SPINE by Villamil MD

An innovative approach to surgery of the spine

TULSA - SAN JUAN

PATIENT INFORMATION:

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	AGE	SSN

STREET ADDRESS / P.O. BOX	CITY	STATE	ZIP

CELL PHONE	HOME PHONE	WORK PHONE	SEX
			□ M □ F

EMAIL ADDRESS	Latino / Hispanic Y or N	RACE

EMPLOYER	EMPLOYER STREET ADDRESS	CITY	STATE	ZIP

PRIMARY PHYSICIAN, ADDRESS & PHONE NUMBER

REFERRING PHYSICIAN, ADDRESS & PHONE NUMBER

EMERGENCY CONTACT:

NAME	PHONE	RELATIONSHIP

INSURANCE/POLICY HOLDER INFORMATION: (Please present insurance cards to receptionist)

PRIMARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX	POLICY HOLDER DOB
			□M □F	

POLICY NUMBER	GROUP NUMBER	RELATIONSHIP TO PATIENT	CO-PAY AMOUNT
		□Self □Spouse □Parent □Child □Other	

SECONDARY INSURANCE:

PRIMARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX	POLICY HOLDER DOB
			□M □F	

POLICY NUMBER	GROUP NUMBER	RELATIONSHIP TO PATIENT	CO-PAY AMOUNT
		□Self □Spouse □Parent □Child □Other	

GUARANTOR/RESPONSIBLE PARTY: (If different from above)

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY #

HOME PHONE	WORK PHONE	CITY	STATE	ZIP

EMPLOYER	EMPLOYER STREET ADDRESS	CITY	STATE	ZIP

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Privacy Policy

The federal Health Insurance and Accountability Act (HIPAA) of 1998 requires that each patient be notified of the entity's privacy policy and evidence of such notification. The Letter of Rights and Obligations of the patient requires to be able to provide our services, we must have their consent to use and disclose their protected health information for the purposes of treatment, payment and other transactions or operations for health care that our organization carries out. To comply with these provisions of the Law, our entity has made this notice of the Privacy and Confidentiality Policy and this document to use or disclose your health information. By signing it, you acknowledge that you have been oriented with our organization, its employees, in accordance with the HIPAA Act, includes people who perform volunteer work for the organization and its business associates, use and disclose your health information for purposes treatment, step and transactions and operations for health care. A copy of our full privacy policy can be found at https://spinebyvillamilmd.com/privacy-policy.

CONSENT FOR COMPUTER FILE

To improve the records, we use at Spine by Villamil MD, we use an electronic information management system where we include your health information. We protect the information in the computerized system limited the access of people who can enter or read information that you share with those who work with you and / or have administrative responsibilities in this organization and the entity that provides these services. Only authorized persons may enter the system. We require that all our personnel who are authorized to access or read electronic information on computers commit to maintaining the security of the system and the confidentiality of the information. Anyone who violates this agreement will be exposed to penalties that complete the applicable laws.

CONSENT TO REVIEW MEDICATION HISTORY

I hereby consent to the release and review of my prescription medication history, including controlled substances, from the Prescription Monitoring Program (PMP) and/or Oklahoma Bureau of Narcotics (OBN) report. I authorize my healthcare provider and their staff to access, obtain, and use this information as part of my medical evaluation and treatment.

I _____ consent to the inclusion of my health information in the Spine by Villamil, M.D. computerized information system.

Print Patient's name _____ **Patient's Signature** _____

Date _____ **Initials** _____

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FINANCIAL POLICY

Payment is due at the time services are rendered 72 hours prior to scheduled procedures; this includes self-pay, insurance co-pays and/or deductibles. A current insurance card must be presented at each office visit. As a service to our patients, we will file your medical claims for the date-of-service with insurance information we have available at that time. It is your responsibility to inform us of any changes in your insurance or personal information, such as address and/or phone changes. Accounts with balances are considered past due at 31 days without a payment. Once an account is delinquent, it may be considered for collection procedures and placed with an independent agency. Should your account be turned for collection procedures, all future services will be suspended until financial matters are resolved.

We realize information surrounding health care and insurance can be difficult and confusing at times, that is why we are here to assist in this process as you seek to improve your health. If you have any questions or should you feel that you cannot meet the terms set forth with the Financial Policy, please feel free to contact us at 918-813-3901.

I the undersigned give my authorization to treat and assign directly to Spine by Villamil, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

PLANS

I hereby assign and convey directly to Spine by Villamil MD, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Spine by Villamil MD, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Spine by Villamil MD to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release Spine by Villamil MD all Plan documents, summary benefit descriptions, insurance policies, and/or settlement information upon written request from Spine by Villamil MD or its attorneys in order to claim such medical benefits.

Patient: _____ **DOB**: _____ **Initials**: _____

_____ I understand that it is my responsibility to notify Spine by Villamil of any and all changes to my insurance coverage before any planned procedure. If I fail to do this, it could result in my treatment being suspended or terminated.

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PATIENT MEDICAL HISTORY

Name patient: _____ Date: _____

What is the reason for today's visit? _____

When did you first notice this symptom? (Or indicate day of injury):

_____

Current height/weight: _____

Preferred pharmacy:

Pharmacy: _____ Location: _____

Phone number of the pharmacy: _____

Please answer:

Claustrophobic ____ YES ____ NO	Heart Stent ____ YES ____ NO	Pacemaker ____ YES ____ NO	Nerve Stimulator ____ YES ____ NO

Social History:

Currently working? ____ Yes ____ No Do you consume alcohol? ____ Yes ____ No

Do you smoke cigarettes? ____ Yes ____ No If so, how many packs a day? _____

Use drugs? ____ Yes ____ No (if yes, which one?) _____

Surgical History:

Allergies:

Medical History:

Medications	Dose	How often	Reason

505 East Main St. Jenks, Oklahoma 74037 Phone (918) 813-3901 Fax (918) 209-4915

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Family History	YES	NO	Relationship
Diabetes			
Heart disease/ High Blood pressure			
Lung diseases			
Kidney disease			
Cancer			
Neurological disease			
Arthritis			

Systems Review		Yes	No	Comments
Constitution	Are you healthy?			
	Have you recently lost weight?			
Skin	Have you had rashes or ulcers?			
Eyes	Do you wear glasses or contacts?			
	Do you have red or puffy eyes?			
Ear/Nose/Throat	Do you have difficulty swallowing?			
	Do you wear hearing aids?			
Cardiovascular	Do you have palpitations?			
	Do your legs swell?			
Respiratory	Do you have a whistle when you breathe?			
Gynecological	Are you pregnant?			
	Date of last menstruation?			
	Are you breastfeeding?			
Genitourinary	Do you have trouble urinating?			
Gastrointestinal	Do you have pain in your abdomen?			
	Are you having trouble evacuating your bowels?			
Psychiatric	Are you feeling anxious or depressed?			
Endocrine	Are you frequently thirsty?			
	Do you sweat excessively?			
Hematological	Do you bruise easily?			
	Do you have swollen glands?			
Neurological	Do you get headaches or Seizures?			

Influenza Vaccine: Yes / No **Pneumonia Vaccine: Yes / No (Over 65)**

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Pain level Identification Area



PAIN LEVEL: _____

Please mark areas of pain with an "X" and circle areas of numbness.

Get Up and Go Test: "Rising from a Chair"
□ Ability to rise in a single movement – no loss of balance with steps
□ Pushes up, successful in one attempt
□ Multiple attempts but successful
□ Unable to rise without assistance

Risk Factors		
□ Confusion	□ Disorientation	□ Impulsivity
□ Depression		
□ Altered Elimination	□ Vertigo	
□ Dizziness		
□ Take anticonvulsants		
□ Take Benzodiazepines		

Patient certification:

I have answered the questions in this document to the best of my knowledge. I understand that giving incorrect or false information can be dangerous to my health. It is my responsibility to inform my doctor of any changes in my health status.

Patient's signature _____ **Date** _____

Authorized person _____ **Relation** _____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Medical Record / Account Number (if known): _____

1. AUTHORIZATION

I hereby authorize **Spine by Villamil, MD** ("Covered Entity") to release/disclose the protected health information described below.

2. INFORMATION TO BE RELEASED

☐ Complete medical record

☐ Specific dates of service: From _____ to _____

☐ Office notes / progress notes ☐ Laboratory results ☐ Imaging / radiology reports

☐ Billing / payment records ☐ Mental health records* ☐ Substance use disorder records*

☐ Other (please specify): _____

** Special categories of records (e.g., psychotherapy notes, substance use disorder treatment records under 42 CFR Part 2) may require additional specific authorization and cannot be disclosed under a general authorization in many cases.*

3. PERSON(S) / ORGANIZATION AUTHORIZED TO RECEIVE THE INFORMATION

Name / Organization: _____

Address: _____

Phone / Fax / Email: _____

Relationship to Patient (if any): _____

4. PURPOSE OF THE DISCLOSURE

☐ At the request of the individual (patient) ☐ Continuity of care / treatment

☐ Legal / attorney request ☐ Insurance / billing

☐ Other (please specify): _____

5. EXPIRATION

This authorization expires on: _____ OR upon the following event: _____

(If left blank, this authorization will expire one year from the date of signature.)

6. REQUIRED STATEMENTS

- I understand that I have the right to revoke this authorization at any time by submitting a written revocation to the Covered Entity, except to the extent that action has already been taken in reliance on this authorization.
- I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization (except in limited circumstances permitted by law).
- I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.
- I understand that I may inspect or copy the information to be used or disclosed, as provided by law.

7. SIGNATURE

I have read and understand this authorization. I am the patient or the patient's authorized personal representative.

Patient / Personal Representative **Signature**: _____ **Date**: _____

Printed Name of Signer: _____

If signed by Personal Representative — Relationship to Patient / Authority to Act: _____

(Attach supporting documentation if required, e.g., power of attorney, guardianship papers)