Work)

___ Text messages to cell phone ___ Email: _____

I understand that it is my responsibility to update Brevard Spine & Joints' office staff with any changes. I understand this authorization will remain in effect until it is revoked by me in writing.

I acknowledge that I have been made aware of Brevard Spine & Joints' HIPAA Policy and Notice of Privacy Practices clearly on display in the reception/lobby area of said practice.

_____ _____

Patient/Guardian Signature Date

“No Show” and “Late Cancellation” Policy Form

Due to the high demand for appointments, Brevard Spine & Joints has had to institute a “no show” and “late cancellation” fee.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When a patient no-shows or cancels late, it takes an available time slot away from another patient. No shows and late cancellations delay the delivery of healthcare to other patients.

A “No-Show” is missing a scheduled appointment without prior notice. A “Late-Cancellation” is canceling an appointment without the proper 48 hour notice before your scheduled appointment. We understand that situations, such as medical emergencies, occasionally arise. **These situations will be considered on a case by case basis.**

If you are not able to make your appointment, we ask that you please cancel by calling the office at least 48 hours in advance of your scheduled appointment. Failing to do so will result in a fee being billed to your account, which will be due upon your next visit. **These fees are not covered by your insurance and you will be responsible for payment.** You may cancel appointments by calling our office at (321) 914-3487. If it is after hours, please wait through the prompt in order to leave a message with our answering service.

All “No Shows” and “Late Cancellations” will be billed as follows:

New/Established patient appointments $35.00

By signing below, I agree that I have read the policy described above and understand it entirely.

Print Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____