

PATIENT INFORMATION

(PLEASE PRINT & FILL OUT COMPLETELY)

Patient Name _____ Date of Birth _____ Age _____ Sex _____ SS# _____
 Local Address _____ City _____ State _____ Zip _____
 Permanent Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____ Email _____
 Name of closest relative not living with you _____ Phone # _____
 Relatives Address _____ City _____ State _____ Zip _____

COMPLAINTS AND MEDICAL INFORMATION

Complaint, Symptoms _____
 Did your pain start _____ gradually or _____ suddenly? When did your back or neck pain begin? _____
 Can you walk without pain? _____ Yes _____ No. What time of day is your pain worse? _____ Morning _____ Later in day _____ Middle of night
 Do you feel unsteady in your gait? _____ Yes _____ No Do you have difficulty buttoning your shirt, combing hair? _____ Yes _____ No
 Cause (Work Comp, Auto, Etc) _____ Date of Injury _____
 Past Treatment for this problem (By whom, Hospital, etc.) _____
 List treatments that have helped _____ List treatments that have made it worse _____
 Were X-Rays taken? Yes _____ No _____ If yes, where? _____
 Consulting Physician _____ (circle one) DO MD DC Phone# _____
 Family Physician _____ Phone# _____
 Have any members of your family been treated by our Physicians? No _____ Yes _____ Whom? _____

PRESENT MEDICATIONS

SOCIAL HISTORY

DRUG	STRENGTH	FREQUENCY
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		

Married _____ Single _____ Divorced _____
 Number of Children Living _____
 Presently Living Alone? _____
 Do you Smoke? _____ Yes _____ No _____ Never _____
 If yes, how many packs per day? _____
 Use tobacco products? _____ Yes _____ No _____ Never _____
 Alcohol: _____ Never _____ Occasional _____ Mod to Heavy _____
 Drug Overuse _____ Never _____ Present _____ Past

Allergies: None Known, Penicillin, Sulfa, Aspirin, Other _____

PAST MEDICAL HISTORY (Circle all that apply)

Diabetes, High Blood Pressure, Heart Attack, Heart disease, Emphysema, Neurological Disease, Hepatitis, Seizures, Thyroid disease, Asthma, Reflux, HIV (Aids), Stroke, TB, Phlebitis, Kidney Disease, Multiple Infections, Cancer (where _____) Other _____

PAST SURGICAL HISTORY (Circle all that apply)

Heart Bypass, Angioplasty/Stents, Tonsillectomy, Appendectomy, Gall Bladder, Prostate, Hysterectomy, Spine (Cervical/Thoracic/Lumbar), Cataract, Fracture (where _____), Cancer (where _____), Other _____

Patient Signature _____ Date _____

Physicians Signature _____ Date _____

EMPLOYMENT INFORMATION

Patient's Employer _____ Your Position _____
 Address _____ City _____ State _____ Zip _____
 Spouse or Parent's Employer _____ Phone # _____

INSURANCE INFORMATION

1. Primary Insurance Co. _____ ID # _____ Group # _____
 Policyholder _____ Relationship _____ Policyholder's date of Birth _____
 Insurance Claim Address _____ Policyholder SS# _____
 2. Secondary Insurance Co. _____ ID# _____ Group # _____
 Policyholder _____ Relationship _____ Policyholders date of Birth _____
 Insurance Claim Address _____ Policyholder SS# _____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I authorize payment from my insurance carrier, attorney and /or other parties to **Southeastern Spine Center** with the understanding that all monies will be credited to my account upon receipt. **However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment.** If **Southeastern Spine Center** is required to attain the services of an attorney or other collection agency to collect the sums which I owe, I will be required to pay for all legal fees and costs incurred by **Southeastern Spine Center**.

I authorize **Southeastern Spine Center** to furnish/me or my insurance company, and physicians or health care providers with my medical records or information requested regarding my past or present condition(s) or treatment(s).

Patient or Guardian _____ Date _____

OUR FINANCIAL POLICY

Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care. Our fees are comparable with the fees of other Orthopedic Physicians in the area.

Insurance "Usual and Customary": Our fees are generally considered to fall within acceptable range of usual and customary by most companies, and therefore are normally covered up to the maximum allowances determined by each carrier. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

Our Policy: Our policy requires payment at time of services. All charges are your responsibility from the date services are rendered. We will assist you in filing your own insurance claim and will provide you with an itemized charge ticket that you can simply send to your insurance carrier to expedite your reimbursement. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.

HMO & PPO Members: If you are a member of an HMO or PPO, in which we participate, your deductible or co payment is required at time of service. You are also responsible to see that we have a current authorization for each visit if your insurance carrier requires one. If you come to the office for an appointment without a valid authorization, you will not be seen.

Private Insurance: Our office files insurance claims to all insurance carriers who we participate with. Please check with our office personnel to be sure that your insurance is one that we file. All services we submit on your behalf are still your responsibility. We expect monthly payments on all services 30 days and older.

No Participating Provider: (Out of Network Insurances). If your insurance provider does not recognize our practice, or a particular Physician within our practice, your appointment would be considered an Out of Network appointment. Therefore it would be solely your responsible to pay **Southeastern Spine Center** any and all of the Out of Network Yearly Deductible plus the co-pay required for services rendered. Additionally, your insurance company would re-reimburse you for services which you would then be required to sign the Insurance Company check over to Southeastern Spine Center for payment of your account.

Medicare: We are participating with Medicare. Our office submits all charges to Medicare. We also as a courtesy file to your supplementary insurance in most cases.

Medicaid: We do not accept Medicaid at **Southeastern Spine Center**. If you have Medicaid as your secondary insurance to Medicare, you will be responsible for the 20% payment to **Southeastern Spine Center**.

FAMILY HISTORY – If a member of your family has had a history of any of the following conditions please circle.

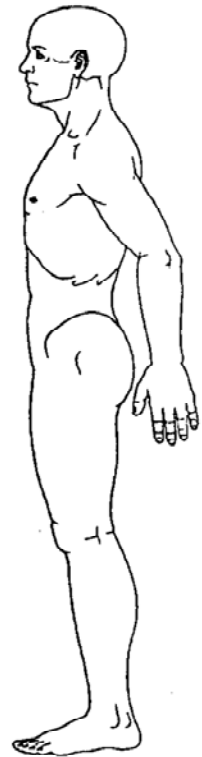
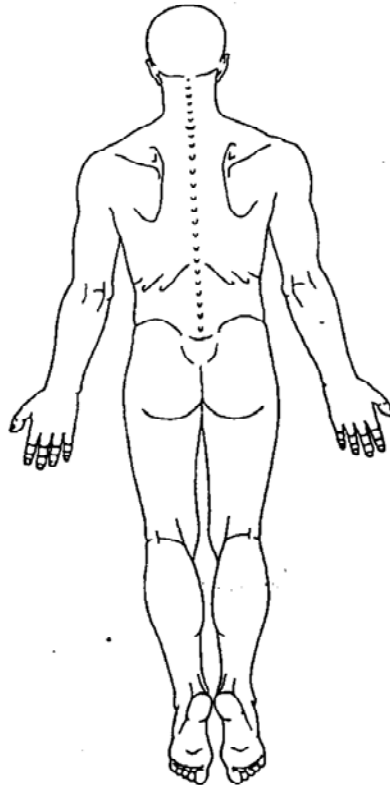
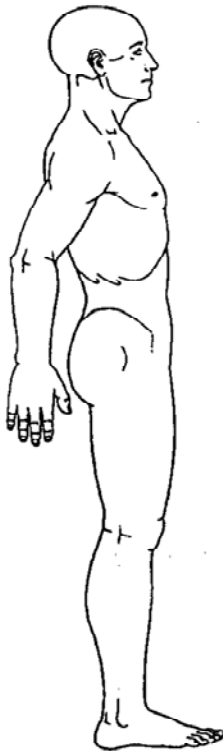
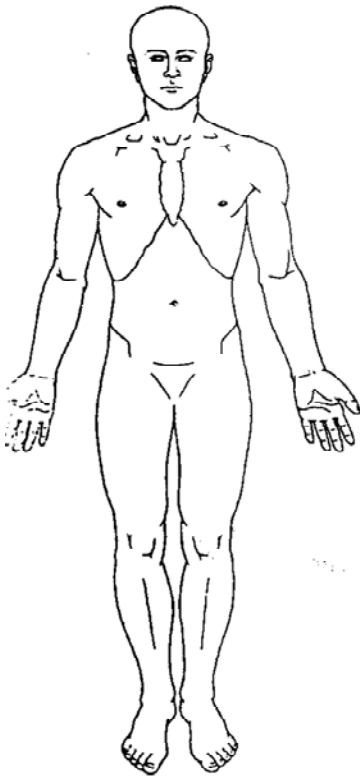
Stroke	Leukemia	Heart Trouble	TB	Cancer
Diabetes	Arthritis	Gout	Seizures	Mental Illness
Kidney Disease	Aids	Bleeding Disorders	Alcoholism	
Heart Disease	High Blood Pressure			

REVIEW of SYSTEMS (Circle all that apply)

Fever, Night Sweats, Weight Loss, Double Vision, Glasses, Dizziness, Deafness, Sinusitis, Ears Ringing, Chest Pain, Palpitations, Shortness of Breath, Coughing Blood, Appetite Change, Diarrhea, Constipation, Abdominal Pain, Nausea, Vomiting, Bloody Stools, Urinary Hesitancy, Incontinence, Painful Urination, Fractures, Painful Joints, Swollen Joints, Swollen Arms or Legs, Weak Arms or Legs, Skin Color Changes, Rashes, Scars, Masses, Ulcers, Eczema, Hives, Hair Changes, Speech Problems, Difficulty Swallowing, Numbness, Tingling, Seizures, Balance Problems, Memory Problems, Coordination, Depression, Excessive Drinking, Painful or Enlarged Lymph Nodes

Please mark the area where you feel the following sensations. Use the appropriate symbols.

Sharp/Stabbing pain ^^^^ Dull aching pain XXX
Burning Pain :::: Numbness/Tingling NNNN



SARASOTA-PRIMARY OFFICE

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Phone: 941.371.9773 Fax: 941.556.0341
Info@southeasternspinecenter.com
www.southeasternspinecenter.com

MEDICATION RENEWAL POLICY

Prescription renewals are always called in at 5 PM, once we complete office hours. Renewing prescriptions must be done during regular office hours Monday through Friday from 8:00AM to 4:00PM. To expedite renewal of prescription medication, call your pharmacist first, they will then place a call to our office for renewal.

We realize that emergencies arise that cannot be anticipated. However, we must insist that our patients anticipate routine medication renewals and abide by our policy of renewals during regular office hours. Additionally, you are required to call your renewal request in to our offices 48 hours in advance. Renewals called in to our office after 3 PM will be handled the next business day.

Patient/Guarantor Signature _____ **Date** _____

Patient Consent to Receive Mail and/or Telephone Messages

Last Name _____ First Name _____ M.I. _____

Do we have your permission to?

- | | | |
|---|------------------------------|-----------------------------|
| 1. Send a yearly appointment reminder or test reminders to your home? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Call you at home? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Call you at work? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Leave messages at your home phone? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Leave messages on your work phone? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Leave messages on your home answering machine? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Leave messages on your work answering machine? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Share your medical and/or appointment information with another person? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. Share your medical information with another person during hospitalization? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. Share your billing information with another person? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Name of Person _____ Relationship _____

Signature of Patient: _____ **Date** _____

ACKNOWLEDGEMENT OF RECEIPT

I, _____, have been given a copy of the Southeastern Spine Center & Research Institute

(Printed patient name)

Summary Notice of Privacy Practices. _____

Patient Signature

Date

Authorization for Family, Friends, or Advisors to receive information about your Medical Condition or the Status of your Bill.

I authorize the following individual(s) to receive written and/or oral communications about my medical condition, care, appointments, and the status of my bill. I understand that they will need to be able to provide the last four digits of my social security number for oral communication. If they should come to pick up a prescription or to discuss my care or the status of my bill, they will need to bring a photo ID.

Patient Signature _____ **Date** _____

For Office Use Only

We attempted to obtain written acknowledgement of receipts of our Notice of Privacy Practices, but acknowledgement could not be obtained because of:

Individual to refused to sign

Communications barriers prohibited obtaining acknowledgement.

An emergency situation prevented us from obtaining acknowledgement. Other (Please Specify) _____

HIPAA- SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices is a condensed version of our Notice of Privacy Practices. Our complete notice is available by request at the reception desk.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and /or items we provide to you as our patients. By law, we are required to make sure that your health plan remains private.

Here are a few examples of how we may use or disclose your information: (For more detail, please refer to our Notices of Privacy Practices.

- * *For medical treatment*
- * *To obtain payment for our services*
- * *In emergency situations*
- * *For appointment reminders*
- * *For worker's compensation*
- * *To avert a serious threat to health or safety*
- * *In response to certain requests arising out of lawsuits or other disputes*
- * *To inform other healthcare providers as a part of your care*

If you believe that your privacy rights have been violated, you may file a complaint with the Practice or the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact Patti Rollins. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- * *The right to inspect and copy*
- * *The right to amend*
- * *The right to an accounting of disclosures*
- * *The right to request restrictions*
- * *The right to a paper copy of this notice*

For more information about these rights please see the detailed Notice of Privacy Practices, available at our front desk.

Due to HIPAA regulations, we will be unable to release your Private Health or Financial Information to your family, friends, or advisor without your permission. If you wish to have such information made available to any of the above, you will need to indicate this in writing on the HIPPA Notice of Privacy Practices Acknowledgement of Receipt form. As an added security measure, you will need to give this individual(s) the last four digits of your social security number if you wish for us to speak to them by telephone. If we speak to them in person, they will need a photo ID.

HIPAA-2 8/04/09



Center of Excellence in Spinal Care

**Fellowship Trained
Spine Surgeons**

Thomas M. Sweeney II, MD, PhD
Board Certified Orthopaedic
Surgery
CEO & Medical Director

David M. Karp, MD, MBA
Board Certified Orthopaedic
Surgery

David L. Scott, MD, PhD
Director of Research
Spine Fellow
Board Eligible Orthopaedic Surgery
Board Certified Internal Medicine

Our office has implemented a new policy beginning January 1, 2009. Any patient that has an appointment they can not keep must notify our office 24 hours in advance. If we do not hear from you, we will charge a fee of \$25.00 to your account. We are sorry for any inconvenience this may cause.

Thank you for your cooperation.

Southeastern Spine Center & Research Institute

Patient Name _____

Patient Signature _____

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www.southeasternspinecenter.com