NeuSpine Institute | Minimally Invasive Surgery

PATIENT INFORMATION

Today's Date: _____

Name: _____Middle Inial: _____ Date of Birth: _____

Address: _____
STREET CITY STATE ZIP CODE

Gender: ☐ Male ☐ Female Social Security #: _____

Home Phone: _____ Cell Phone _____ Work Phone: _____

E-mail: _____ Marital Status: _____Single _____Married _____Divorced _____ Widowed

Race/Ethnicity: _____American Indian _____Hispanic/Latino _____Asian _____African American _____White _____Other

Is your visit related to an Auto Accident? _____Yes _____No
Is your visit related to a Work Accident? _____Yes _____No
Is your visit related to a Slip & Fall? _____Yes _____No

How were you referred? _____ Primary _____Specialty _____Friend/Family _____Advertising _____Other (please specify)

Referring Physician (if applicable): _____

EMERGENCY CONTACT INFORMATION

1. Name: _____ Relationship: _____
Address: _____
STREET CITY STATE ZIP CODE
Home Phone: _____ Cell Phone: _____ Work Phone: _____

2. Name: _____ Relationship: _____
Address: _____
STREET CITY STATE ZIP CODE
Home Phone: _____ Cell Phone: _____ Work Phone: _____

PROVIDER HISTORY

Primary Care Physician:
Name: _____Phone Number: _____ Fax: _____

Address: _____
STREET CITY STATE ZIP CODE

Cardiologist:
Name: _____ Phone Number: _____

Address: _____
STREET CITY STATE ZIP CODE

Other:
Name: _____ Phone Number: _____

Address: _____
STREET CITY STATE ZIP CODE

INSURANCE INFORMATION

Primary Insurance

Person Responsible: ☐ Self ☐ Other Relationship to Patient: _____
Name: _____ DOB: _____ Social Security #: _____
Insurance Company: _____ ID Number: _____
Insurance Phone: _____ Group #: _____

Secondary Insurance

Person Responsible: ☐ Self ☐ Other Relationship to Patient: _____
Name: _____ DOB: _____ Social Security #: _____
Insurance Company: _____ ID Number: _____
Insurance Phone: _____ Group #: _____

MEDICAL INFORMATION

Please circle:

Do you smoke cigarettes? Yes No How many per day? _____
Are you a former smoker? Yes No Last used? _____
Do you drink alcohol? Yes No How often? _____
Do you participate in recreational drug use? Yes No What kind? _____

MEDICATIONS

Please list all medications you are taking or provide a list
(Include all over the counter medications and medications taken within the last month)

Name	Dosage	Directions	Reason for Medication

PHARMACY INFORMATION

Local Pharmacy
Name: _____
Address: _____
_____
Phone Number: _____

Mail Order Pharmacy
Name: _____
Address: _____
_____
Phone Number:_____

Please list all allergies and symptoms if known:

_____

_____

LIST OF SURGERIES AND HOSPITALIZATIONS

Hospital Name	Reason	Date

Past Medical History: (check all that apply)

*****Mark the following conditions/diseases that you have been treated for in the past*****

Cancer/Oncology:
Cancer-Type: _____ Cancer-Type: _____ Cancer-Type:_____

Cardiovascular/Hematologic:

___ Anemia
___ Heart Attack
___ Coronary Artery Disease
___ Stroke/TIA
___Heart Valve Disorder
___ Peripheral Vascular Disease
___ Presence of stent/pacemaker/ defibrillator
___ High Blood Pressure

Gastrointestinal:

___ GERD (Acid Reflux)
___ IBS
___ Gastrointestinal Bleeding
___ Crohn's's Disease
___ Stomach Ulcers

Neurological:

___ Multiple Sclerosis
___ Seizures
___ Balance Disorder
___ Peripheral Neuropathy
___ Head Injury
___ Headaches
___ Migraine

Psychological:

___ Depression
___ Anxiety
___ ADD/ADHD
___ Schizophrenia
___ PTSD
___ Bipolar Disorder
___ Other- Type: _____

Urological:

___ Chronic Kidney Disease
___ Kidney Stones
___ Urinary Incontinence
___ Dialysis

Respiratory:

___ Asthma
___ Bronchitis/Pneumonia
___ Emphysema/COPD

ENT:

___ Glaucoma
___ Vertigo
___ Hearing Problems
___ Nosebleeds

Musculoskeletal/Rheumatologic:

___ Bursitis
___ Osteoarthritis
___ Osteoporosis
___ Fibromyalgia
___ Carpal Tunnel Syndrome
___ Rheumatoid Arthritis
___ Chronic Joint Pains

Endocrinology:

___ Diabetes - Type: _____
____ Hyperthyroidism
___ Hypothyroidism

Other Diagnosed Conditions:

_____
_____

Psychological:

ACKNOWLEDGEMENT AND CONSENT FOR NOTICE OF PRIVACY

Acknowledge of Receipt

I have reviewed NeuSpine Institute LLC Notice of Privacy, which explained how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at no cost to me.

Patient requested copy: ☐ Yes ☐ No

_____ _____ _____

Name of Patient *(Please Print* Signature of Patient of Legal Guardian Date

Consent to Release Medical Information to Personal Representative

I, _____, hereby consent to have my information released to the following individuals. This consent will remain in effect until otherwise notified by me in writing.

☐ Appointment times ☐ Medical Information ☐ Billing/Demographic Info

Do NOT release my information, except to health care providers and...

_____ _____ , _____ _____

Name Relationship Name Relationship

_____ _____ , _____ _____

Name Relationship Name Relationship

_____ _____

Signature of Patient of Legal Guardian Date

PATIENT AUTHORIZATION & CONSENT

I hereby voluntarily consent to medical treatment, including diagnostic procedures, surgical and other medical services, provided by NeuSpine Institute LLC or their authorized designees, as they may in their professional judgment be necessary to provide appropriate medical, surgical or emergency care. I agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, all costs, and expenses, including but not limited to reasonable attorney's fees that may incur in such collection efforts.

I authorize NeuSpine Institute LLC physicians to submit claims to my insurance for services rendered by my medical providers. I authorize the release of any medical information necessary to process this assignment on the claim. I authorize payment to be made to NeuSpine Institute LLC physicians for services provided by them.

TO ALL PATIENTS:

In order to provide you with good service, it is of great importance we have your current address and phone number on file. Please be sure to contact us if your phone number and/or address changes. This information will be utilized to remind you of your appointment date and time.

Cancellation/No Show Policy:

Any Follow-up appointment cancellation or no-show in which a 24-hour notice is not provided, will result in a $50 charge.

Any Injection appointment cancellation or no show in which a 24-hour notice is not provided, will result in a $75 charge.

After three occurrences you will be terminated from NeuSpine Institute. If we terminate our service with you, we will be happy to transfer a copy of your medical records to your new physician upon receipt of a signed authorization to release records.

Late Policy:

The clinic has limited waiting time for your appointment. If you are more than 15 minutes late your appointment will be rescheduled.

_____ _____

Patient/Legal Guardian Signature Date

NEUSPINE INSTITUTE

HIPAA Privacy Authorization Form

Authorization for Use of Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I Authorize **NEUSPINE INSTITUTE LLC.** to use and disclose the protected health information described below.

By signing,

1. I authorize the release of my complete health record (including records related to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
2. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
3. This authorization shall be in force and effect during my entire care at NeuSpine Institute LLC.
4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on the authorization or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
6. I may inspect and receive a copy of the information being used and disclosed pursuant to this Authorization form.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____	_____	_____
Printed Patient Name & DOB	Patient Signature	Date

NeuSpine Institute Minimally Invasive Surgery

Assignment of benefits, liens, direct payment authorization, authorization to release insurance information, and authorization to escrow unpaid medical & PIP benefits
NEUSPINE ANCILLARY LLC

Insurance Carrier_____

For and consideration of NEUSPINE INSTITUTE LLC agreeing to pursue the responsible insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to NEUSPINE INSTITUTE LLC for Medical Payment Coverage, and other benefits which I may have accordance with Florida Statute § 627.736. This includes any benefits from my insurance company and any other entity may be responsible for medical expenses incurred. I further authorize NEUSPINE INSTITUTE LLC to collect payments & prosecute any necessary actions to collect payments for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

This assignment concerns only the bills for NEUSPINE INSTITUTE LLC and those costs including, but not limited to,attorney's fees other costs, and interest necessary in procuring payment from the above-names insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or copayment not covered by any policy of insurance cited above . I understand that as a benefit and convenience to me, NEUSPINE INSTITUTE LLC will bill any pursuit collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to NEUSPINE INSTITUTE LLC on the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to NEUSPINE INSTITUTE LLC at the address on the bill. NEUSPINE INSTITUTE LLC medical care is being provided for a reasonable fee for treatment that I have sought out for under my above mentioned insurance carrier and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part,my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by NEUSPINE INSTITUTE LLC. I further instruct my insurance company to make payment for charges submitted by NEUSPINE INSTITUTE LLC in priority to any other request to escrow benefits,including a request by myself to reserve benefits for pending disability claims . I hereby give NEUSPINE INSTITUTE LLC limited power of attorney to endorse and sign my name on any draft for payment to either NEUSPINE INSTITUTE LLC or myself if said draft represents payment for charges related to services rendered by NEUSPINE INSTITUTE LLC.

I further direct my insurance carrier ir responsible other entity to provide information to NEUSPINE INSTITUTE LLC which is otherwise available to me including but not limited to a copay of any applicable insurance policy, declaration page,all applicable endorsements, transcripts and/or copies of any recorded statements,examinations under oath and request for same,independent medical evaluations and requests for same, and peer review reports, this request includes the name of other medical providers to whom payments have been under my policy of insurance in favor of NEUSPINE INSTITUTE LLC. If any language within this agreement has the effect of invalidating this agreement , that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original .

_____	_____	_____
Patient Signature	Patient Name	Date

If patient is incapacitated or under the age of 18, please indicate the patient's name, guardian name and relation to patient and obtain guardian signature.

NeuSpine Institute | Minimally Invasive Surgery

NEW PATIENT INFORMATION

Please make sure that a response is written in EVERY SPACE

Name: _____

Previous SPINAL Surgeries:

WHERE:	**WHEN:**	**WHO:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

When did your pain start? _____

Was there an event/injury that caused your pain to start?

_____

_____

What makes your pain worse?

_____

_____

What makes your pain feel beer?

_____

_____

Previous Treatment (please answer yes/no and details as applicable)

Bracing therapy _____ When _____ How long _____ Did it help _____

Physical Therapy _____ When _____ How long _____ Did it help _____

Chiropractor _____ When _____ How long _____ Did it help _____

Acupuncture _____ When _____ How long _____ Did it help _____

Massage Therapy _____ When _____ How long _____ Did it help _____

Pain Management _____ Doctor's name: _____ When _____ How long _____

Did it help _____ What did they do?

_____

Injections? _____ What part of the body? _____What kind? _____
When_____ How many _____ Did it help_____

Previous evaluated by spinal surgeon?(If so, who and for what?) _____

_____

Other tests/Doctors:

_____

_____

Are you on any blood thinners such as aspirin? _____

Review of Systems:

Mark the following symptoms that you **currently** suffer from within the last 2 weeks:

Constitutional:
__Fevers
__Chills
__Sweats
__Weakness
__Fatigue
__Decreased Activity
__Malaise
__Unexplained Weight Loss
__Unexplained Weight Gain
__Low Sex Drive
__Difficulty Sleeping

Eyes:
__Blurriness
__Double Vision
__Pain
__Visual Disturbance
__ Visual Change

Respiratory:
__Sputum Production
__Shortness of Breath
__Cough
__Wheezing

Ears/Nose/Throat/Neck:
__Hearing Problems
__Ear Pain
__Sore Throat
__Sinus Problems
__Nose Bleeds

Integumentary:
__Rash
__Itching
__Lesion
__Bruising

Musculoskeletal:
__Back Pain
__Neck Pain
__Joint Pain
__Muscle Pain
__Muscle Cramp
__Muscle Spasm
__Gait Disturbances
__Joint Stiffness
__Joing Swelling
__Trauma

Neurological:
__Abnormal Balance
__Confusion
__Numbness
__Tingling
__Dizziness
__Headaches
__Loss of Coordination
__Memory Loss
__Seizures
__Tinnitus
__Tremors
__Vertigo

Cardiovascular:
__Chest Pain
__Palpitations
__Swelling in Feet
__Bleeding Disorder
__Blood Clots
__Fainting
__Shortness of Breath during sleep

Psychiatric:
__Feeling Anxious
__Depressed Mood
__Suicidal Thoughts
__Hallucination
__Stress Problems
__Suicidal Planning
__Thoughts of harming others

Hematological:
__ Anemia
__ Blood Clots
__ Easy bruising/bleeding
__ Swollen Legs
__ Transfusion

Gastrointestinal:
__Nausea
__Vomiting
__Diarrhea
__Constipation
__Heartburn
__Abdonminal Pain

Genitourinary/Nephrology:
__Painful Urination
__Blood in Urine
__Change in Urine Stream
__Unusual Discharge
__Flank Pain
__Urinary Incontinence

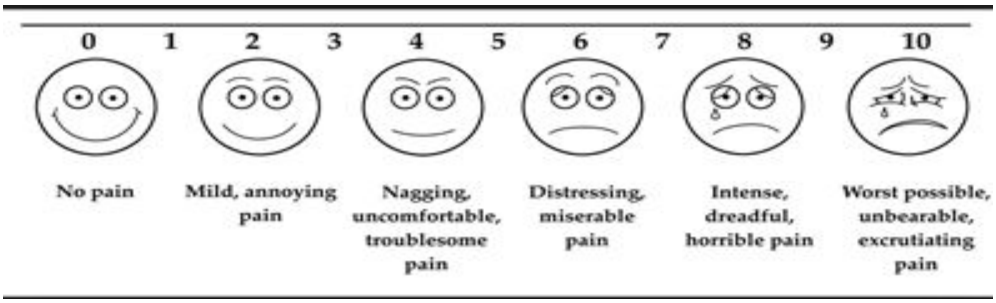
Endocrine:
__ Cold Intolerance
__ Heat Intolerance
__ History of Diabetes
__ Thyroid Disease

Immunologic:
__ HIV Exposure
__ Hives
__ Persistent Infections

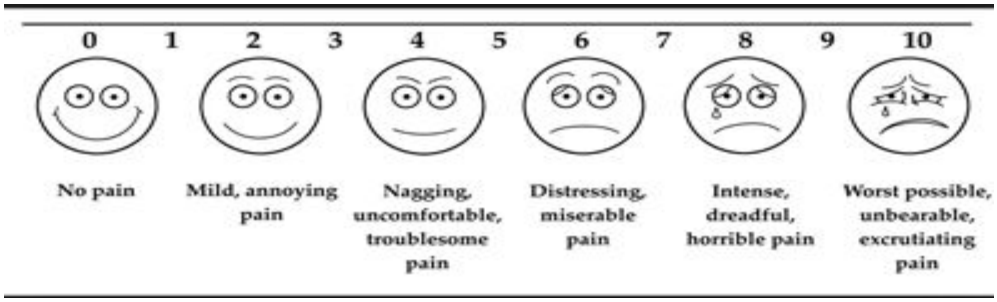
Pulmonary:
__ Chest Pain
__ Cough
__ Coughing up blood
__ Shortness of breath
__ Sputum production
__ Wheezing

Visual Analogue Scale

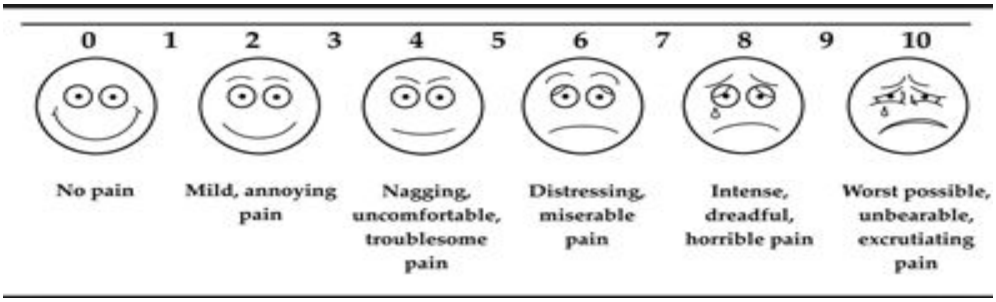
Mark your current **NECK PAIN** based on the scale below



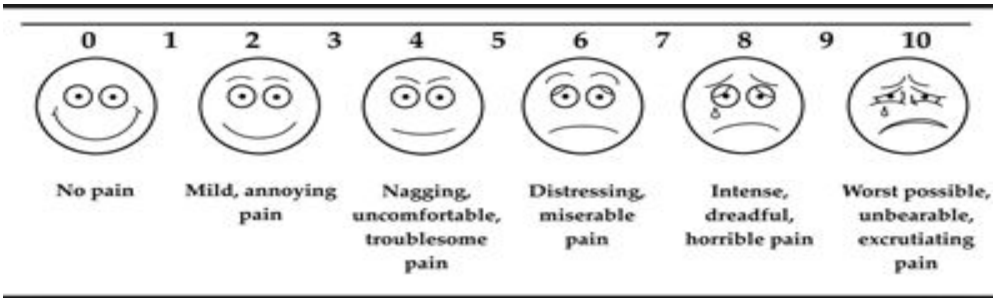
Mark your current **ARM PAIN** based on the scale below



Mark your current **BACK PAIN** based on the scale below

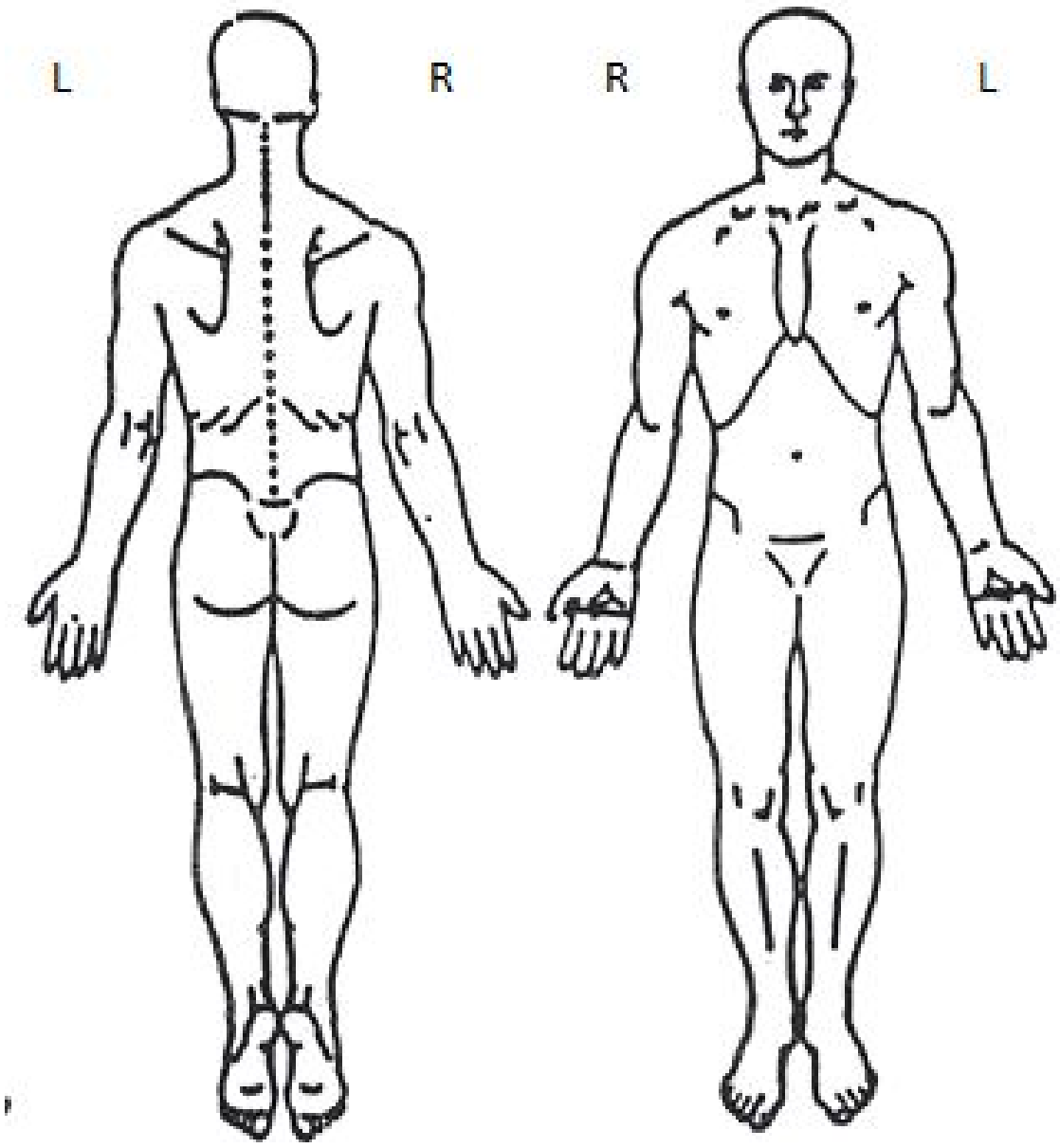


Mark your current **LEG PAIN** based on the scale below



What area is the most bothersome (neck, right arm, left arm, back, right leg, left leg): _____

Name: _____ **Date:** _____



Please color in the area with the following:
Red: Burning
Blue: Numbness
Yellow: Stabbing Pain
Green: Weakness
Brown: Aching