Spine Surgery

Richard M. Foltz, MD
Robert P. Norton, MD

FLORIDA SPINE ASSOCIATES
TAKE BACK YOUR LIFE

Interventional Pain Medicine

Brian J. Burrough, MD

PATIENT INFORMATION

PLEASE PRINT

Last Name: _____ *First Name*: _____ *MI*: _____

Address: _____ *City*: _____

State: ____ *Zip Code*: _____ *Email*: _____

Home Phone: (____)_____-_____ *Cellphone*: (____)_____-_____ *Work Phone*: (____)_____-_____

Date of Birth: ____/____/_____ *Age*: _____ *Sex*: M / F *Social Security*: _____-_____-_____

Race: _____ *Ethnicity*: Hispanic / Not Hispanic

Language: _____ *Marital Status*: _____

Employer: _____ *Work Address*: _____

Referring Doctor: _____ *Phone*: (____)_____-_____ *Fax*: (____)_____-_____

Primary Care Doctor: _____ *Phone*: (____)_____-_____ *Fax*: (____)_____-_____

Pharmacy Name: _____ *Address*: _____ *Phone*: (____)_____-_____

Emergency Contact: _____ *Relationship*: _____ *Phone*: (____)_____-_____

Is this office visit due to an accident? Yes / No *Date of Injury*: ____/____/_____

Please circle one: Auto Worker's Comp Other: _____

Attorney's name: _____ *Phone*: (___)____-_____ *Fax*: (____)_____-_____

APPOINTMENT POLICY FOR FLORIDA SPINE ASSOCIATES

I _____ *(print name)* understand the appointment policy as outlined below.

Florida Spine Associates offers appointment times from 8:30 A.M. to 5:00 P.M. to accommodate our patients' specific needs. Your appointment time is reserved just for you and scheduled specifically to provide quality medical care during your scheduled visit.

As a courtesy, our staff provides a telephone reminder 1 day before your appointment, providing you with options to confirm and cancel prior to your scheduled time. Our check-out staff will also offer you a reminder card with your appointment times listed.

In the event that you must cancel your appointment, we request that you provide our office at minimum 24-hours' notice.

Effective 06/01/2017, a $50.00 fee will be assessed to any patient who does not show for a scheduled visit or who cancels an appointment without 24-hours' notice.

In the event an unforeseen circumstance requires an appointment to be cancelled without 24-hours' notice, the $50.00 fee will be waived provided the appointment is rescheduled within 1 business day*.

_____ ____/____/_____

Patient / Guardian Signature ***Date***

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AUTHORIZATION FOR USE OF PROTECTED HEALTH

Last Name: _____ *First Name*: _____ *MI*: _____

Date of Birth: ____/____/_____

1. I authorize Florida Spine Associates to disclose / receive my health information specific to the following date or time period: _____
2. I authorize Florida Spine Associates to receive my health information if applicable, including but not limited to:

   Practitioner Summary, History and physical exam, Office chart notes, Emergency room report, Laboratory Report, Radiology Report, Consultations, Prescriptions, HIV, Treatment for alcohol and/or drug abuse, Mental Health, Genetic Testing, and/or information related to my injury/illness and/or settlement.
3. I understand that if the person(s) or entity (ies) that received the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Florida Spine Associates, its employees, and my physicians from all liability arising from this disclosure of my health information.
4. I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will not expire from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the Medical Records Department, knowing that previously disclosed information would not be subject to my revoke request.
5. ___I DO NOT authorize the release of my medical information other than to myself.
6. ___I DO authorize the following person(s) to receive or discuss my medical conditions:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ ____/____/_____

Patient Signature ***Date***

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FINANCIAL RESPONSIBILITY

Insurance Benefits: I, the undersigned, hereby authorize Florida Spine Associates to release any information acquired in the course of my examination and/or treatment to social security administration and healthcare financing administration or its intermediaries or carries, any information needed for Medicare, MEDIGAP, or other insurance claims. I permit a copy of this authorization to be used in place of the original and I request payment of medical insurance benefits either to myself or to the party who accepts assignment. This is a lifetime authorization. I agree to pay in full for all medical services rendered by Florida Spine Associates. If I fail to pay my charges, I agree to pay the cost of collection, including reasonable attorney fees.

HEALTH INSURANCE INFORMATION

Insurance carrier name: _____ *Subscriber name:* _____

Subscriber date of birth: ____/____/_____ *Subscriber Social Security*: _____-_____-_____

Patient relationship to subscriber: _____

ASSIGNMENT OF BENEFITS

I, the undersigned, whose name appears below, hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Florida Spine Associates for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any.

CONSENT FOR TREATMENT

I, the undersigned, whose name appears below, hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the attending physician.

AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned, whose name appears below, hereby authorize Florida Spine Associates to:

1. Release any information necessary to insurance carriers regarding my illness and treatments.
2. Process insurance claims generated in the course of examination or treatment.
3. Allow a photocopy of this assignment is to be considered as valid as the original and may be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Florida Spine Associates on behalf of myself and/or my dependents, and I understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

_____ ____/____/_____

Patient Signature ***Date***

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PAIN TREATMENT WITH OPIOD MEDICATIONS: PATIENT AGREEMENT

I understand that I have a right to comprehensive pain management. I wish to enter a treatment agreement to prevent possible chemical dependency. I understand that failure to follow any of these agreed statements might result in the doctor not providing ongoing care for me. **I agree to the following statements:**

– *I will not accept any narcotic prescriptions from another doctor.*
– *I will be responsible for making sure that I do not run out of my medications on weekends and holidays, because abrupt discontinuation of these medications can cause severe withdrawal syndrome.*
– *I understand that I must keep my medications in a safe place. I understand that the doctor will not supply additional refills for the prescriptions of medications that I may lose.*
– *I will not give my prescriptions to anyone else.*
– *I will only use one pharmacy.*
– *I will keep my scheduled appointments with the doctor unless I give notice of cancellation 24 hours in advance.*
– *I agree to refrain from all mind/mood altering/illicit/addicting drugs including alcohol unless authorized by the doctor.*
– *My treatment plan may change based on outcome of therapy, especially if pain medications are ineffective. Such medications will be discontinued.*
– *I agree to give a blood, urine, or saliva sample, if asked, to test for drug use.*

I understand that the doctor believes in the following "Pain Patients Bill of Rights." **As a patient, I have the right to:**

– *Have your pain prevented or controlled adequately.*
– *Have your pain and medication history taken.*
– *Have your pain questions answered.*
– *Know what medication, treatment or anesthesia will be given.*
– *Know the risks, benefits, and side effects of treatment.*
– *Know what alternative pain treatments may be available.*
– *Ask for changes in treatments if your pain persists.*
– *Receive compassionate and sympathetic care.*
– *Receive pain medication on a timely basis.*
– *Refuse treatment without prejudice from your physician.*
– *Include your family in decision-making.*

SAMPLE TERMINATION CLAUSES

– The doctor may terminate this agreement at any time if he has cause to believe that I am not complying with the terms of this agreement, or to believe that I have made a misrepresentation or false statement concerning my pain or my compliance with the terms of this agreement.
– I understand that I may terminate this agreement at any time.
– If the agreement is terminated, I will not be a patient of the doctor and would strongly consider treatment for chemical dependency if clinically indicated.

_____ ____/____/_____

Patient's Signature ***Date***

_____

Patient's Printed Name

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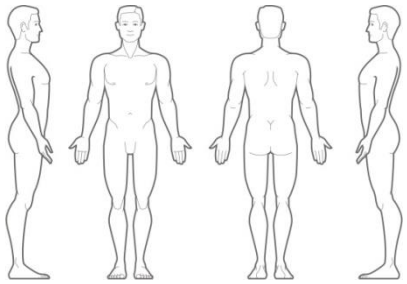
MEDICAL QUESTIONNAIRE

Patient's Name: _____ *Date of Birth*: ____/____/_____

1. Reason for Visit (If pain, mention body part): _____



2. Date of Onset / Duration of Symptoms: _____
3. What conservative treatment have you had since your injury/problem began?
   - ☐ Ice/heat
   - ☐ Chiropractic Care
   - ☐ Physical Therapy
   - ☐ Acupuncture
   - ☐ **Previous Medications**:_____
   - ☐ Injections (Ex, epidurals, nerve blocks, etc). If yes, please specify and include dates: _____
4. On a scale of 0-10 (with 10 being the worst pain imaginable), how would you score your pain today? ____/10
5. Check the words that best describe the character of the pain you are having today:
   - ☐ Aching pain ☐ Numbness ☐ Sharp pain ☐ Shooting pain ☐ Burning pain
   - ☐ Throbbing pain ☐ Stabbing pain ☐ Other:_____
6. What makes your symptoms better? _____
7. What makes your symptoms worse? _____

WORK/MOTOR VEHICLE INJURY

1.	Is your injury work related?	☐ Yes	☐ No
2.	Do you have any work restrictions?	☐ Yes	☐ No
3.	Have you missed any work as a result of this injury?	☐ Yes	☐ No
4.	Is your injury due to a motor vehicle accident?	☐ Yes	☐ No
	If yes:		
a.	Were you wearing a seatbelt?	☐ Yes	☐ No
b.	Did you hit your head?	☐ Yes	☐ No
c.	Did you lose consciousness?	☐ Yes	☐ No
d.	Were the airbags of your vehicle deployed?	☐ Yes	☐ No

e. How fast was your car traveling? _____
f. How fast was (were) the other car(s) traveling? _____
g. Were you the driver, front passenger, rear passenger, or pedestrian? _____
h. Were you hit from the back, front, driver, passenger, or driver side? _____
i. Did you go to the hospital after the incident? If so, which hospital? _____

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MEDICAL HISTORY

Medication **allergies**: _____

Current Medications, including over-the-counter and herbal supplements: _____

_____

_____

Please check the following options if applicable:

Past Medical History

☐ Cancer (If yes, please specify)
Location: _____
Type: _____
☐ Diabetes
☐ High Blood Pressure
☐ Heart Disease
☐ Liver Disease
☐ Peptic Ulcers
☐ Anemia
☐ HIV or AIDS
☐ Kidney Disease
☐ Asthma
☐ Epilepsy
☐ Glaucoma
☐ Thyroid Disease
☐ Arthritis
☐ Gout
☐ Stroke/TIA
☐ Alcohol/Drug Abuse
☐ Other: _____
_____

Past Surgical History and Date

☐ Cervical _____
☐ Thoracic _____
☐ Lumbar _____
☐ Tonsils _____
☐ Appendectomy _____
☐ Gallbladder _____
☐ Cardiac Bypass _____
☐ Joint replacements _____
Joint(s) _____
☐ Cataracts _____
☐ Other: _____
_____

Family History

☐ Cancer (If yes, please specify)
Location: _____
Type: _____
☐ Diabetes
☐ High Blood Pressure
☐ Heart Disease
☐ Liver Disease
☐ Peptic Ulcers
☐ Anemia
☐ HIV or AIDS
☐ Kidney Disease
☐ Asthma
☐ Epilepsy
☐ Glaucoma
☐ Thyroid Disease
☐ Arthritis
☐ Gout
☐ Stroke/TIA
☐ Alcohol/Drug Abuse
☐ Other: _____
_____

Social History:

☐ Married ☐ Single
☐ Divorced ☐ Widowed

Alcohol Use

☐ None ☐ Rare
☐ Social ☐ Frequent

Smoking History

☐ Nonsmoker
☐ Current Smoker
If yes, how many packs a day?
_____
☐ Previous Smoker
If yes, how long ago did you quit?_____

Review of Systems

In the last 30 days, have you experienced any of the following symptoms?

☐ Fevers/chills
☐ Weight changes
☐ Vision changes
☐ Hearing Changes
☐ Difficulty Swallowing
☐ Rash
☐ Palpitations
☐ Shortness of Breath
☐ Nausea/vomiting
☐ Diarrhea
☐ Constipation
☐ Difficulty urinating
☐ Inability to control bowels
☐ Inability to control bladder
☐ Fatigue
☐ Depression/Anxiety
☐ Suicidal Ideation
☐ Migraines/Headaches
☐ Insomnia