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

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 _____Specialist _____Friend/Family _____Advertising

Referring Provider (if applicable): _____

HEALTH 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 #: _____

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.

SLR QUESTION FOR YOU: Do you not want a cancellation charge if a surgery or procedure other than injection (RFA?) is canceled without or on very short notice. 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.

_____ _____
Signature of Patient or Legal Guardian Date

Name: _____ 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'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 Eliquis 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

ACKNOWLEDGMENT AND CONSENT; NOTICE OF PRIVACY

Acknowledgment 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 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

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 be incurred in such collection efforts. I authorize but do not require NeuSpine Institute LLC physicians to submit claims to my insurance for services rendered by my medical providers. To be clear, **NeuSpine Institute LLC** is free to choose not to bill or seek payment from any insurance carrier of mine, except for PIP (as required by Florida law). 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 if **NeuSpine Institute LLC** chooses to bill insurance.

_____ _____

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)

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 request to receive and inspect 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 INSTITUTE LLC

Insurance Carrier_____

For and consideration of NEUSPINE INSTITUTE LLC agreeing to pursue the responsible person(s), which may include tortfeasor(s) and/or insurance carrier(s), 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 in accord with Florida Statutes § 627.736. This includes any benefits from my insurance company and any other entity that 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-named 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 I may have. I understand that as a benefit and convenience to me, NEUSPINE INSTITUTE LLC may choose to bill or pursue collection against an insurance company or other responsible entity.. I hereby instruct and direct my insurance company that if billed by NEUSPINE INSTITUTE LLC 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 that if billed by NEUSPINE INSTITUTE LLC to make the check payable to me and mail it to NEUSPINE INSTITUTE LLC at the address on the bill. NEUSPINE INSTITUTE LLC's medical care is being provided for a reasonable fee for treatment that I have sought out under my above-mentioned insurance carrier and is medically necessary from my perspective. I instruct my insurance carrier 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 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 that if billed by NEUSPINE INSTITUTE LLC, to make payment for charges thusly 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 to provide information to NEUSPINE INSTITUTE LLC which is otherwise available to me including but not limited to the amount of 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 made under my policy of insurance . 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. Nothing in this agreement constitutes a delegation of any duties I may have under any policy of insurance to which I am a party.

If NEUSPINE INSTITUTE LLC elects to bill my insurance, I am responsible for copays, co-insurances, and deductibles prior to my office visits and surgery date if surgery is necessary.

_____	_____	_____
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.

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

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? _____ **Was this due to a Slip & Fall ?** _____

Was this due to some other incident/accident? _____

Did this happen at work? _____

If Yes to any of the above, please describe and advise when/where _____

_____.

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?

On your best day: _____ **On your worst day:** _____

Current pain level _____

Please mark with an "x" what your pain is aggravated by: _____Sitting _____Standing _____Bending ____Twisting _____ 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 Which 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
- ☐ Painkillers 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

Disclosure for outstanding balances with active appointments.

Please be advised that Neuspine Institute is required to collect on any outstanding balances prior to appointments. It is the patient's responsibility to check what is owed from their insurance company's explanation of benefits (EOB) to determine what is outstanding. Any balances over thirty (30) days will need a full payment before being seen. In the event that no payment(s) can be made, then Neuspine Institute has the right to reschedule/cancel the appointment until the balance is paid in full or on an active payment plan is on file. Please keep in mind that payment plans for any accounts with balances over $500.00 will be considered after review.

By signing this form, you acknowledge that you are aware of the possibility for your appointment to be canceled or rescheduled due to the outstanding balance(s) and that a full payment may be needed to place you back on the schedule. If you have any question(s) regarding this disclosure, you may contact the Financial Counselor at 813-333-1186 ext. 425. Thank you for your cooperation on this matter.

Acknowledgement

Patient Signature: _____ Date: _____