The Spine Institute on the Emerald Coast

☎ (850) 460-2350
🖷 (866) 490-1517
emeraldcoastspine.com

Patient Name (Last, First): _____ Date: _____

Height: _____ Weight: _____ Specific pharmacy & location: _____

Primary Care Physician: _____ Referring Physician: _____

Past Medical History: If you have had any of the following, check the box.

Head
- ☐ Trauma

Eyes
- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Wear glasses/contacts

Ears
- ☐ Hearing aids

Nose/Sinuses
- ☐ Allergic rhinitis
- ☐ Sinus infections

Mouth/Throat/Teeth
- ☐ Dentures

Cardiovascular
- ☐ Aneurysm
- ☐ Angina
- ☐ Deep Vein Thrombosis
- ☐ Irregular Heart Beat
- ☐ High Blood Pressure
- ☐ Murmur
- ☐ Heart Attack
- ☐ Other heart disease

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD/Emphysema
- ☐ Pleuritis
- ☐ Pneumonia

Gastrointestinal
- ☐ Cirrhosis
- ☐ Gallbladder disease
- ☐ GERD
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ Jaundice
- ☐ Ulcer

Genitourinary
- ☐ Hernia
- ☐ Incontinence
- ☐ Nephrolithiasis
- ☐ Other kidney disease
- ☐ Sexually Transmitted Disease (STD)
- ☐ UTI(s)

Musculoskeletal
- ☐ Arthritis
- ☐ Gout
- ☐ Multiple Sclerosis injury

Skin
- ☐ Dermatitis
- ☐ Mole(s)
- ☐ Other skin condition(s)
- ☐ Psoriasis

Neurological
- ☐ Epilepsy
- ☐ Seizures
- ☐ Severe headache/migraine
- ☐ Stroke
- ☐ Transient Ischemic Attack (mini stroke)

Psychiatric
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Hallucinations/delusions
- ☐ Suicidal thoughts
- ☐ Suicide attempts

Endocrine
- ☐ Goiter
- ☐ Hyperlipidemia
- ☐ Hypothyroidism
- ☐ Thyroid disease
- ☐ Thyroiditis
- ☐ Type I Diabetes
- ☐ Type II Diabetes

Hematology/Oncology
- ☐ Anemia
- ☐ Cancer

Infectious
- ☐ HIV
- ☐ Tuberculosis (treated for)
- ☐ Tuberculosis (exposure)

Past Surgical History: List any surgeries that you have had.

Family History: Has anyone in your family had the following? <u>If so, identify which family member (mother, father, etc.).</u>

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Blood Clots
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ Gout
- ☐ Heart Attack
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Muscle Disease
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis

Social History: If you have had any of the following, check the box.

Use Tobacco? ☐ Yes ☐ No ☐ Former
If yes, how much a day? _____
If former, quit when? _____

Use Alcohol? ☐ Yes ☐ No
If yes, how many times a week? _____

Use Caffeine? ☐ Yes ☐ No
Use Illicit Drugs? ☐ Yes ☐ No
Hand Dominance? ☐ Right ☐ Left
Could you be pregnant? ☐ Yes ☐ No

We are now required to collect race, ethnicity & language. You may decline to specify this information.

Ethnicity: ☐ Decline to specify ☐ Hispanic /Latino ☐ Not Hispanic/Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Decline to specify ☐ Native Hawaiian or other Pacific Islander ☐ Other Race ☐ White

Language spoken: _____

Medication History: List any medications that you take. ***(may attach list and/or write on back)***

Allergies: List any allergies that you have. ***(may attach list and/or write on back)***

Effective: 4/14/2003
Updated 5/20/2018

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESES THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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 other 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 DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information 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's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided 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 protected health information will be used, as needed, to obtain payment for your health care services. For Example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of other medical professionals, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. 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 protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without 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 proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under 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 law. You may revoke the 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 authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply)-Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information- This means you may ask us not to use or disclose any part of your protected health information and by law we must comply. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

**You have the right to restrict disclosure of your personal protected health information to your health plan/insurance company- This means you have the right to restrict disclosure of your personal protected health information to your health plan/insurance company if that information pertains solely to healthcare for which you (or a person on your behalf) paid for the testing or treatment in full, out of pocket. You must continue to pay out of pocket for subsequent care related to restricted disclosure.

You have the right to request to receive confidential communications- You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information- If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures- You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying out Compliance Officer of your complaint. We will not retaliate against you for filling a complaint.

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF, AND PROVIDE INDIVIDUALS WITH, THIS NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION. WE ARE ALSO REQUIRED TO ABIDE BY THE TERMS OF THE NOTICE CURRENTLY IN EFFECT. IF YOU HAVE ANY QUESTIONS IN REFERENCE TO THIS FORM, PLEASE ASK TO SPEAK WITH OUR HIPAA COMPLIANCE OFFICER IN PERSON OR BY PHONE AT OUR MAIN PHONE NUMBER.

Authorization to release appointment/financial information

Due to the HIPAA Privacy Act, we CAN'T give out any information or leave messages for you without your consent. If there is a family member or friend that you would like us to be able to talk to regarding the scheduling, cancelling or rescheduling of your appointments or for any other reason, please list them below.

Name/Relation_____ Phone # _____

Name/Relation_____ Phone # _____

Name/Relation_____ Phone# _____

You will be able to change this information at ANY TIME!

Please sign below to acknowledge that you have read and received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Signature of patient/patient representative: _____ Date: _____

Explanation of Insurance Benefits and Patient Responsibility

We verify your insurance benefits as a courtesy to you. However, The Spine Institute on the Emerald Coast does not accept responsibility for any incorrect information given by your insurance carrier regarding your insurance benefits or benefit plans. If you have any questions or concerns regarding your policy information please contact your insurance company.

PLEASE FILL THIS FORM OUT IN ITS ENTIRETY

WE REQUIRE THAT ALL CO-PAYS AND CO-INSURANCES DUE BE PAID AT TIME OF SERVICE.

If you are unable to pay at each date of service, please contact the billing department with The Spine Institute on the Emerald Coast PRIOR to treatment to set up payment plan. If a payment plan is not discussed before the visit you will be REQUIRED to pay the full amount owed.

General Information

Patient's name_____
Last name Suffix First name Middle initial

Address_____
Street City State Zip code

Home# (____)_____ Cell# (____)_____ Work#(_____)_____

Date of Birth____/____/____ Sex M___ F___ Marital Status_____
Mo. day year S, M, D, W

Social Security #_____ _____ _____ Email address_____

Employer_____
Name Address Phone number

Referring physician_____
Name Phone number

Primary Care Physician_____
Name Phone number

Emergency Contact_____
Name Phone number

Responsible Party Information **IF SAME AS PATIENT, CHECK HERE___, LEAVE THIS SECTION BLANK AND CONTINUE ON TO INSURANCE INFORMATION SECTION**

Responsible Party Name_____
Last First Middle initial

Date of Birth ____/____/____ Social Security #_____ _____ _____ Phone Number_____

Address_____

Insurance Information

Primary Health Information:

Insurance Carrier_____

Policy Holder's Name_____ Relationship to Policy Holder_____

Policy Holder's date of birth ____/____/____ Policy Holder's Social Security # ____ ____ ____

Policy Holder's Employer _____

Secondary or Other Health Insurance:

Insurance Carrier_____

Policy Holder's Name_____ Relationship to Policy Holder_____

Policy Holder's date of birth ____/____/____ Policy Holder's Social Security # ____ ____ ____

Policy Holder's Employer_____

Worker's Compensation/Motor Vehicle Insurance:

Insurance Carrier_____ _____
ADDRESS

Adjuster_____
Name Phone Number

Policy/Case/Claim#_____ Date of Accident____/____/____ Place of Accident: _____

Is this visit authorized? _____ By whom? _____ Authorization # _____

PatientName/Respresentative:_____

Signature: _____

Date: _____

The Spine Institute on the Emerald Coast

ASSIGNMENT OF BENEFITS & LIMITED POWER OF ATTORNEY

I, _____, irrevocably assign to you, my medical provider, all my rights and benefits under my insurance contract and/or any employee welfare benefit plan for payment for services rendered to me, but not limited to all my rights under the Employee Retirement Income Security Act ("ERISA") applicable to the medical services at issue. I irrevocably authorize you to file insurance claims on my behalf against the PIP carrier/health care carrier/employee welfare benefit plan for any and all rights under ERISA or applicable statute/law, including but not limited to the claim for penalties and fees under ERISA for failure to provide Plan Documents. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills and/or to file insurance claims on my behalf for services rendered to me. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage and I especially authorize you to pursue any administrative appeals conducted pursuant to ERISA, including but not limited to the authority to request and/or receive applicable Plan Documents.

In the event the insurance carrier responsible for making medical payments in this matter doesn't accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney-in-fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.

I authorize you and your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I especially authorize such health care provider(s) to release such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

Patient or Guarantor Signature: _____Date: _____

Print Name: _____

Authorization/Consent Acknowledgment

RELEASE OF INFORMATION:
I acknowledge that records concerning the patient are the property of The Spine Institute on the Emerald Coast and are maintained for the use and benefit of The Spine Institute on the Emerald Coast and its staff in providing care and treatment to the patient. I hereby authorize The Spine Institute on the Emerald Coast to disclose all or any part of my patient record to my referring physician, primary care physician, admitting physician, consulting physician, and/or hospital based physician. I further authorize The Spine Institute on the Emerald Coast and providing physicians to disclose all or any part of my patient record to any person or corporation which is or may be liable under contract to The Spine Institute on the Emerald Coast, myself or a family member of mine, for all or part of The Spine Institute on the Emerald Coast charges, including but not limited to, hospital or medical service companies, insurance companies, Worker's Compensation carriers, welfare agencies, or my employer, provided such release of information shall be in accordance with state and federal laws and regulations.

COLLECTION PROCESS:
In the event that an account is referred to an outside collection agency and/or small claims suit, that responsible party will be subject to paying any/all fees associated with the collection processes. I hereby authorize The Spine Institute on the Emerald Coast to obtain a credit history for such collection purposes. In the event that our office must commence legal action against the patient for payment of the patient's balance, the patient agrees to be liable for attorney fees and costs incurred by the office as part of such action and any attorney fees and costs incurred by this office in order to recover on the resulting judgment. I acknowledge a fee of $50 for any returned checks.

You agree, in order for us to service your account or to collect monies you may owe, The Spine Institute on the Emerald Coast, and/or agents may contact you by the telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email addresses you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing services as applicable. I/We have read this disclosure and agree that The Spine Institute on the Emerald Coast, its employees and/or agents may contact me/us as described above.

MEDICARE: (for Medicare patients only)
I certify that the information given by me in applying for payment under the Title XVII of the Social Security Act is correct. I authorize all medical records to be released to the Social Security Administration or its intermediaries or carriers and request that payment of authorized benefits be made on my behalf and I assign the benefits payable for physician service to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

AUTHORIZATION FOR MEDICAL CARE AND TREATMENT:

1. I recognize that a medical condition may exists requiring medical care and I voluntarily consent to such medical care, treatment and diagnostic procedures by The Spine Institute on the Emerald Coast and its medical and professional staffs, associates and agents as deemed necessary.
2. I hereby authorize my physician, as provided by law to furnish medical treatment, diagnostic procedures, x-ray/MRI diagnosis or therapy as he/she considers necessary and proper in the treatment process.
3. I am aware that the practice of medicine and surgery, and the administration of medical care, are not exact sciences and I acknowledge that no guarantees have been made to me as to the result of diagnostic procedures, treatments, examinations or care undertaken with The Spine Institute on the Emerald Coast**.**

ACKNOWLEDGMENT OF HEALTH INFORMATION PRACTICES

The Spine Institute on the Emerald Coast Notice of Privacy Practices provides information about how health information about patients may be used and disclosed. I have been offered and opportunity to review the Notice of Privacy Practices before signing this consent. I understand the terms of the Notice may change and that a copy of the revised Notice will be posted at all of The Spine Center on the Emerald Coast facilities. By signing this form, I acknowledge that I have been offered and/or received The Spine Institute on the Emerald Coasts' Notice of Privacy Practices.

The contents of the form have been fully explained to me and I have been given the opportunity to ask questions. Any questions that I have asked have been answered to my satisfaction. I certify that I understand the contents of this form in its entirety.

Termination of care any result from failure to cooperate and/or comply with The Spine Institute on the Emerald Coast Policy and Procedures as well as failure to cooperate and/or comply with medical care and/or treatment deemed necessary by The Spine Institute on the Emerald Coasts' physicians and medical staff.

Cancellation Policy

We discourage cancellations: however we do understand that emergency situations can arise. It is our policy that you call at least 24 hours in advance if you must cancel your appointment. This gives us adequate time to reschedule or allow a new patient to make an appointment. If 24 hours advance notice is not given or you do not show to your scheduled appointment, there will be a $50.00 charge.

If you are more than 15 minutes late for your appointment, you may not be seen. If you are seen, your appointment time may be shortened at the discretion of the physician.

It is our policy that if you have more than three cancellations or three no-shows within a six month period, you may be discharged from the practice. Your primary care physician will be notified and further treatment will require a new referral.

Medication Refill Policy

There will be an administrative fee of $25.00 for any medication refill requests made outside of a regular scheduled appointment. This fee will need to be collected prior to having your RX called into your pharmacy. This policy will not apply towards Workers Compensation patients unless it is a medication that you need to pick up at the office. This policy will also not apply to patients who are less than 3 weeks post operation.

I understand and agree to the above mentioned.

Signature of patient/patient representative: _____ Date: _____

Patient Pain Medication Consultation Form

Pain Medication

- You may be prescribed pain medication to help control pain for the next 7 to 10 days following surgery or for an acute painful condition. After 10 days, the dosage of narcotics will typically be decreased over a 2 to 4 week period. You will then be placed on non-narcotics such as anti-inflammatory medication when appropriate. This treatment period will be discussed at your follow up visit.

After Surgery

- For all patients who continue to have pain following surgery or have a condition that requires ongoing pain medication, the office has a consulting service to help with chronic pain. Chronic pain management patients will be referred to this service.

Refills

- You are expected to take your medication exactly as it is prescribed. In the event that you run out of this medication early, the office will not be able to refill the prescription unless your doctor or physician's assistant examines you.
- The office will not re-write prescriptions for pain medication that are lost, stolen, destroyed, or misplaced.
- To get a prescription refill, please call the main office at (850) 460-2350 during office hours. Due to the high volume of patients and requests, as well as our doctors' surgical schedule, please allow 48 to 72 business hours, excluding holidays and weekends to process the request. Once the refill request is processed, you will receive a call. Please check with your pharmacy before calling the office to check the status of a refill request. Thank you for your cooperation.

Patient name: _____

Signature: _____

Date: _____