COMPREHENSIVE SPINE CENTER PLLC
PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: ___/___/___

A. *CHIEF COMPLAINT*

1. Describe your current problem or injury: *Please list all injuries and specify which side.*
   _____
2. Current Problem is the result of (i.e. car accident, work accident, slip and fall, or other injury): _____
3. Date of Injury or Onset of Problem: _____
4. Have you been treated for this problem before: *If yes, please describe below. If no, please write 'No'*
   a. _____
5. Who referred you to our office? _____Physician/Friend/Relative
6. Who is your Primary Care Physician? _____

B. *CURRENT MEDICATIONS* ***(if you are not taking any medication, please write 'None')***

Name of Medicine_____Dose_____How Long_____Side Effects If Any_____
_____
_____
_____

C. *ALLERGIES* ***(If none, please write 'None'):*** _____

D. *SURGERIES/HOSPITALIZATIONS* ***(If none, please write 'None'****)*_____Date_____Any Complications__
_____
_____

E. *MEDICAL PROBLEMS -PLEASE LIST ALL-****(If None, please write 'None')*** *(ie, hypertension, diabetes, high cholesterol, osteoporosis/osteopenia, blood disorders, heart problems, cancer, stroke, mental health disorders, arthritis, etc.)*
_____
_____
_____

F. *DO YOU HAVE A FAMILY HISTORY OF MEDICAL PROBLEMS? (ie, parents or grandparents) (ie, hypertension, diabetes, high cholesterol, osteoporosis/osteopenia, blood disorders, heart problems, cancer, stroke, mental health disorders, arthritis, etc.)* ***If yes, please list. If no, please write 'No'.***
_____
_____
_____

G. *SOCIAL HISTORY*
Children (*Please indicate 'yes' or 'no'. If 'yes' please include how many)* _____
Alcohol Use: (*Please indicate 'yes' or 'no'. If 'yes' please include how often)* _____
Smoke Cigarettes: (*Please indicate 'yes' or 'no'. If 'yes' please include how many per day)* _____

COMPREHENSIVE SPINE CENTER PLLC

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other_____

Patient's Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined

Language Preferred ☐English ☐Spanish ☐Creole

Race ☐White ☐Asian ☐Black (African American) ☐American Indian or Alaskan Native

☐Native Hawaiian or Other Pacific Islander ☐Other_____

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Cellular_____

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship to Patient_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

Only for Auto Accident Patients:

Auto Ins. Name:_____ Claim Number: _____Date of Accident:_____

Adjuster Name: _____ Phone: _____ Ext: _____

Attorney Name: _____ Phone: _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Insured Date of Birth_____/___/_____ Insured's Social Security Number_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

Comprehensive Spine Center PLLC

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in my treatment
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that signing below may include consent at satellite offices under common ownership.

I, the undersigned, authorize the physicians of Comprehensive Spine Center to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) Signature ***Date***

Revision Date: December 22, 2014

Comprehensive Spine Center

AUTHORIZATION TO RECEIVE MEDICAL RECORDS/INFORMATION

I authorize the release of my medical records by the organization or physician listed below:
Physician's Name: _____
Physician's Address: 7710 NW 71st Court Suite 205, Tamarac, FL 33321
Physician's Phone #: 954-747-1221 Fax # of Physician: 954-747-1231
Reason for Records Release: Consultation

These records are to be sent to Comprehensive Spine Center at the fax number listed above.

Patient's Name: _____Date Of Birth: _____
Address: _____State:_____ Zip Code: _____
Social Security #: _____Phone#:_____
The type and amount of information to be disclosed is initialed as follows: (specify dates where appropriate)

____ X-Ray films (Specify type/date)
____Radiology Report
____Most recent 3 years of Records
____Entire Medical Record
____ Substance and Drug Abuse, if any
____ AIDS/HIV, if any
____ Genetic testing, from date
____Psychological or psychiatric conditions, if any
Other: _____

I understand this authorization will expire, without my revocation, two years from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I accept full financial responsibility for any copying or shipping fees and any applicable sales tax that may be charged.

Patients Signature_____ Date_____
Patient Name (Print) _____

Authorization to Discuss Medical Information

I hereby authorize you to use or disclose my medical condition/treatment/appointments/surgery/Misc. information to the parties listed below.

Patient Name: _____ Date of Birth: _____

Information to be given to:

Name: _____ Name: _____
Relationship: _____ Relationship: _____
Phone: _____ Phone: _____

This authorization shall remain in effect from the date signed below until (please check one):

□ NO EXPIRATION DATE
□ (specify expiration date or event) _____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting Comprehensive Spine Center, attention Medical Records.
- This authorization is giving Comprehensive Spine Center the right to discuss my medical information with the one or more people listed above.
- I may refuse to sign this authorization and the provider will not condition treatment on my providing this authorization

Signature: _____ **Date**: _____

ASSIGNMENT OF BENEFITS

Between

Client Name: _____ Date of Birth:_____

Primary Insurance Company:_____

And Comprehensive Spine Center

I have voluntarily agreed to be treated at Comprehensive Spine Center, I give Comprehensive Spine Center permission to bill and collect directly from my insurance company, and I am assigning my benefits to Comprehensive Spine center. I give Comprehensive Spine Center permission to release any information requested by my insurance company.
Ancillary charges included psychiatric consultations, medications, special therapies, and any outside medical care. These charges are not included in Comprehensive Spine Centers inclusive rate. I understand that the provider rendering care will be given my insurance information, and that I am responsible to that provider for services rendered.

I fully understand and agree that I am directly responsible to Comprehensive Spine Center for all bills submitted to my insurance company from Comprehensive Spine Center for treatment for services rendered to me. I understand that payment is not contingent on any insurance payment. I understand that I am personally responsible for my account. I agree that, should this account be referred to a collection agency that I would directly be responsible for all collections costs, attorney fees and court costs.

Patient: _____ Date: _____

Policy Holder Name:_____

FINANCIAL POLICY

As your physician(s), we are committed to giving you the best possible medical care. To achieve this goal, we need your assistance and understanding of our payment policy. We must emphasize that our concern is with you and your health, not with your insurance company. We realize that emergencies do arise and may effect timely payment of your account. If such extreme cases do occur, please contact our office promptly for assistance in the management of your account.

You will be required at each visit to present the office with your insurance card. You are also expected to notify of any changes in name, address, phone, or insurance information. Prior to your appointment, please check your insurance information so you can be informed about referrals, co-payments, and any deductibles required at the time of visit.

Unless arrangements have been made in advance, co-payments, co-insurance and any outstanding balances are expected at the time of service. Patient may be financially responsible for payment of all services, even if their insurance company does not pay. Patients accounts not paid promptly are the subject to third part collections and/or legal procedures.

If your insurance carrier has not responded to a claim within 90 days, we reserve the right to formally transfer all associated liability for the claim to the patient/guarantor. Failure to promptly resolve this balance may result in third party collections procedures.

MEDICARE PATIENTS: Any service routinely not covered by Medicare (i.e. Preventative Exams) we request that the services be paid at the time of service. We request the payment for the 20% of the allowable Medicare charges and any deductibles (if applicable) that has not been met at your time of visit.

If we are not participating providers with your plan, we will provide you with a receipt for you to file with your insurance company.

Any checks returned from the bank will result in a ($20) charge that will appear on your account.
If at any time you have an unanswered questions or concerns, please feel free to address those issues directly with our Office Manager.

By signing below I acknowledge I have read and understand the Comprehensive Spine Center financial policy.

Patient Signature: _____ Date: _____

OFFICE PRACTICES AND POLICIES

Cancellation, Rescheduling and Missed Appointment Policies:

- Appointment and cancellations:
  - Our office will confirm your appointment in advance by phone. If you are unable to keep your appointment as scheduled please make our office aware so that other patients may have the opportunity to take any available slots.
  - To cancel an appointment, please call our office at (954)-747-1221. Our regular office hours are Monday-Thursday, 9am-5pm, and Fridays, 9am-12pm.
    - If you cannot reach us in person or by phone, you may leave a message with your name, date and time of your scheduled appointment and your request to cancel or reschedule.
  - Missed appointments or appointments that were cancelled with less than 24 hour notice may be subject to a fee. This fee will vary by the type of appointment (i.e. provider appointment, therapy, or procedure)
- Prescription Refills Policies
  - If you call to request a refill but are overdue for a follow-up, the provider may agree to call in enough medication to a local pharmacy to last until we are able to schedule an office visit. It is your responsibility to schedule an appointment before you run out of medication. Please schedule and keep all appointments as directed by your physician. Periodic office visits are required to continue to receive medication in order to evaluate for possible side effects and provide continuity of care. Failure to keep regular office visits may result in the denial of medication refills.
- Disability Forms/ Reports
  - To cover the time that it takes the physician and staff to complete these requested forms, there may be an applicable fee. If the forms are presented and can be completed as part of your scheduled visit, there will be no charge. For the completion of forms and/or reports for someone other than your insurance company that are to be faxed outside of your appointment, there will be a charge of $10.00
- Duplication of Records
  - For the copy of your complete chart, our office will reserve the right to charge for the duplication of records per the Florida Statute fee schedule.

The Signature of the patient and/or patient representative below acknowledges that I have read and understand the office practices & policies.

Signature of Patient and/or Guardian: _____Date:_____

Print Full Name: _____

HIPPA NOTICE OF PRIVACY PRACTICES

This notice is effective as of ____/_____/_____

I have read the privacy notice and understand my rights contained in this notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____

Patients Name (Print)

_____ _____

Patients Signature Date

_____ _____

Authorized Facility Signature Date