THOMAS TOLLI MD SPINE SURGERY

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: ☐ MALE ☐ FEMALE

PATIENT ADDRESS | STREET | APT | CITY | STATE | ZIP | MARITAL STATUS ☐ M ☐ D ☐ S ☐ W

PRIMARY PHONE ( ) | DATE OF BIRTH | AGE | SOCIAL SECURITY NUMBER

PATIENT EMPLOYER | WORK PHONE ( )

ADDRESS | STREET | CITY | STATE | ZIP

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 ☐ HMO ☐ PPO ☐ PRIVATE
PRIMARY CARE PHYSICIAN		PHONE NUMBER ( )
OTHER HEALTH INSURANCE		INSURANCE PHONE ( )
I.D NUMBER	GROUP NUMBER	CHECK ONE ☐ HMO ☐ PPO ☐ 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 deductables. 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_____

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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 tor 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

THOMAS TOLLI MD
SPINE SURGERY

AUTHORIZATION TO RELEASE PROTECTED HEALTH CARE INFORMATION

Date: _____

To: _____ *Health Care Provider*

_____ *Address*

_____ *City, State, Zip*

Information requested: _____

_____

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR §164.508, I, _____, authorize the provider listed above to release to **THOMAS C. TOLLI, MD PA** all medical records concerning any medical treatment that I have received from you, at your institution, as well as all such records which you keep in the regular course of business which are found in my medical records file. I hereby authorize a copy of my medical records pursuant to Florida Statutes and Administrative Code Regulations.

_____ _____
Name Date

_____
Date of Birth

_____
Signature

_____
Social Security Number

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	___Yes	___No	Liver Disease	___Yes	___No
Respiratory Problems	___Yes	___No	Cancer	___Yes	___No
Bleeding Problems	___Yes	___No	Hepatitis	___Yes	___No
Diabetes	___Yes	___No	Stomach/Ulcers	___Yes	___No
Stroke	___Yes	___No	Heart Trouble	___Yes	___No
Thyroid	___Yes	___No	Infections	___Yes	___No
Kidney/Renal	___Yes	___No	Psychological	___Yes	___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	___Yes	___No	_____	Liver Disease	___Yes	___No	_____
Respiratory Problems	___Yes	___No	_____	Cancer	___Yes	___No	_____
Bleeding Problems	___Yes	___No	_____	Hepatitis	___Yes	___No	_____
Diabetes	___Yes	___No	_____	Stomach/Ulcers	___Yes	___No	_____
Stroke	___Yes	___No	_____	Heart Trouble	___Yes	___No	_____
Thyroid	___Yes	___No	_____	Infections	___Yes	___No	_____
Kidney/Renal	___Yes	___No	_____	Psychological	___Yes	___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

Hematologic/Lymphatic
Bruise Easily __Yes __No
Slow to Heal __Yes __No
Enlarged Glands __Yes __No
Anemias __Yes __No
Varicose Veins __Yes __No

Endocrine
Excessive thirst/urination __Yes__ No
Thyroid Disease __Yes__ No
Hormone Problem __Yes__ No

Urology
Frequent Urination __Yes__No
Burning Urination __Yes__No
Blood in Urine __Yes__No

Cardiology
Chest Pain __Yes __No
Heart Palpitations __Yes __No
Shortness of Breath __Yes __No
Leg Swelling __Yes __No

Respiratory
Shortness of Breath __Yes __No
Cough __Yes __No
Wheezing/Asthma __Yes __No
Coughing up Blood __Yes __No
Other_____ __Yes __No

Psychiatric
Insomnia __Yes __No
Confusion/Memory Loss __Yes __No
Depression __Yes __No

Immunodeficiency Disorders
Autoimmune Diseases __Yes __No
Chemotherapy __Yes __No
Hepatitis __Yes __No
HIV/AIDS __Yes __No

Musculoskeletal
Muscle Pain/Cramps __Yes __No
Stiffness/Swelling Joints __Yes __No
Joint Pain __Yes __No
Trouble Walking __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

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

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: _____

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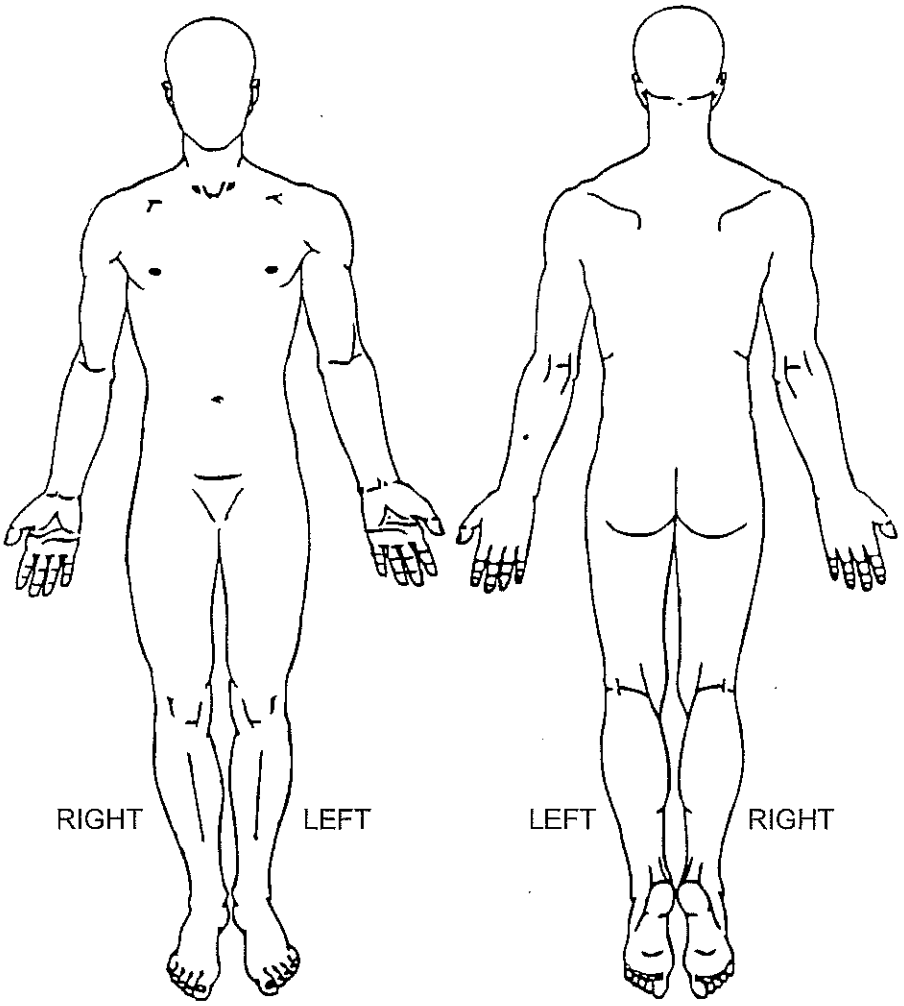
PAIN DRAWING

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		/ / /



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