NeuSpine Institute | Minimally Invasive Surgery

PATIENT INFORMATION

Today's Date: _____

Name: _____Middle Initial: _____ 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 THERE A LEGAL CASE/LITIGATION? ☐ Yes ☐ No
Is your visit related to a Work Accident? ☐ Yes ☐ No. IS THERE A LEGAL CASE/LITIGATION? ☐ Yes ☐ No
Is your visit related to a Slip & Fall? ☐ Yes ☐ No. IS THERE A LEGAL CASE/LITIGATION ? ☐ Yes ☐ No
Is your visit related to any other accident? ☐ Yes ☐ No. IS THERE A LEGAL CASE/LITIGATION ? ☐ Yes ☐ No

If you answered "yes" to any of the above, describe the event(s) in detail, including the date(s) of the event(s):

_____
_____
_____
_____
_____
_____

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

Referral Source: ☐ **Primary Physician:**_____ ☐ **Friend/Family**
☐ **Advertisement:**_____ ☐ **Specialist:**_____ ☐ **Chiropractor:**_____
☐ **Online Search:**_____

HEALTH INSURANCE INFORMATION

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

Additional Insurance

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

I, the Patient, recognize and agree that neither NeuSpine Institute nor its healthcare providers must bill any insurance available to me (except as required by Florida PIP laws) when the cause, in whole or part, of my condition(s) for which I seek any service(s) from NeuSpine Institute is a tort (the negligence of another), be it a motor vehicle collision, slip or trip and fall, or any other tort event, and in a tort setting NeuSpine Institute is hereby authorized not to bill any health insurance source that might be available to me, including but not limited to Medicare, Medicaid, or other governmental insurance source. Regardless of whether there is any other possible payer (other than me) that may be available to NeuSpine Institute as a source for payment of my medical bills in whole or part, no matter what the cause of my condition(s) for which I seek any services from NeuSpine Institute, I, the Patient, hereby agree to pay the full charges issued to me and that I shall remain liable to NeuSpine Institute for payment of the full amounts charged to me by NeuSpine Institute for the services rendered by NeuSpine Institute, I have no right to seek or compel NeuSpine Institute to reduce any bill to me, and in any event, I hereby waive any alleged right I may have to seek or compel NeuSpine Institute to reduce any bill to me. I promise to pay the full charges billed to me by NeuSpine Institute within 30 days from the date of billing, and if not fully paid within that time, interest at the highest rate allowed by law shall accrue until all principal and interest is paid in full.

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. I, the Patient, recognize and agree that even if NeuSpine Institute terminates its relationship with me, I shall remain liable for payment of the full amount of all charges billed to me by NeuSpine Institute.

Late Policy:

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

_____ _____
Signature of Patient of Legal Guardian Date

Social History:

Occupation: _____ When was the last time you worked? _____

___ Temporary Disability ___ Permanent Disability ___ Retired ___ Unemployed

Alcohol Use:

___ Social Use ___ Daily use of alcohol ___ Never ___ History of alcoholism ___ Current alcoholism

Tobacco Use:

___ Current user ___ Former user How long has it been since you stopped smoking: _____
___ Packs per day. How many years: _____

Illegal Drug Use:

___ Denies any illegal drug use ___ Currently uses illegal drugs ___ Formerly used illegal drugs

Have you ever abused narcotic or prescription medications: ___ Yes ___ No

Family History:

Mark all appropriate diagnoses as they pertain to your parents and siblings:

___ Arthritis ___Diabetes ___Cancer ___Headaches/Migraines

___ High Blood Pressure ___Kidney Problems ___Liver Problems ___Osteoporosis

___ Rheumatoid arthritis ___Seizures ___Stroke Other Medical Problems: _____
___I have no significant family medical history

Past Medical History/Treatment:

LIST OF SURGERIES AND HOSPITALIZATIONS

Hospital Name	Reason	Date

____ I have NEVER had any surgical procedures performed.

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 Disease
___ Stomach Ulcers

Neurological:

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

Urological:

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

ENT:

___ Glaucoma
___ Vertigo
___ Hearing Problems
___ Nosebleeds

Respiratory:

___ Asthma
___ Bronchitis/Pneumonia
___ Emphysema/COPD

Musculoskeletal/Rheumatologic:

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

Endocrinology:

___ Diabetes - Type: _____
____ Hyperthyroidism
___ Hypothyroidism

Psychological:

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

Other Diagnosed Conditions:

_____
_____
_____
_____
_____

NONE of the above:_____

MEDICATION HISTORY:

Are you currently taking any blood thinners or anti-coagulants? Yes No

If YES, Which ones? Aspirin Plavix Coumadin Lovenox Other: _____

Please list all medications you are CURRENTLY taking. Attach additional sheet if required:
(Include all over the counter medications)

Name	Dosage	Directions	Reason for Medication

PHARMACY INFORMATION:

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

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

Do you have any drug/medication allergies? ____ Yes ____ No

If so, please list all allergies and symptoms if known:

Medication Name:	Symptom:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Topical Allergies: ____ Latex ____ Iodine ____Tape ____ IV Contrast

Please list all past pain medications that you have been on at any point for your current pain complaints.
(Include all over the counter medications)

Name	Dosage	Directions	Did this help you? Y/N

ACKNOWLEDGEMENT AND CONSENT FOR NOTICE OF PRIVACY

Acknowledge of Receipt

I have reviewed the 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 or 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

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 deem to be necessary to provide appropriate medical, surgical, or emergency care to me. I agree that I am liable for the total of all charges by NeuSpine Institute LLC and all costs and expenses of collection efforts, including but not limited to attorneys' fees, that NeuSpine Institute may incur in seeking to collect from me any debt I owe to NeuSpine Institute. Although not required to bill any health or other insurance available to me (except as required by Florida PIP laws), I authorize NeuSpine Institute LLC and its physician employees or contractors, at their election, to submit claims to my insurance for services rendered by my medical providers and hereby assign to NeuSpine Institute the right to receive, directly, any and all payments that otherwise are or may become due to me. I authorize the release of any medical information necessary to process this assignment on the claim. I authorize payment to be made directly to NeuSpine Institute LLC for services rendered. I do not, however, delegate any duties of mine under any type of insurance or healthcare program to NeuSpine Institute, and hereby retain all such duties.

I, the referenced or undersigned patient, agree that NeuSpine Institute LLC, the corporate entity with which I am hereby contracting, does not owe me a non-delegable duty to provide me with non-negligent healthcare. Therefore, I agree that as to any claim that I may have or acquire concerning or involving my healthcare that includes, in whole or part, a claim of liability for negligent or deficient conduct (whether by act or omission), I hereby release the aforesaid NeuSpine Institute LLC corporate entity from any and all liability, and will look solely to the individual doctor, physician, or individual healthcare person who interacts with me, diagnoses or treats me, or operates on me, for any and all claims of liability or damages.

I understand that Dr. Armen Deukmedjian and Dr. Amir Amahdian are the sole physicians with an ownership interest in the above-referenced NeuSpine Institute LLC corporate entity with which I am contracting for services, and I further recognize and agree that said physicians are not personally liable or responsible for the NeuSpine Institute corporate entity or the acts or omissions of other persons working for the NeuSpine Institute corporate entity.

_____

Signature of Patient of Legal Guardian 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 ("HIPAA"))

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). abuse), including billing information, to any attorney or law firm that is representing me in any matter, and to any healthcare provider that has provided or may come to provide any healthcare service to me, and to any billing or collections service.

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.

8. I authorize that a copy of this authorization shall be as binding and effective as an original.

_____	_____	_____
Printed Patient Name & DOB	Patient Signature	Date

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

Insurance Carrier_____

For and consideration of NEUSPINE INSTITUTE LLC agreeing to provide me with medical care and related services and not requiring prepayment for rendition of services, I hereby irrevocably assign all rights and benefits I have to NEUSPINE INSTITUTE LLC for Personal Injury Protection and Medical Payment Coverage, and other benefits from my health insurance company, if any, which I may have according to Florida Statute § 627.736, or otherwise under Florida law. I further authorize NEUSPINE INSTITUTE LLC to collect payments & prosecute any necessary actions to collect payments for services as it sees fit in accord with law. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS NOT A DELEGATION OF DUTIES.

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-referenced insurance company(ies). This assignment is not intended to assign any other causes of action that may belong to the undersigned patient, nor does it delegate any duties of mine to Neuspine Institute. As part of my liability for the total charges of NeuSpine Institute, I agree to pay any applicable deductible or copayment not covered by any policy of insurance. I understand that NEUSPINE INSTITUTE LLC may pursue collection for any debt owed by me as it sees fit, at its election. I hereby instruct and direct my insurance company/companies to pay my benefits directly to NEUSPINE INSTITUTE LLC at the address provided on the bill(s). If my current policy(ies) prohibit(s) direct payment to doctors or healthcare providers, then I hereby instruct and direct my insurance company(ies) to make the check or other instrument payable to me and mail it to NEUSPINE INSTITUTE LLC at the address on the bill, and I hereby authorize NeuSpine Institute to endorse any such instrument of payment with my name and negotiate or deposit it to NeuSpine Institute's account, at NeuSpine Institute's election. I agree that NEUSPINE INSTITUTE LLC is providing me healthcare services that I have sought out for my benefit, at charges I hereby determine to be reasonable to me, and that the care / services I seek from NeuSpine Institute and the charges therefor are reasonable and medically necessary from my perspective.

I instruct my insurance carrier(s) to pay these bills to the full extent of my available benefits under any insurance policy and Florida law. If any portion of the charge for these services is either delayed, reduced, or denied in whole or in part, my insurance company or other processing 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 a limited power of attorney to endorse and sign my name on any draft or other instrument for payment to either NEUSPINE INSTITUTE LLC or myself if said draft or instrument represents payment for charges related to services rendered by NEUSPINE INSTITUTE LLC, and in any event, to deposit/negotiate any and all such payments for the account and benefit of NeuSpine Institute.

I further direct my insurance carrier as the responsible entity to provide information to NEUSPINE INSTITUTE LLC which is otherwise available to me including but not limited to PIP logs, information relating to any copay under any applicable insurance policy, declaration page(s), all applicable endorsements, transcripts and/or copies of any recorded statements and examinations under oath and requests for same, independent medical evaluations and requests for same, and peer review reports. This request includes the name and address of other medical providers to whom payments have been made under my policy/policies of insurance. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed revised *ab initio* to the extent necessary to render such binding and effective under Florida Law, and the remainder of the assignment shall maintain full force and effect. A photocopy or electronic copy or transmittal of this assignment shall be considered as effective and valid as the original.

In addition, I am responsible for copays, co-insurances, and deductibles prior to my office visits and surgery date(s) if surgery is necessary.

Direction of Payment

I hereby authorize and instruct any insurance company to pay directly to Assignee the amount of all bills for services rendered. Without limitation of any other terms of this assignment or any other agreement with the Assignee, I also agree that if any insurance company makes any payment to Assignee regarding services rendered to me by Assignee, I will pay directly to Assignee, in a current manner, any difference between the total charges and the amount paid by the insurance company. This assignment also allows Assignee to endorse any check, draft, or other instrument provided to Assignee in my name for purposes of payment for services rendered to me by Assignee or its employees, contractors, or agents.

PIP Log & Declaration Sheet Request

I hereby authorize Assignee to release requested information, which is pertinent to my case or condition(s), to my insurance company or any/all of my attorneys now or hereafter involved in my case, pursuant to 627.4137 Florida Statutes. I hereby request that a copy of the pip log and declaration sheet, which reflects the policy limits available at the time of this accident, be provided to this Assignee. I hereby authorize this Assignee to request and receive a copy of my pip log periodically as Assignee deems necessary. If any term or provision of this Assignment, Lien, and Authorization or the application thereof to any person or circumstance shall, to any extent, be determined to be invalid or unenforceable, the remainder of this Assignment, Lien, and Authorization, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Assignment, Lien, and Authorization shall be valid and enforced to the fullest extent of the law.

Reservation of Benefits

Be further advised, I am hereby placing you on notice pursuant to Florida case law that should you (the insurance company/carrier) deny, reduce, delay, or fail to pay any part of or the entire bill which was submitted on my behalf from this health care provider, I (the assignor) as well as the assignee (health care provider) are requesting, in advance, that you reserve, or “set-aside,” the amount reduced or denied or delayed until the dispute is resolved. Should you submit a check to this health care provider which is less than the correct contractual amount, and it contains any language referring to or purporting to declare payments as “Full and Final Payment,” or the like, then I have instructed this health care provider to return the check to you (the insurer) and consider the bill still due and owing (i.e. a late payment as defined in F.S. 627.736). Additionally, should the remaining amount of my benefits approach an amount where there would be insufficient funds to pay the amount you reduced, delayed, or failed to pay, please notify me (the assignor) and this health care provider (the assignee) immediately.

Health Care Provider: NeuSpine Institute, LLC (“NeuSpine Institute”)

_____	_____	_____
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

P# 813-333-1186 F# 844-691-5928

FINANCIAL RESPONSIBILITY AGREEMENT

I, the below-named patient, hereby knowingly and voluntarily agree, acknowledge, and represent to the above-named health care provider that in addition to any other contract(s) existing or hereafter entered into between myself and the said healthcare provider, I am responsible for paying the full amount(s) billed to me or on my account for the healthcare services provided to me or for my benefit, including but not limited to care, treatment, other services, medicine, and supplies, and that no act or omission by the healthcare provider shall constitute a waiver of the right to charge to and be paid by me the entire amount(s) billed to me or on my account. In further consideration of the care, treatment, services, medicine, and/or supplies provided to me or on my behalf by the healthcare provider, I do hereby waive any and all statutes of limitation on any claim or cause of action that the healthcare provider may have or hereafter acquire against me regarding the care, treatment, services, medicine, and supplies provided to me or for my benefit, including the charges and bill(s) due therefor, whether any such claim be in law or equity, and do further waive any and all head of family or other protection(s) from collection by a creditor under Florida and/or Federal law. If one provides more than one-half of the support for a child or other dependent, all or part of the supporter's income is exempt from garnishment under Florida law. The supporter can waive this protection only by signing this document. By signing below, I, as the supporter, agree to waive the protection from garnishment. I understand and agree that the said healthcare provider is relying on my aforesaid inducements, promises, agreements, and representations in agreeing to provide me with healthcare, and I agree that such reliance by the healthcare provider is reasonable in all respects. Further, if I should have any right to seek or compel arbitration of any matter with the said healthcare provider, I hereby irrevocably waive that right, and agree that all of the rights given to the healthcare provider by me herein, are and shall constitute a grant coupled with an interest, and therefore, among other things, shall be irrevocable by me, the undersigned patient, and no obligation of mine to this healthcare provider is or can become delegable to any other person.

By signing below, I hereby acknowledge that I have read and understand this agreement and have freely made my own decision in agreeing to this document. Any questions I have about this document have been answered to my satisfaction by the Practice and I have had an opportunity to consult my attorney, if any.

_____ _____

Signature of Patient Date

If the Patient is a Minor, signature of Parent or Guardian: _____

THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your healthcare provider or health care facility recognize your rights while you are receiving medical care, and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of the patients.

1. A patient has the right to be treated with courtesy and respect with appreciation of his/her individual dignity, and with protection of his or her need for privacy.
2. A patient has the right to prompt and reasonable response to questions and requests.
3. A patient has the right to know who is providing medical services and who is responsible for his or her care.
4. A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
5. A patient has the right to know what rules and regulations apply to his or her conduct.
6. A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
7. A patient has the right to refuse any treatment, except as otherwise provided by law.
8. A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
9. A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
10. A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of the charge for medical care.
11. A patient has the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have the charges explained.
12. A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or resource of payment.
13. A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
14. A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
15. A patient has the right to express grievances regarding any violation of his or her right, as stated in Florida Law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
16. A patient is responsible to give the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalization, medications, and other matters related to his or her health.
17. A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
18. A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
19. A patient is responsible for following the treatment plan recommended by the health care provider.
20. A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
21. A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
22. A patient is responsible for following the health care provider’s or facility’s rules and regulations affecting patient care and conduct.

ADVANCE DIRECTIVE

An advance directive is a written or oral statement about how you want medical decisions made should you not be able to make them yourself. Additional information and/or forms are available at your request.

Upon admission to a surgery center, advance directives are waived for the duration of the surgery and recovery period.

PHYSICIAN OWNERSHIP

Dr. Armen Deukmedjian, Dr. Amir Ahmadian, and Dr. Kamal Patel, any of whom may or may not be physicians treating you,are owners of a financial interest in Comprehensive Outpatient Joint and Spine Institute surgery center. All of the physicans at Neuspine Institute have a financial interest in Neuimage Diagnostic Radiology Services (MRI/Xray). Neuspine Institute wants to make sure you understand that you are not required to use COJSI or NeuImage and have the option to use an alternative healthcare facility (listed below)

You will not be treated differently by your physician if you choose to obtain health care services at a facility other than COJSI or NeuImage.

We can discuss with you your alternative locations where you may receive services.

By signing below, you or your legal representative, acknowledge that you have read and understand the foregoing notice.

Facilities:

Advent Health Weslet Chapel:
2600 Bruce B Downs Blvd, Wesley Chapel, FL 813-929-5000

Advent Health Zephyrhills:
7050 Gall Blvd, Zephyrhills, FL 813-788-0411

Tower Diagnostic:

1. 2324 Osk Myrtle Ln 813-751-0422
2. 14499 Dale Mabry Hwy #150 813-968-6998
3. 3069 Grand Pavilion Dr 813-977-9777

Akumin:

1. 27662 Cashford Cir 813-788-2500
2. 6900 Gall Blvd 813-783-6736
3. 10010 N Dale Mabry Hwy, Suite 150 813-637-2911

_____ _____

Signature of Patient or Legal Representative Date

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
bruising/bleeding
__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

__ Swollen Legs
__ Transfusion

Gastrointestinal:
__Nausea
__Vomiting
__Diarrhea
__Constipation
__Heartburn
__Abdominal 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

NONE of the above:_____

Pain History

Chief complaint (Reason for your visit today): _____

Previous SPINAL or Brain/Head Surgeries:

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

Onset of Symptoms:

Approximately, when did your symptoms begin?

_____

What caused your current or most recent episode?

_____

Was this due to a motor vehicle accident? _____If Yes, When?_____
Was this due to a Slip & Fall ? _____If Yes, Where? _____
Did this happen at work? _____

How did your current/most recent symptoms or pain begin? _____ Gradually _____ Suddenly

Since this began, how has it changed? _____ Improved ____ Worsened _____ Stayed the same

Pain Description:

What time of day is your pain at its worst?

_____

How often does the pain occur? ___ Constant ___ Changes in severity but always present ___ Intermittent

Please mark with an "x" the nature of your pain: ___ Dull ___ Achy ___ Burning ___ Numbness ___ Tingling ___ Sharp ___ Shooting ___ Stabbing ___ Electrical ___ Radiating ___ Weakness Other:

_____

If "0" is no pain and "10" is the worst pain, how would you rate your pain?

Current pain level _____ **On your best day: _____** **On your worst day: _____**

Please mark with an "x" what your pain is aggravated by: ___ Sitting ___ Standing ___ Bending ___Twisiting ___ Stretching ___ Walking ___ Exercise ___ Daily Activities ___ Working ___ Sneezing Other:

_____

Please mark with an "x" how your pain is relieved: ___ Sitting ___ Elevating legs ___ Lying down flat ___ Exercise ___Massage ___ Stretching ___ Topical Meds ___ Oral Meds Other:

_____

Does the pain radiate? If so, where?

_____

Please list any additional areas of pain:

_____

Treatment History

Interventional Pain Treatment History:

___ Epidural Steroid Injection - Please circle: Cervical Thoracic Lumbar
___ Joint Injection - Joint(s) : _____
___ Medial Branch Blocks/Facet Injections - Please circle: Cervical Thoracic Lumbar
___ Nerve Blocks - Area/Nerve(s) : _____
___ Radiofrequency Nerve Ablation - Please circle: Cervical Thoracic Lumbar
___ Spinal Cord Stimulator - Trial Only/Permanent Implant: _____
___ Trigger Point Injections - Where? _____
___ Vertebroplasty/Kyphoplasty - Level(s): _____
___ Other: _____

Which of these procedures helped with your pain? _____

Please mark all of the following treatments you have had for pain relief:

Treatment:	**Completed?**	**When?**	**How Long?**	**Did it help?**
Spine Surgery: Who? _____				
Physical Therapy				
Chiropractic Care				
Massage Therapy				
Brace Therapy				
Acupuncture				
Hot/Cold Packs				
TENS UNIT				
OTHER: _____				

Have you seen any other physician or specialist for this pain? If yes, who and when? _____
_____
_____

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY

- I can tolerate the pain I have without having to use pain killers
- The pain is bad but I manage without taking pain killers
- Pain killers give complete relief from pain
- Pain killers give moderate relief from pain
- Pain killers give very little relief from pain
- Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but manage most of my personal care
- I need help every day in most aspects of self care
- I don't get dressed, I was with difficulty and stay in bed

3. LIFTING

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- I can lift very light weights
- I cannot lift or carry anything at all

4. WALKING

- Pain does not prevent me walking any distance
- Pain prevents me walking more than one mile
- Pain prevents me walking more than ½ mile
- Pain prevents me walking more than ¼ mile
- I can only walk using a stick or crutches
- I am in bed most of the time and have to crawl to the toilet

5. SITTING

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than one hour
- Pain prevents me from sitting more than ½ hour
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

6. STANDING

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than one hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

7. SLEEPING

- Pain does not prevent me from sleeping well
- I can sleep well only by using medication
- Even when I take medication, I have less than 6 hrs sleep
- Even when I take medication, I have less than 4 hrs sleep
- Even when I take medication, I have less than 2 hrs sleep
- Pain prevents me from sleeping at all

8. SOCIAL LIFE

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

9. TRAVELLING

- I can travel anywhere without extra pain
- I can travel anywhere but it gives me extra pain
- Pain is bad, but I manage journeys over 2 hours
- Pain restricts me to journeys of less than 1 hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOMEMAKING

- My normal homemaking/ job activities do not cause pain.
- My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chore