NeuroSpine
Minimally Invasive Spine Surgery • Robotic Assisted Spine Surgery
Neurological Surgery • Regenerative Spine Medicine

Intake form

CONFIDENTIAL PATIENT INFORMATION & HISTORY

This questionnaire was designed to provide important facts regarding your medical history. `Please take the time to answer each question as completely as possible

First Name:____________________ Last Name:_____________________________ MI:_______
Address:____
City/State:_________________________________Zip:____________
Home Phone: (______)________________ Cell Phone:(______)______________
Email Address: ____
Gender: ☐ Male / ☐ Female Date of Birth: _____/_____/______ Age:_________
Handedness (dominate hand use) ☐ Right ☐ Left ☐ Ambidextrous
Occupation: ____
Social Security#:______-_____-______
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow Height:________________
Emergency Contact Name: ____________________________ Weight: _______________
Relationship: ____
Emergency Contact Phone#: ___________________________

**********************************ACCIDENT INFORMATION**************************************

Is your visit today related to or a result of an accident or injury? ☐ Yes ☐ No

Is your visits related to a workers compensation? ☐ Yes ☐ No

If yes, type of accident/injury: ☐ Auto Accident ☐ Slip & Fall ☐ Other:______________________

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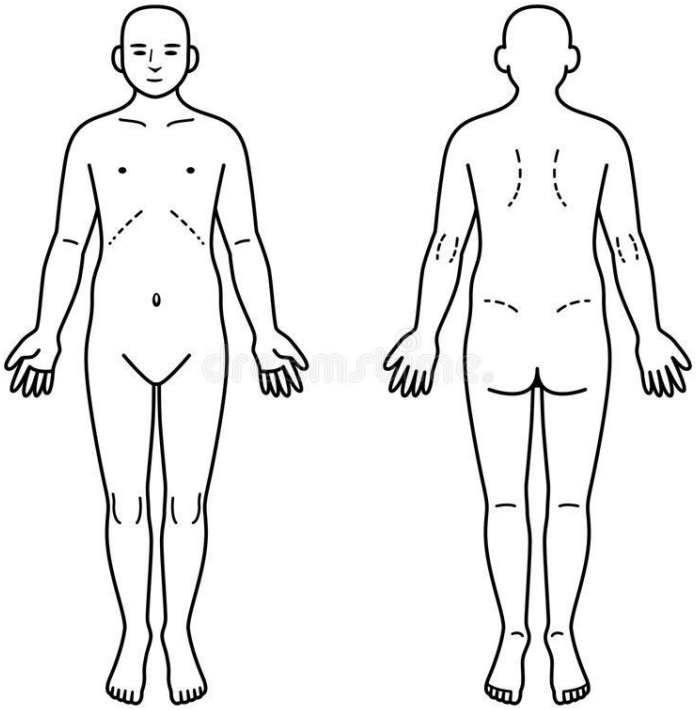
Who referred you to our office?

Pharmacy:	Phone #
Primary Care Physician:	Phone #
Preferred Imaging center:	Preferred lab facility:

NeuroSpine
8355 Northcliffe Blvd Spring Hill, FL 34606

Reason for today's visit	Draw your pain or symptom pattern/location
□ Neck pain □ Mid back pain □ Low back pain □ Arm pain □ Leg pain □ Arm or Leg numbness □ Brain Bleed □ Head injury □ Headache □ Hospital Follow up □ Post Op □ Other:	

Previous treatments for current symptom(s)

Treatment type	Effect on symptoms			Facility/ Frequency/Dates
Physical Therapy	□ Improved	□ No change	□ Worse	
Chiropractor	□ Improved	□ No change	□ Worse	
Medications	□ Improved	□ No change	□ Worse	
Injections	□ Improved	□ No change	□ Worse	

Do you have any limitations to your activity of daily living (ADL) due to your condition?

□ Personal hygiene – bathing/showering, grooming, nail care, and oral care.

□ Dressing – being able to make appropriate clothing decisions and physically dress and undress oneself.

□ Eating – the ability to feed oneself, though not necessarily the capability to prepare food.

□ Maintaining continence – being able to mentally and physically use a restroom and self cleaning oneself.

□ Toileting: The ability to get on and off the toilet.

□ Transferring/Mobility- being able to stand from a sitting position, as well as get in and out of bed. The ability to walk independently from one location to another.

NECK / CERVICAL Related Issues / Pain

When did symptoms start?	
Timing of symptoms:	constant • intermittent • mornings • nights • Other:
Current pain level:	_____/10 (0= no pain to 10 worse pain imaginable)
Duration of symptoms:	_____ days • weeks • months • years
Describe pain	Dull • achy • constant • burning • numbness • stabbing • pressure • cramping • heavy • Pins & needles • sharp • Other:
Does pain/symptoms radiate? If so where?	YES • NO Right arm • Left arm • Right leg • left leg• down spine• up spine •to head Other
What makes symptoms better?	Rest • Ice • Heat • massage • medications (OTC • pain • narcotic) chiropractic • physical therapy • laying down • Other:
What makes symptoms worse?	Standing • walking • bending • twisting • lying flat • sitting • Other:

LOW BACK / LUMBAR Related Issues / Pain

When did symptoms start?	
Timing of symptoms:	constant • intermittent • mornings • nights • Other:
Current pain level:	_____/10 (0= no pain to 10 worse pain imaginable)
Duration of symptoms:	_____ days • weeks • months • years
Describe pain	Dull • achy • constant • burning • numbness • stabbing • pressure• cramping • heavy • Pins & needles • sharp • Other:
Does pain/symptoms radiate? If so where?	YES • NO Right leg • left leg• both legs • up spine Other
What makes symptoms better?	Rest • Ice • Heat • massage • medications (OTC • pain • narcotic) chiropractic • physical therapy • laying down • Other:
What makes symptoms worse?	Standing • walking • bending • twisting • lying flat • sitting • Other:

OTHER Related Symptoms / Problems

Describe Current symptom(s)	
When did symptoms start?	
Timing of symptoms:	constant • intermittent • mornings • nights Other:
Current pain level:	_____/10 (0= no pain to 10 worse pain imaginable)
Duration of symptoms:	_____ days • weeks • months • years
Describe pain	Dull • achy • constant • burning • numbness • stabbing • pressure Pins & needles • sharp • cramping • heavy • Other:
Does pain/symptoms radiate? If so where?	YES • NO (if yes, where?)
What makes symptoms better?	Rest • Ice • Heat • massage • medications (OTC • pain • narcotic) chiropractic • physical therapy • laying down • Other:
What makes symptoms worse?	Standing • walking • bending • twisting • lying flat • sitting • Other:

Medical History

Past Medical History (current or ongoing medical problems)

□ I have no previous medical problems
□ High blood pressure □ heart attack □ CAD □ pacemaker □ heart Stent □ high cholesterol □ Heart problems
□ COPD/ emphysema □ sleep apnea □ oxygen use □ pulmonary embolism □ asthma
□ Diabetes □ Thyroid disorder □ Osteoporosis □ GERD □ reflux □ IBS
□ Frequent urinary infections □ kidney stones □ prostate problems
□ DVT □ osteoarthritis □ rheumatoid arthritis
□ Stroke/CVA/ TIA □ Seizures □ aneurysms □ brain injury □ neuropathy □ multiple sclerosis
□ Cancer: □ lung □ breast □ prostate □ colon □ lymphoma □ other:
□ fibromyalgia □ posttraumatic stress disorder (PTSD)
□ spine/back problems □ previous back or neck injury
Others:

Past Surgical History or □ No previous surgeries

□ Appendix □ tonsils & adenoids □ Gallbladder □ Hip replacement □ Heart surgery
□ Knee replacement □ Brain surgery □ Hysterectomy □ Tubal Ligation
□ problems with anesthesia
□ Neck or Back surgery Type:_____
□ Other:_____

Social History (□ None of the below)

□ Current or previous smoker/tobacco use. Packs/ day_____, How many years?_____
□ Alcohol use: Drinks/day _____, Drinks/week_____
□ Recreational drugs use □ caffeine use Stress level: □ low □ medium □ High

Family History

□ Back or Spine problems □ Bleeding disorders □ Heart Disease □Diabetes
□ Aneurysms □ Stroke/TIA □ Cancers
Father age_____age if passed?_____ Mother age:_____ age if passed away_____
Other:

Allergies: (please list) □ No Known Drug Allergies	**Please list reaction**

Patient Name Date

Current Medications:
Please list ALL medications you currently take. Please include ANY vitamins, herbal supplements, over-the-counter medications as well as pain medications, muscle relaxers If you do not take any medications, please write "none".

☐ No changes from previous visit	

Review of Systems *(please circle any current or ongoing problems listed below)*	
Constitutional	Fevers•chills•weight loss•weight gain•fatigue•nights sweats
Eyes	Vision loss • double vision• blurred vision• glaucoma• cataracts• glasses
ENT	Hearing loss• hearing aids • runny nose•hoarseness of the voice•swallowing problems
Cardiovascular	Chest pain•irregular heart beat•cardiovascular disorder • swelling of the legs
Respiratory	Shortness of breath• cough• oxygen use
Gastrointestinal	Heartburn • abdominal pain • nausea • vomiting • dark or bloody in stool diarrhea • constipation • incontinence of stool
Genitourinary	Painful or burning urination • blood in urine• difficulty starting or stopping urination• urinary retention • incontinence of urine •increased frequency
Hematology	Bleeds easy • Blood clots swollen glands or lymph nodes
Endocrinology	Heat intolerance • cold intolerance • excessive thirst • excessive hunger
Neurological	Headaches• problems walking• balance problems• loss of consciousness • muscle weakness• extremity numbness/tingling • tremors
Musculoskeletal	Neck pain • thoracic pain• low back pain• extremity pain• decreased range of motion of joint(s) Joint swelling
Skin	Rash • non-healing sores • skin growth
Reproductive	Erectile dysfunction • decreased sexual drive• menopause
Psychiatric	Memory loss • depression • anxiety • post-traumatic stress disorder • restless sleep

*********ACCIDENT RELATED INFORMATION*********

Was your injury a result of:	☐ Auto Accident ☐ Slip & Fall ☐ Other:
Accident Date:	If Auto, amount of damage to your vehicle: $_____
Please describe how this accident happened: _____ _____ _____	
Your Current Symptoms? _____ _____	
Name of doctor(s) currently treating you for this injury?	
Have you ever been treated for any previous accidents?	☐ Yes ☐ No When?:_____
Have you had any of the following treatments for your current injury?	Physical Therapy ☐ Yes ☐ No Chiropractic Treatment ☐ Yes ☐ No Traction ☐ Yes ☐ No E-Stim/TENS Treatment ☐ Yes ☐ No Trigger Point Injections ☐ Yes ☐ No Epidural Steroid Injections ☐ Yes ☐ No Medications ☐ Yes ☐ No
Do you have an attorney? ☐ Yes ☐ No	Attorney/Firm Name:
Contact person at firm & phone #	

IF YOU <u>ARE NOT</u> BEING EVALUATED FOR AN AUTOMOBILE, PERSONAL INJURY, OR WORKERS COMPENSATION, PLEASE ACKNOWLEDGE BELOW	
My visit today is not for or relate to an automobile, personal injury or workers compensation; I want everything to be billed to my health insurance on file.	
Patient Signature	Date

IF YOU ARE BEING EVALUATED FOR AN AUTOMOBILE OR PERSONAL INJURY, PLEASE COMPLETE BELOW	
AUTOMOBILE/PERSONAL INJURY Florida is a "NO-FAULT" car insurance state. Florida follows a "no-fault" when it comes to the payment of auto insurance claims after a car accident. In a no-fault state, drivers are required to carry auto insurance that pays personal injury protection, or PIP, benefits. Because of this NEUROSPINE, LLC will file your claim for dates of service (when seen by the doctor or mid-level provider) to the auto insurance you provided. If no auto insurance is provided you will be responsible for the full amount of your bill. If you would like your claim filed in another way you must notify NEUROSPINE, LLC in writing below	
☐ I do not have auto insurance and I will be responsible for the full amount of my bill	
☐ I have an attorney and I would like my claim sent to them:	
Attorney	Phone
Address:	Fax
☐ I have auto insurance; I would like my claim filed to:	
Auto Insurance	Claim#
Adjusters name	Phone
If you have an attorney NEUROSPINE, LLC will require a letter of protection signed by you and your attorney. A letter of protection protects you against outstanding charges while your case is in litigation	
Patient Signature	Date

WORKERS' COMPENSATION Workers' compensation is a form of insurance proving wage replacement and medical benefits to employees injured in the course of employment in exchange for mandatory relinquishment of the employee's right to sue their employer for tort of negligence. https://myfloridacfo.com/Division/wc/	
Claim #:	Phone #
Case manager:	Fax
Workers' Compensation name & address	
Patient Signature	Date

Authorization for Release of Protected Health Information Form

Patient: _____ **DOB:**_____

I authorize this NeuroSpine, LLC to use or disclose my health information as described below.

1. **Type of information**: The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated):

☐ The entire health record (all information)	☐ Minimum Data Set
☐ Activity documentation	☐ Medication and treatment records
☐ Admission/re-admission documentation	☐ Nursing documentation/progress notes
☐ Advance directives	☐ Progress notes
☐ Assessments, flow-sheets	☐ Reports from lab, x-ray, and other diagnostic
☐ Care plan	☐ Tests results
☐ Informed consent	☐ Face sheet
☐ History, exams and other records	
☐Other: (Describe as specifically as possible)	

2. **Recipient of information**: The information identified above may be used by, or disclosed to the following individual(s) such as family members or organization(s) including primary physician:

Name:	Phone
Primary Care Physician:	

Authorization for Release of Protected Health Information Form

3. **Purpose of use/disclosure**: This information described on the previous page will be used for the following purpose(s):
    a. ☐Initiated at the request of the patient
    b. ☐My personal records
    c. ☐Sharing with other healthcare providers as needed
    d. ☐Other: _____

Authorization Statements/Signatures

1. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and HIPAA may no longer protect the information.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a licensed Facility staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.
3. Unless I specify differently, this authorization will expire (insert date or event):

_____

4. I understand that the Facility will not condition the provision of treatment or payment on the provision of this authorization.

Patient Name:	
Signature of Patient or Personal Representative:	
Name of Personal Representative(if applicable)	
Date:	

HIPAA Notice of Privacy Practices

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Uses and Disclosure of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician and other use required by the law.

Treatment: We will use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes coordination or management of your health care third party. For example, we would disclose your PHI as necessary to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay, surgery or diagnostic imaging that may require your PHI be disclosed to the health plan to obtain approval for these services.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support business activities for your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training medical staff/students that see patients in our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations with your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable diseases; Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal proceeding: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosure: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by the law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorizations.

Patient Name:_____ Date:_____

Signature: _____

Relationship to patient: _____

Witness: _____

Patient Financial Policy:

Welcome to Neurospine LLC. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. Please read carefully the Financial Policies as described below.

Payment of Services:

Payment for services rendered is ultimately the patient's responsibility. Your insurance is a contract between you and your insurance company; it is your responsibility to give us the correct information about your insurance plan. If you cannot provide a current medical insurance card/policy, full payment must be made at the time of service.

Co-Payments and Deductibles:

Your insurance company requires you to pay your co-pay, deductibles and co-insurances at time of service. We cannot waive co-payments, deductibles or co-insurances. We make every effort to follow the guidelines required by your insurance company. However, every insurance contract is unique. If you do not inform us of any special requirements in your plan and we subsequently perform a service that is denied, we have no choice but to bill you directly for those charges.

Collection Policy:

If you have an outstanding balance, we will mail you a statement monthly. Failure to pay your portion of insurance allowable is a violation of your insurance contract. If you default on your promised payment, our policy is to refer to a collection agency. The balance will accrue an additional fee for the expenses related to collections. Checks returned to our office for non-sufficient funds will incur a $30.00 service charge.

Cancellation/Missed Appointments:

Patients are seen by appointment. If you cannot keep your appointment it is your responsibility to call at least 24 hours in advance. Patients that no show/miss their appointments will be charged $50.00 for that missed appointment. After three no show appointment; it is at the practices discretion to dismiss the patient for non-compliance.

Our staff will be happy to answer any questions you may have about our policies.

I have read and understand the terms of this Financial Policy. I understand and agree that such terms may be amended from time to time by the practice. I agree to assign insurance benefits to Neurospine LLC. I authorize the release of medical information to my primary and referring physician, and/or consultants if needed and as necessary to process insurance claims, insurance authorizations and prescriptions.

X_____ Date _____

NeuroSpine

MEDICAL RECORDS RELEASE FORM

Patient: _____ DOB:_____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician / person / facility/ entity listed below:

The information you may release subject to this signed release form is as follows:

☐ Complete Records	☐ History and physical	☐ Progress Notes
☐ Care Plan	☐ Treatment record	☐ Operative Reports
☐ Hospital Reports	☐ Medication record	☐ Other (specify)

Release my protected health information to the following physician, person, facility, entity and/or those directly associated with my medical care:

Name:_____

Address:_____

City, State, Zip:_____

The purpose/reason for this release of information is as follows:

_____ _____

Signature Date

_____ _____

Patient Name Signature of Patient or Personal Representative

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