***In Room New Patient Questionnaire***

|  |  |
| --- | --- |
| **Patient Name**:  |   |
|  |  |

What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where is your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What caused your pain? Have you had any treatment for this pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past history of this pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous injury or motor vehicle accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 0-10 what is your pain level?\_\_\_\_\_ On a scale of 0-10 what is your worst pain?\_\_\_\_\_

Is the pain: (Circle all that apply)

Shooting Tingling Numbness Aching Burning Deep Dull Sharp Stabbing Throbbing

What makes the pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications you are currently taking for pain or need refills on.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please use the key ↓below to indicate what you feel.**

**Key:**

****X = PAIN (dolor)

O = NUMBNESS (adormecimiento)

/ = ACHING (adolorido(a)) **\*** = PINS/NEEDLES (cosquilleo)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ SS# \_\_\_\_\_\_\_/\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ (required)

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: M F Married Widow Single Divorced/Separated Minor

Patient Employer/School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Physician** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance please give receptionist your photo ID and insurance cards**

**Do you have Health Insurance? YES / NO (If yes, please provide information and card)**

Insured Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address if different then above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health or Auto (PIP) Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Accident or Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_

Do you have secondary Insurance? Yes No Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance or Workers Compensation**

Claim Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance or WC Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address for Claims \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse Case Manager \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*If Attorney: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize USA Spine or insurance company to release any information required to process my claims.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Legal Guardian Signature Date

**PATIENT CONSENT FORM**

Welcome to USA SPINE. We will strive to help restore and improve your health but there are no guarantees or promises of improvement or complete recovery.

Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability, religious or political beliefs; these quality healthcare services will be delivered with dignity and concern.

Your signature on this document fully authorizes our doctor and staff to perform any examination, diagnostic tests and/or treatments as well as we may consider medically necessary & to release all information pertinent to your health, insurance, or benefits to any & all applicable parties on your behalf.

Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document confirms that you have read, understand and agree to comply with all terms & conditions regarding your responsibilities to USA SPINE and that you grant the physician and staff to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern USA SPINE operations and responsibilities.

As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in a while.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**FINANCIAL POLICY-COMMERCIAL, MEDICARE & SELFPAY**

**FINANCIAL POLICY-COMMERCIAL, MEDICARE & SELFPAY**

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility and staff are NOT responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligation or arrangements between you and your attorney, insurance company, liable or third party payer are between you and said person or party.

1. Our facility will file initial insurance claims for you. Secondary claims submissions and/or additional reports and/or documents sent on your behalf may result in an additional filing and/or medical report charges, which you will be responsible for paying. (These fees and payments will be discussed prior to so that proper payment can be made prior to any further services being rendered).
2. Co-pays, Deductibles and all Non-Covered Services charges will be due at the time of service. Due to our office being a multi-disciplinary practice all providers are subject to separate co-pays. For your convenience this office accepts: **Cash/Check/Debit/Credit Cards.**
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. A service charge is computed by a “periodic rate” of 1 ½% per month. 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collections related expenses, attorney fees, court & filing fees.
5. Returned checks, debit and credit charges made payable to the facility for insufficient funds, stop payments or other expenses of non-payment will be assessed a $30.00 charge.

MEDICARE PATIENTS/MEDICARE REPLACEMENT POLICIES

Patients who qualify for Medicare and those Medicare replacement policies will be limited to the services that are covered under their healthcare insurance. We try to do our very best to notify these types of patients in advance by having you sign an ABN form (Advance Beneficiary Notice). This form outlines the services that ARE and are NOT covered in our office. Please be sure and inquire with our front desk if you have NOT received one of these forms.

**MEDICARE PATIENT CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I certify that the information given to me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or related Medicare claim(s). I request that payment of authorized benefits be made on my behalf; I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

ASSIGNMENT OF BENEFITS

I hereby assign rights and benefits of any applicable insurance policy directly to USA Spine accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician’s regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay. It is further agreed that any credit or balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician by the insured or his/her family.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: Date:

What is the main reason you are here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Past Medical History (Check all that apply)**

\_\_ Diabetes \_\_High Blood Pressure \_\_Heart Disease \_\_Heart Attack

\_\_ Asthma \_\_Bronchitis or Emphysema \_\_Pneumonia \_\_Ulcers

\_\_Hypo/Hyper Thyroid \_\_Rheumatoid Arthritis \_\_History of Cancer \_\_Blood Clots

\_\_High Cholesterol \_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_ type: \_\_\_\_\_\_\_\_\_ \_\_HIV/Hepatitis C

 **Past Surgical History**

\_\_Appendix (Appendectomy) \_\_Breast Surgery \_\_Tonsillectomy

\_\_Gall Bladder (Cholecystectomy) \_\_ Back Surgery \_\_Hysterectomy

\_\_Heart Bypass \_\_Total Joint Replacement \_\_Arthroscopy

\_\_Prostate \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Family Medical History**

Has anyone in your immediate family died of heart disease: YES NO

Has anyone in your family had an adverse reaction to anesthesia: YES NO

Has anyone in your family had an adverse reaction to Latex: YES NO

List any medical illnesses that run in your family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Social History**

Who do you live with now: By yourself Spouse Other family Friends Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke tobacco? YES NO How much? \_\_\_\_\_\_\_\_ packs per day How long? \_\_\_\_\_\_ years

Do you drink alcohol? YES NO How much? \_\_\_\_\_\_\_ drinks per day How long? \_\_\_\_\_\_\_ years

Are you currently working? YES NO If yes, where do you work?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING? Please circle if yes

**Constitutional Symptoms Eyes Allergic Ear/Nose/Throat Genitourinary**

Fever Blurred vision Hay Fever Ear Infection Urine Retention

Chills Double Vision Drug Allergies Sore Throat Painful Urination

Headache Pain Other\_\_\_\_\_\_\_\_ Sinus Problems Urinary Frequency

**Neurological Endocrine Gastrointestinal Respiratory Hematologic/Lymphatic**

Tremors Excessive Thirst Abdominal Pain Frequent Cough Swollen Glands

Dizzy Spells Too hot/ cold Nausea/Vomiting Short of Breath Blood Clots

Numbness/Tingling Tired/sluggish Rectal bleeding Wheezing Bleeding Problems

**Cardiovascular** **Integumentary** **Musculoskeletal** **Psychological**

Chest Pain Skin Rash Joint Pain History of depression

Varicose Veins Boils Neck Pain History of bipolar disorder

High BP Persistent Itch Back pain History of schizophrenia

Other Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Height\_\_\_\_\_\_\_\_Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications: YES NO If so what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please specify any prior tests you have undergone for this problem.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Test** | **Date** | **Test** | **Date**  | **Test** | **Date** |
| Plain X-ray |  | Nuclear Bone Scan |  | Myelogram |  |
| MRI |  | NCS/EMG |  | Arthrogram |  |
| CT scan |  | Dexa scan |  | Discogram |  |
| Other |  |  |  |  |  |
|  |  |  |  |  |  |

Please mark any prior treatments that you have had for this problem and the number of times you have had each

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Treatment** | **X** | **Helpful Yes/No** | **# of injections** | **Dates of each** |
| Epidural steroid injection |  |  |  |  |
| Facet injection |  |  |  |  |
| Sacroiliac injection |  |  |  |  |
| Hip injection |  |  |  |  |
| Radiofrequency ablation |  |  |  |  |
| Discectomy |  |  |  |  |
| Vertebroplasty |  |  |  |  |
| Trigger Points |  |  |  |  |
| Nerve blocks |  |  |  |  |

Please list any other PHYSICIANS (MD, DO, CHIROPRACTIC) you have or are currently seeing for this problem

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Physician** | **Specialty** | **Treatment/Testing** | **Phone Number** | **Date of Last Visit** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

CURRENT MEDICATIONS (List all medications. Use back of this sheet if you need more room)

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICATION** | **DOSAGE**  | **#PER DAY/FREQUENCY** | **REASON FOR TAKING** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please use the key below to indicate the location(s) of pain.

 

Key:

X= PAIN

O= NUMBNESS

/= ACHING

\*= PINS/NEEDLES

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Activities of daily living:**

**Please mark the items which are difficult to perform or you are unable to perform since the injury. Please only mark if you were previously performing the activity.**

Difficult Unable To Perform

Laundry \_\_\_\_\_\_ \_\_\_\_\_\_

Vacuum \_\_\_\_\_\_ \_\_\_\_\_\_

Dishes \_\_\_\_\_\_ \_\_\_\_\_\_

Mop Floors \_\_\_\_\_\_ \_\_\_\_\_\_

Sweep Floors \_\_\_\_\_\_ \_\_\_\_\_\_

Dust \_\_\_\_\_\_ \_\_\_\_\_\_

Make Bed \_\_\_\_\_\_ \_\_\_\_\_\_

Cook Meals \_\_\_\_\_\_ \_\_\_\_\_\_

Drive Car \_\_\_\_\_\_ \_\_\_\_\_\_

Put On Clothes \_\_\_\_\_\_ \_\_\_\_\_\_

Get Into/Out of Bath or Shower \_\_\_\_\_\_ \_\_\_\_\_\_

Walk From House to Get Mail \_\_\_\_\_\_ \_\_\_\_\_\_

Brush Hair \_\_\_\_\_\_ \_\_\_\_\_\_

Shave \_\_\_\_\_\_ \_\_\_\_\_\_

Other \_\_\_\_\_\_ \_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Records Release Authorization**

**In order to avoid a delay this form must be completed in its entirety. PLEASE PRINT CLEARLY**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B. **(Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** SS# **(Required)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission is hereby granted to Colleen Maxcy, MD and USA SPINE to release medical information to the individual / organization as noted below or to have records released to Colleen Maxcy, MD and USA SPINE:

Mail to: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Fax to another medical entity Call when ready for pick up Person picking up records

(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check information to be released:

 All records, excluding records from other physicians. Office Notes only

 Surgical Records X-ray/MRI films

 Therapy reports X-ray/MRI reports

 Diagnostic test results Patient information

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization will be valid for two years after the date of the patient’s signature as it appears below, or by whichever comes sooner.

I understand I have the right to refuse this authorization, in writing, Dr Colleen Maxcy, MD and USA SPINE is released from all legal liability that may arise from the released information requested.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient/Legal Guardian Date

**Notice of Privacy Practice**

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review carefully.

At USA Spine we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act require us to continue to maintain your privacy, to give you this notice and follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we will want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your medical records to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copies, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice.

Patient Name (Printed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain Management Agreement

The purpose of this agreement is to prevent misunderstanding about certain medicine(s) you will be taking for the control of your pain. This is also to help you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that if I break this agreement which is essential to the trust and confidence necessary in a doctor/patient relationship, based on this agreement, the doctor has the right to discharge me as a patient of the practice.

I understand that if I break this agreement, my doctor will stop prescribing these pain control medicines. In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment program will be recommended.

I have communicated, and will continue to communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve the pain.

I will not use illegal controlled substances, including marijuana, cocaine etc. at any time.

I will inform Dr. Maxcy/Dr.Panagakos of all the medications I am presently taking, including all remaining refills. I will not attempt to obtain any controlled medicines which include controlled opium pain medicines and refills, controlled stimulants or anti-anxiety medicines from any other doctor.

I will not share, sell or trade my medication with anyone.

I will safeguard my pain medicine(s) from loss or theft. Lost or stolen medicines will not be replaced.

I understand that Dr. Maxcy/Dr.Panagakos reserves the right to terminate my care and treatment if such is the case at anytime.

Medication refill requests should be made at a minimum of 48 hours in advance. By law, some medications require a written prescription or a follow up appointment for refills. Prescriptions will not be called in on the weekends or after hours. If there is an emergency please go to the nearest emergency room.

I agree to use the pharmacy listed below to fill my pain medicine(s).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name Location Phone #

I have read, understand and agree with ALL of the above mentioned

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Print) Patient Signature Date

NO SHOW AND CANCELLATION POLICY

\_\_\_ Initials: Your time is very important to us, to be respectful of the medical needs of our Patients, please be courteous and call promptly if you are unable to attend an appointment/Procedure. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment/Procedure, we require that you call 48Hours in advance. Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care.

If you show up more than 15 minutes after your scheduled appointment/Procedure time, you will be considered a "No Show" and will need to reschedule your appointment.

To cancel an appointment/Procedure, please contact our office at (813)-855-8400; if you’re unable to reach someone please leave a detailed message stating your Name, Date, and time of the appointment.

Any cancellations within 48 hours or no-shows will be considered as " No Show" and will be subjected to a $75.00 cancellation fee.

GUARENTEE OF PAYMENT

\_\_\_ Initials: For value received, including, but not limited to the services rendered, I agree to pay USA Spine all charges and expenses incurred in my treatment. This would include those expenses not covered by my insurance policy, any co-payment and/ or deductible. Unless specifically agreed in writing, all charges shall be paid at discharge, time of visit or upon presentation of any bills by USA Spine.

Patients/Guarantor (Print Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guarantor (Signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_

USA SPINE, LLC- LETTER OF AGREEMENT

RE: Patient Name: ("Patient")

 Attorney Name: Date of Accident:

In recognition of the foregoing, Patient hereby authorizes and directs the attorney, ("Attorney"), upon receipt by the Attorney of any proceeds of my claim or lawsuit relating to my Injury (whether such proceeds arise from a settlements judgment, structured settlement or otherwise) (collectively, "Proceeds"), to pay directly to USA SPINE their entire Medical Bill. Payment or my Medical Bill shall be paid to USA SPINE prior to the Attorney disbursing any Proceeds to the patient.

Patient fully understands that they are directly responsible to USA SPINE for the entire amount of the Medical Bill. Furthermore, Patient understands that their payment obligation is not contingent upon my recovery of any Proceeds.

In order to secure my obligation to pay the amount of my Medical Bill to USA SPINE, and in consideration for USA SPINE's agreements set forth herein, Patient hereby grants to USA SPINE, in accordance with the Uniform Commercial Code as in effect in the applicable jurisdiction, a security interest in and lien upon: (i) the Proceeds; and (ii) all proceeds thereof, in each case whether now owned or hereafter existing, acquired or arising, and wherever located, Patient authorizes USA SPINE to file one or more UCC financing statements (and continuations thereof) naming me as debtor and evidencing USA SPINE's security interest in such collateral.

Patients understand that they are not assigning or granting any interest in the lawsuit to USA SPINE, but rather the Patient is granting a security interest in a portion of the proceeds of the lawsuit. USA SPINE will play no role whatsoever in the prosecution or the settlement of the lawsuit. In consideration of the Patient's acknowledgments and agreements contained herein, USA SPINE agrees that it will forbear from taking any action to collect the Medical Bill (including by forbearing from reporting this matter to a collection agency and/or filing suit against the Patient) while the Patient is prosecuting any lawsuit relating to Patient's Injury.

If any provision of this agreement is held to be illegal, invalid, or unenforceable, such provision shall be fully severable, and the remaining provisions of this agreement shall remain in full force and effect and shall not be affected thereby.

This agreement may be executed in any number of counterparts, each of which when so executed shall be deemed to be an original and all of which when taken together shall constitute one and the same agreement.

This agreement in no way waives any rights of USA SPINE to pursue payment from the Patients personal injury protection insurance carrier, provided that any insurance recovery by USA SPINE shall be applied against the amount of the outstanding Medical Bill. Patient agrees to hold the Attorney harmless for disbursing Proceeds to USA SPINE in accordance with this agreement. This agreement is irrevocable and shall apply in the event that Patient retains substitute counsel or CO-counsel or elects not to have counsel. This agreement shall be governed by and construed in accordance with the laws of the State of Florida. This agreement shall be binding on, and shall insure to the benefit of, the parties hereto and their respective successors and permitted assigns. USA SPINE may at any time assign or transfer any of its rights or obligations hereunder without notice to or the consent of the Patient. The Patient may not assign or transfer any of its rights or obligations hereunder without the prior consent of USA SPINE. Any purported assignment in violation of the foregoing shall be null and void.

The Attorney does hereby agree to observe all the terms of the above agreement and agrees to withhold from the Proceeds and disburse to USA SPINE after attorney fees and costs are paid first the amount of the Medical Bill (to the extent that the Proceeds that are recovered are sufficient to pay the Medical Bill). The Attorney further agrees to withhold the amount of the Medical Bill from any recovery and retain the total Proceeds in the Attorney's client trust account until such time as USA SPINE and the Attorney agree to the amount of distribution.

The Attorney shall keep USA SPINE fully apprised of the status of the Patient's claim or lawsuit upon request. Attorney will provide USA SPINE with a closing statement, including, but not limited to, the total Proceeds, Other provider bills, costs, attorneys' fees and amounts distributed to the Patient.

The Attorney further agrees to notify USA SPINE of any substitution of counsel, addition of co-counsel or any subsequent termination of the Attorney's attorney-client relationship with the Patient within ten (10) days of any such event.

Attorney Signature Date

Patient Signature Date

USA SPINE LIEN OF RESPONSIBILITY

THE UNDERSIGNED patient, for good consideration does hereby unconditionally agree to pay USA Spine, 4728 N Habana Ave 33614, Tampa, Florida, for charges and fees from any settlement proceeds, insurance payments, or third-party compensation for USA Spine services received as the result of injury, accident or condition which relates to services rendered by, USA Spine before any other expenses or fees are paid from the proceeds. USA Spine is granted an irrevocable primary lien on said funds. This agreement is irrevocable by the patient and may be considered fully effective as a promissory note in the event a collection action is necessitated.



IN THE EVENT THAT Counsel is not representing patient at the time proceeds are received or if they are received directly by patient, USA Spine lien shall attach to said funds, notwithstanding the lack of counsel or changes with respect to counsel. Alternatively, patent further agrees that this lien shall continue to bind patient and successor counsel will acknowledge this agreement in writing to USA Spine promptly in the event of any change of counsel. I authorize USA Spine to furnish my attorney with medical records and ledger for myself in regard to the accident referenced below. I also authorize my attorney to discuss my case with representatives of USA Spine.

USA Spine may record as lien on its behalf in public records and shall have the authority to execute financing statements with respects hereto. USA Spine reserves the discretionary right to at any time to pursue collection of the fees and charges owed, plus interest, court costs, and professional fees reasonably incurred at any time after (10) days’ notice given.

IF SIGNED by patient before being signed by patient's legal counsel, patient agrees to forward a copy of this Agreement to patient's legal counsel and to request that such counsel promptly sign and forward the agreement to USA Spine.

 DATE PATIENT'S SIGNATURE

##  PATIENT'S FULL NAME DATE OF INJURY DOB

USA Spine

BY:

 DATE Title:

THE UNDERSIGNED, as attorney for the above referenced patient, does herby confirm agreement to the above.

 SIGNATURE ATTORNEY'S NAME

ASSIGNMENT OF BENEFITS, LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE BISURANCE INFORMATION. AND AUTHORIZATION TO ESCROW UNPAID MEDICAL & PIP BENEFITS

**USA Spine**

NSURANCE CARRIER: POLICY NUMBER: DATE OF LOSS:

For and in consideration of USA Spine agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assiB1 all rights and benefits to USA Spine for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute 5627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize USA Spine to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to USA Spine against any and all insurance benefits named and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by USA Spine as a result of the above stated loss date. This document acts as an irrevocable absolute assignment of my rights and benefits to the extent of the charges for services provided. I agree to cooperate with USA Spine and their attorney’s (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to USA Spine including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns only the bills for USA Spine 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 co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, USA Spine will bill and pursue 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 USA Spine at 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 USA Spine at the address on the bill. USA Spine medical care is being provided for a reasonable fee for treatment causally related to the above loss date 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 charges into escrow and hold the escrowed funds until agreement or resolution of legal action by USA Spine. I further instruct my insurance company to make payment for charges submitted by USA Spine in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give USA Spine limited power of attorney to endorse and sign my name on any draft for payment to either USA Spine or myself if said draft represents payment for charges related to services rendered by USA Spine.

I further direct my insurance carrier or responsible other entity to provide information to USA Spine which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, review reports, and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly as a "PIP log". This request includes the name of other medical providers to whom payments have been under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor Of USA Spine. 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 Date Patient Name

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.