

PATIENT REGISTRATION

(PLEASE PRINT)

1001 37th Street North, Suite C
St. Petersburg, FL 33713
Phone (727) 328-1001
Fax (727) 327-0413
www.ThomasTolliMD.com

PATIENT NAME	LAST NAME	FIRST NAME	MIDDLE INITIAL	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
PATIENT ADDRESS	STREET	APT	CITY	STATE ZIP
PRIMARY PHONE ()	DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER	
PATIENT EMPLOYER	STREET		CITY	STATE ZIP
ADDRESS				
IS PATIENT A MINOR (Check one): YES _____ NO _____ NAME OF LEGAL GUARDIAN _____				
NEXT OF KIN/EMERGENCY CONTACT & PHONE _____				
PRIMARY CARE PHYSICIAN _____ PHONE _____				
WAS INJURY RELATED TO AN ACCIDENT YES _____ NO _____ INJURY DATE _____				
IF YES: _____ AUTO _____ WORK RELATED _____ SLIP/FALL _____ HOME _____				
INSURANCE INFORMATION (PLEASE FILL OUT COMPLETELY)				
PRIMARY HEALTH INSURANCE	INSURED'S NAME	INSURANCE PHONE ()		
I.D NUMBER	GROUP NUMBER	CHECK ONE <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> PRIVATE		
PRIMARY CARE PHYSICIAN	PHONE NUMBER ()			
OTHER HEALTH INSURANCE	INSURANCE PHONE ()			
I.D NUMBER	GROUP NUMBER	CHECK ONE <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> PRIVATE		

INSURANCE AUTHORIZATION

HEALTH CARE INSURANCE PLAN OBLIGATION: Thomas C. Tolli, MD PA maintains a list of the health care service plans with which it has contracted to provide service to patients. Thomas C. Tolli, MD PA has agreed to bill those carriers for all services rendered. Authorization from your insurance company does not always guarantee payment. The undersigned and/or patient shall remain responsible for all charges, applicable co-payments and deductibles. Payment to Thomas C. Tolli, MD PA is due upon receipt of statement. There will be a \$22.00 charge for returned checks.

Initials of Patient or Responsible Party: _____

RELEASE OF MEDICAL INFORMATION / ASSIGNMENT OF BENEFITS:

- A. I hereby authorize Thomas C. Tolli, MD PA to release any medical information in connection with these services for health insurance purposes or to the patient's personal physician.
- B. I authorize Thomas C. Tolli, MD PA to release any medical information to medicare and/or its intermediaries. A copy of this form can be used in place of the original.
- C. I hereby authorize any direct payment to Thomas C. Tolli, MD PA for the medical and/or surgical benefits, if any otherwise payable to me under the terms of my insurance.

Initials of Patient or Responsible Party: _____

The undersignee certified that he/she has read the above, and is the patient, guarantor, or patient's representative duly authorized to execute this agreement and accept its terms.

Date: _____ X _____ (Signature of Patient or Representative)

PRESCRIPTION DRUG POLICY

The law requires responsible usage of prescription drugs by physicians and patients. If you accept a prescription from one of our physicians, you are also accepting the responsibility to use the drug for yourself and only as prescribed. Our responsibility is to prescribe medications in an appropriate dosage and amount, with clear instructions. We will also inform you of the reason we are prescribing the drug, the expected benefits from its use and the major precautions and side effects. We will answer any questions you may have about the prescription drug you are being given.

Prescription drugs have potential for abuse and are regulated closely by the state and federal agencies. Certain more closely controlled drugs (narcotics pain medications and tranquilizers) require even more responsibility on your part. We will accept NO excuses for their loss, theft and will not order replacements. We will not prescribe them if you are using them other than exactly as prescribed or receiving them from another source. We expect you to notify our office if you change pharmacies or are getting medications from another source, so we may cancel the first order.

Many prescription drugs are appropriate for short-term use only. You will be advised if and when we feel it is not in your best interest to continue on a medication. If we cannot agree about your continued use of a substance, then we will require additional consultation with other specialists to help decide on the correct course of action.

When your medications are getting low and you feel you will need a refill, please call our office for a refill request. We do not accept refill requests from pharmacies. Our office policy requires a call 5 business days in advance to receive a refill of your prescriptions so that there will be ample time to obtain permission from your treating physician. An appointment with a provider will be required for all refills on controlled substances.

Failure to follow these policies will force our office to terminate our professional relationship and may require us to file a report with the Department of Professional Regulation (DPR) or the local police.

If you are in agreement with all the information that has been provided above, please sign below to indicate your agreement to abide by these policies.

Patient's or Patient's Guardian's Signature _____

Date _____

THOMAS
TOLLI MD
SPINE SURGERY

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Thomas C. Tolli MD PA

Notice of Privacy practices and Electronic Submissions

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice also describes electronic submissions. Please review carefully.

Thomas C. Tolli, MD PA may use your health information for purposes of providing you treatment, obtaining payment for your care and conducting health care operations. Thomas C. Tolli, MD PA has established policies to reasonably protect health information as defined in the Health Insurance portability and Accountability Act (HIPAA) Privacy and Security Rules.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Provide Treatment. Thomas C. Tolli, MD PA may use your health information to coordinate care within Thomas C. Tolli, MD PA and with others involved in your care, such as your attending physician and other health care professionals who have agreed to assist Thomas C, Tolli, MD PA in coordinating care. For example, physicians involved in your care will need information about your symptoms in order to prescribe appropriate medications.

To Obtain Payment. Thomas C. Tolli, MD PA may include your health information in invoices to collect payment from third parties for the care you receive from Thomas C. Tolli, MD PA. For example, Thomas C. Tolli, MD PA may be required by your health insurer to provide information regarding your health care status so that the insurer will reimburse you or Thomas C. Tolli, MD PA. Thomas C. Tolli, MD PA also may need to obtain prior approval from your insurer and may need to explain to the insurer your need for care and the services that will be provided to you.

To Conduct Health Care Operations. Thomas C. Tolli, MD PA may use and disclose health information for its own operations in order to facilitate the function of Thomas C. Tolli, MD PA and as necessary to provide quality care to all of Thomas C. Tolli, MD PA's patients. For example, Thomas C. Tolli, MD PA may use or disclose your health information to perform quality assessment activities or evaluate the performance of it's staff.

For Appointment Reminders. Thomas C. Tolli, MD PA may use and disclose your health information to contact you as a reminder that you have an appointment.

For Treatment Alternatives. Thomas C. Tolli, MD PA may use and disclose your health information to inform you about or recommend possible treatment options or alternatives that may be of interest to you.

OTHER USES OR DISCLOSURES OF YOUR HEALTH INFORMATION:

Business Associates. Thomas C. Tolli, MD PA provides some services by using outside vendors (business associates). Thomas C. Tolli, MD PA may share your information with them so that they can perform the job Thomas C. Tolli, MD PA has asked them to do. To protect your information, Thomas C. Tolli, MD PA requires the business associate to contractually agree to appropriately safeguard your information.

When Legally Required. Thomas C. Tolli, MD PA will disclose your health information when it is required to do so by any Federal, State or local law.

When There Are Risks to Public Health. Thomas C. Tolli, MD PA may disclose your health information for public activities and purposes like reporting vital events such as birth or death, tracking medical devices or reporting communicable diseases.

To Report Abuse, Neglect, or Domestic Violence. Thomas C. Tolli, MD PA is allowed to notify government authorities if Thomas C. Tolli, MD PA believes a patient is the victim of abuse, neglect, or domestic violence. Thomas C. Tolli, MD PA will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, Thomas C. Tolli, MD PA will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time. However, Thomas C. Tolli, MD PA is unable to take back any disclosures it has already made with your permission and that Thomas C. Tolli, MD PA is required to retain for its records of care.

In conjunction with these practices, you will need to provide us with the following information:

1. Name of person(s) we may speak to regarding your health: (i.e. spouse, child, etc. including phone numbers)

2. Emergency Contact: (relative or person not living with you)

3. May we leave a message regarding your health or upcoming appointments on your answering machine?

Home: _____ Yes _____ No _____
Work: _____ Yes _____ No _____

I ACKNOWLEDGE I WAS OFFERED A COPY OF THIS OFFICE'S "NOTICE OF PRIVACY PRACTICES, EFFECTIVE MAY 01, 2018". _____ (int.)

ACKNOWLEDGEMENT OF ELECTRONIC SUBMISSION OF PRESCRIPTIONS AND CONSENT FOR UNENCRYPTED EMAIL/TEXT MESSAGES:

Risk of using email and/or text messaging:

The transmission of client information by email and/or text messaging has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

1. Email and text messages can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
2. Email and text message senders can easily misaddress an email or text message and send the information to an undesired recipient.
3. Backup copies of emails and text messages may exist even after the sender and/or recipient has deleted his or her copy.
4. Employers and online services have a right to inspect emails sent through their company systems.
5. Emails and text messages can be intercepted, altered, forwarded or used without authorization or detection.
6. Emails and text messages can be used as evidence in court
7. Emails and text messages may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the use of email and text messaging:

Thomas C. Tolli, MD PA cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text message information sent and received. Patients/Parents/Legal Guardians must acknowledge and consent to the following conditions:

1. Emailing and texting is not appropriate for urgent or emergency situations. Providers cannot guarantee that any particular email and/or text message will be read and responded to within any particular period of time.
2. Emails and text messages should be concise. The patient should call and/or schedule an appointment to discuss complex and/or sensitive situations.
3. All emails will usually be filed in the patient's electronic medical record. Text messages may be printed and filed as well.
4. Patients should not use email or text messaging for communication of sensitive medical information.
5. The provider is not liable for breaches of confidentiality caused by the patient or any third party.
6. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

I HAVE READ AND UNDERSTAND THE INFORMATION ON UNENCRYPTED EMAIL/TEXT MESSAGING. _____ (int.)

Printed Patient Name: _____

Signature of Patient: _____

Date: _____

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that Thomas C. Tolli, MD PA maintains. If you wish to exercise this right, you may contact the office. The contact information is shown at the end of this Notice.

Right to request restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request limit on Thomas C. Tolli, MD PA's disclosure of your health information to someone who is involved in your care or the payment of your care. In most cases, Thomas C. Tolli, MD PA is not required to agree to your request. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. Also, we cannot agree to restrict disclosures that are required by law. You have a right to request that we not disclose PHI to health plans because you paid for services or items out of pocket and in full. If you wish to make a request for restrictions, please tell Thomas C. Tolli, MD PA:

1. what information you want to limit;
2. whether you want to limit Thomas C. Tolli, MD PA's use, disclosure, or both; and
3. to whom you want the limit to apply (e.g. spouse).

If you think you should be classified as a self-pay patient, please note that as well. However, you should be aware that if you choose to use a medical expense reimbursement/flexible spending account (FSA) or a health savings account (HSA) to pay for the health care items or services that you wish to have restricted, those plans will still require you to provide the necessary substantiation of the expenses in order to receive reimbursement.

Right to receive confidential communications. You have the right to request that Thomas C. Tolli, MD PA communicate with you in a certain way. For example, you may ask that Thomas C. Tolli, MD PA only conduct communications pertaining to your health information with you privately with no other family members present. Thomas C. Tolli, MD PA will not request that you provide any reasons for your request and will attempt to honor your reasonable requests for confidential communications.

Right to inspect and copy your health information. You have the right to inspect and copy your health information, including billing records. If you request a copy of your health information, Thomas C. Tolli, MD PA may charge a reasonable fee for copying and assembling costs associated with your request. If you wish to receive electronic copies of your information, please put this in the request.

Right to an Electronic Copy of Electronic Medical Records. If your protected health information is maintained in an electronic format, you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your protected health information in the form or producible in the form or format, you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to amend health care information. You or your representative has the right to request that Thomas C. Tolli, MD PA amend your records, if you believe that your health information is incorrect or incomplete. That request may be made as long as the information is maintained by Thomas C. Tolli, MD PA. Thomas C. Tolli, MD PA may deny the request if it is not in writing or does not include a reason for the amendment. The request will be denied if your health information records were not created by Thomas C. Tolli, MD PA, if the records you are requesting are not part of Thomas C. Tolli, MD PA's records, if the health information you wish to amend is not part of the health information you or your representative are permitted to inspect and copy, or if, in the opinion of Thomas C. Tolli, MD PA, the records containing your health information are accurate and complete.

Right to an accounting. You or your representative have the right to request an accounting of disclosures of your health information made by Thomas C. Tolli, MD PA for certain reasons, including reasons related to public purposes authorized by law and certain research. The request must specify the time period for the accounting which may not be longer than six (6) years. The request should describe the accounting you wish to receive (e.g. a list of disclosures to a certain person or for a certain reason). Thomas C. Tolli, MD PA will provide the accounting request subject to a cost-based fee.

Right to receive notice of breach of Protected Health Information. In the event of any unauthorized acquisition, access, use or disclosure of Protected Health Information by Thomas C. Tolli, MD PA, we shall fully comply with the breach notification requirements, including any and all regulations which have been or may be promulgated, which will include notification to you of any impact that breach may have had on you.

I authorize Thomas C. Tolli MD PA to:

- 1. Submit my prescriptions electronically to my preferred pharmacy _____ (init.)
- 2. Retrieve my prescription history via an electronic clearinghouse _____ (init.)
- 3. Make referrals on my behalf and share relevant clinical and demographic information electronically _____ (init.)
- 4. Use unencrypted email/text to contact me _____ (init.)

My Pharmacy is: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

My email address is: _____

**Thomas C. Tolli, MD PA
1001 37TH Street North, Suite C.
St. Petersburg, FL 33713
(727)328-1001**

The services of Thomas C. Tolli, MD PA have been requested.

In some instances, your insurance company will mail you a check in your name for services rendered by Thomas C. Tolli, MD PA. This check will be accompanied by an EOB (explanation of benefits) which describes services rendered by Thomas C. Tolli, MD PA. This information is also supplied to Thomas C. Tolli, MD PA.

These funds are the property of Thomas C. Tolli, MD PA for services rendered.

This check **must** be endorsed (signed) on the back and mailed to:

Thomas C. Tolli, MD PA
1001 37th Street North, Suite C.
St. Petersburg, FL 33713-6010

Failure to endorse and forward the check to Thomas C. Tolli, MD PA would be considered **Grand Theft by Florida law**, which defines theft as "Knowingly obtaining and uses the property of another, with the intent to, either temporarily or permanently deprive the person of a right to the property or a benefit from the property, or appropriates the property to his or her own use or to the use of any person not entitled to use of the property".

I have received a copy of this notice. The signature of the party below indicates agreement and understanding of the above.

Patient Signature

Date

Witness

Date

PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Have you had any of the following? (Please check all that apply)

➤ Accidents Yes No

If yes, please circle one: motor vehicle slip/fall work-related home

➤ Injuries/Symptoms Yes No

➤ Restrictions Yes No

➤ Accident - Describe the accident using as many details as possible.

➤ Injuries/Symptoms - Describe ALL of your injuries/symptoms using as many details as possible.

➤ Restrictions - Do you have any physical restrictions due to your current problems?

➤ Treatment- List ALL treatments you have had.

➤ Pre-existing conditions - Did you have any previous injuries, symptoms or treatments before your current problems?

Yes No (Check One)

THOMAS
TOLLI MD
SPINE SURGERY

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Patient Name: _____

Past, Family and Social History

Patient Medical History: Please check Yes or No if you have any of the following medical problems.

- | | | | | | |
|----------------------|------------------------------|-----------------------------|----------------|------------------------------|-----------------------------|
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Respiratory Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stomach/Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thyroid | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney/Renal | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychological | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Current Medications: _____

Allergies: _____

Past Hospitalization: _____

Past Surgeries: _____

Past Injuries: _____

Patient Social History: (Please Check)

- Marital Status: Single Married Divorced Widowed Separated
- Tobacco Use: Never Quit/When _____ Current Smoker/packs per day _____
- Alcohol Use: Never Rarely Moderate Daily How Much? _____
- Recreational Drug Use: Never Type and Frequency _____
- Occupation: _____

Family Medical History: Please check Yes or No and indicate which relative.

- | | Relative | | | Relative | | | |
|----------------------|------------------------------|-----------------------------|-------|----------------|------------------------------|-----------------------------|-------|
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Respiratory Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Bleeding Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | Stomach/Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | Heart Trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Thyroid | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | Infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Kidney/Renal | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | Psychological | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |



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Patient History Questionnaire (con't.)

Patient Name: _____ Date of Birth: _____

Review of Systems (Please circle Yes or No)

Neurological

Frequent Headaches ___ Yes ___ No
Paralysis or Tremors ___ Yes ___ No
Convulsions/Seizures ___ Yes ___ No
Numbness/Tingling ___ Yes ___ No

Cardiology

Chest Pain ___ Yes ___ No
Heart Palpitations ___ Yes ___ No
Shortness of Breath ___ Yes ___ No
Leg Swelling ___ Yes ___ No

Musculoskeletal

Muscle Pain/Cramps ___ Yes ___ No
Stiffness/Swelling Joints ___ Yes ___ No
Joint Pain ___ Yes ___ No
Trouble Walking ___ Yes ___ No

Hematologic/Lymphatic

Bruise Easily ___ Yes ___ No
Slow to Heal ___ Yes ___ No
Enlarged Glands ___ Yes ___ No
Anemias ___ Yes ___ No
Varicose Veins ___ Yes ___ No

Respiratory

Shortness of Breath ___ Yes ___ No
Cough ___ Yes ___ No
Wheezing/Asthma ___ Yes ___ No
Coughing up Blood ___ Yes ___ No
Other _____ ___ Yes ___ No

Eyes

Wear Glasses/Contacts ___ Yes ___ No
Blurred/Double Vision ___ Yes ___ No
Eye Disease or Injury ___ Yes ___ No
Glaucoma ___ Yes ___ No
Cataracts ___ Yes ___ No

Endocrine

Excessive thirst/urination ___ Yes ___ No
Thyroid Disease ___ Yes ___ No
Hormone Problem ___ Yes ___ No

Psychiatric

Insomnia ___ Yes ___ No
Confusion/Memory Loss ___ Yes ___ No
Depression ___ Yes ___ No

Gastrointestinal

Nausea/Vomiting ___ Yes ___ No
Abdominal Pain ___ Yes ___ No
Rectal Bleeding ___ Yes ___ No
Bowel Problems ___ Yes ___ No
Swallowing Difficulties ___ Yes ___ No
Stool Incontinence ___ Yes ___ No

Urology

Frequent Urination ___ Yes ___ No
Burning Urination ___ Yes ___ No
Blood in Urine ___ Yes ___ No

Immunodeficiency Disorders

Autoimmune Diseases ___ Yes ___ No
Chemotherapy ___ Yes ___ No
Hepatitis ___ Yes ___ No
HIV/AIDS ___ Yes ___ No

Integumentary

Changes in hair/nails ___ Yes ___ No
Rashes or itching ___ Yes ___ No

Height _____ Weight _____

Women: (circle one) Pregnant Not Pregnant Maybe Pregnant, though not likely

What would you like the provider to focus on the most today?

- ___ Therapy
- ___ Pain Management (cortisone injections/medications)
- ___ Surgery (because I don't want to live with this problem and I want it corrected)

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Signed: _____ Date: _____

PAIN DRAWING

Patient Name: _____

Date: _____

Where is your pain now?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.

ACHE ^ ^ ^	NUMBNESS o o o	PINS & NEEDLES ■ ■ ■	BURNING x x x	RADIATING PAIN / / /
^ ^ ^	o o o	■ ■ ■	x x x	/ / /
^ ^ ^	o o o	■ ■ ■	x x x	/ / /

