SOUTHEASTERN
SPINE CENTER
& RESEARCH INSTITUTE

Center of Excellence in Spinal Care

Patient Information

Patient Name:____ Today's Date: _____________

Patient Date of Birth: _______________________________ Current Age: _____________

Sex (Circle One) Male Female

Patient Social Security Number: __________________

If Patient is a minor – Guarantor Name: ____

If Patient is a minor – Guarantor Social Security #: ____

Local Address:_____________________________City: ________________ State __________Zip ________

Permanent Address:________________________City: ________________ State __________Zip ________

Home Phone #: _____________Work Phone #:_________________ Cell Phone #: ___________________

Name of closest relative not living with you: _____________________ Phone #: __________________

Relative's Address:____________________________ City: ____________ State __________ Zip ________

Email: ____

Employment Information

If Retired check here: ________ Occupation prior to retirement: ____________________________________

Patient's Employer: ____

Position:____

Address: _________________________________ City: ______________________ State: _________ Zip: ____________

Phone #: ____

Spouse or Parent's Employer: _________________________________Phone #: ___________________________

Emergency Contact Information

Emergency Contact : ____

Relationship: ____

Address: _________________________________ City: ______________________ State: _________ Zip: ____________

Phone #: _____________________________________ Alternate Phone #: _______________________________

SOUTHEASTERN SPINE CENTER & RESEARCH INSTITUTE

Patient Name:___________________________ **Date of Birth:**___________ **Date:**_______________

Please complete the following questionnaire. It is designed to assess pain intensity, description, and location. **Please answer every section**.

Please mark on the diagram the type and location of your pain.

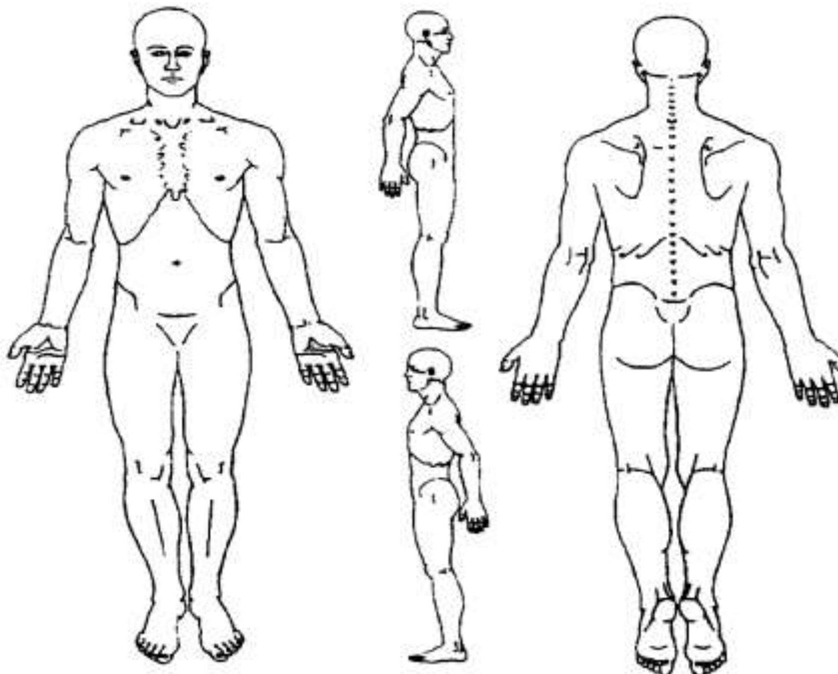
Please describe the **type of pain** or sensation you are currently experiencing by marking the pain diagram with the appropriate symbol using the descriptive words below.

Dull/Aching Pain XXXXX

Sharp/Stabbing Pain ^^^^

Burning Pain ::::

Numbness/Tingling NNNNN



BACK PAIN

Circle the **intensity** of **BACK** pain discomfort during the past week.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

LEG PAIN

Circle the **intensity** of **LEFT LEG** pain discomfort during the past week.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Circle the **intensity** of **RIGHT LEG** pain discomfort during the past week.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

NECK PAIN

Circle the **intensity** of **NECK** pain discomfort during the past week.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

ARM PAIN

Circle the **intensity** of **LEFT ARM** pain discomfort during the past week.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Circle the **intensity** of **RIGHT ARM** pain discomfort during the past week.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Patient Signature:____ **Date:** _______________

Thomas M Sweeney II, MD, PhD, PA, dba Southeastern Spine Center & Research Institute

Financial Policy and Acknowledgement of Notice of Privacy Practices

Thank you for choosing us for your orthopaedic and spinal healthcare needs. We are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and understanding of our payment policy. The following is a statement of our financial policy which we require you to read and sign prior to any treatment. Also included is the patient acknowledgment of the "Notice of Privacy Practices".

Payment for Service is Due at the Time Service is Rendered: We accept cash, checks, Visa, MasterCard, American Express and Discover. If you are unable to pay at the time of service, your appointment may be rescheduled unless other arrangements have been made. There is a $25.00 charge for returned checks.

Insurance: We may accept assignment of your insurance benefits. Assignment is taken on a case by case basis. Our office files insurance claims to all insurance carriers for those plans with whom we participate with (in network), It is your responsibility to check with our office personnel to be aware of our participation status with your insurance plan.

HMO & PPO Members: If you are a member of a HMO or PPO in which we participate, your deductible or co-payment is required at the 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 arrive at our office for an appointment without a valid authorization, your appointment will be rescheduled or you may opt to keep the appointment and be financially responsible for the services provided during that visit. If we are out of network with your insurance plan payment is due at time of service unless prior payment arrangements have been made with our billing office.

Authorization for payment to Thomas M Sweeney II, MD, PhD, PA, dba Southeastern Spine Center & Research Institute: I authorize payment from my insurance carrier, auto insurance carrier, attorney and/or other parties to Thomas M Sweeney II, MD, PhD, PA, dba Southeastern Spine Center & Research Institute with the understanding that all monies will be credited to my account upon receipt.

I authorize Thomas M Sweeney II, MD, PhD, PA, dba Southeastern Spine Center & Research Institute to furnish me or my insurance company and my physicians or healthcare providers with my records or information requested regarding my past, or present condition(s) or treatment(s).

I understand that the balance is my responsibility whether my insurance company pays or not. We cannot bill your insurance company unless you provide us with your insurance cards and billing addresses. Your insurance policy is a contract between you and your insurance company only. We are not a party to that contract. You are responsible to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance or third party payer at the time of service unless prior payment arrangements have been made with our billing office. If your insurance company has not paid your amount in full within 45 days, you are responsible for the balance due unless prior payment arrangements have been made with our billing office. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance policy. You are still responsible for payment.

Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for those medical treatments. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care.

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 a secondary insurance to your Medicare, you will be responsible for the 20% payment to Southeastern Spine Center.

PATIENT NAME: ________________________________ **PATIENT DATE OF BIRTH:** ____________

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Accident or Auto Injury Patients: It is our goal to offer our services to a wide range of patients and understand that some patients may require our care due to injuries sustained, at least in part, by the negligence of third parties. We attempt to bill any insurance available to you including Personal Injury Protection through your automobile insurer where applicable, your health insurance carrier AND we will refrain from collecting any unpaid or non-covered services until you have concluded your claim. In return, it is your obligation to provide us with the name and contact information of any insurer you wish to have billed as well as your policy and/or claim number at the time of your initial visit. If you fail to provide us with that information, your insurance will not be billed and you will be responsible for the full payment of all charges incurred and to the extent allowed by law. You also understand that any services which are not paid or covered by any insurer will remain your personal responsibility regardless of the outcome of any claim you may have pending against other parties. At the conclusion of any such claim, it is your responsibility to contact our facility, or instruct your legal representative to contact our facility, to inform us that the claim has been concluded and to arrange final payment for the charges incurred.

During the pendency of any claim for which you have retained legal counsel, we will refrain from collection efforts but strongly encourage you to make payment arrangements for any balance remaining after the payment of insurance benefits to the extent you are financially able.

It is your responsibility to inform us of the name and contact information of your legal representative at the time of your initial visit. You are also responsible to notify us of any change in your legal representation within ten (10) days of the change.

In the event that you are no longer represented by legal counsel, we will initiate collections efforts within ten (10) days of notification. In the event you have any balance at the conclusion of your claim but do not recover enough to pay the balance, you remain personally liable for the balance and we will commence collection efforts sixty (60) days after the conclusion of your claim if other arrangements to pay the balance have not been made. Balances incurred for our services remain your responsibility regardless of whether the treatment rendered by our physicians or in our facilities are deemed unrelated to the incident giving rise to your claim by any first or third-party insurance carrier, judge, jury, arbitrator, or other finder of fact.

You understand and acknowledge that you are freely choosing to receive treatment by our physicians or in our facilities and that you have not been made any promises or received any inducements to incur the expenses of such treatment based upon the outcome of any pending claim you have.

Financial Disclosure: The physicians/surgeons of Thomas M Sweeney II, MD, PhD, PA, dba Southeastern Spine Center & Research Institute frequently provide educational seminars and participate in educational meetings for a number of medical device companies to educate surgeons and sales staff for these companies. Your physician/surgeon at Thomas M Sweeney II, MD, PhD, PA, dba Southeastern Spine Center & Research Institute may have participated in the development of spinal instrumentation & techniques through which he may be awarded a royalty if they are used. These implants and techniques may be used during your surgical procedures should you have surgery through Thomas M Sweeney II, MD, PhD, PA, dba Southeastern Spine Center & Research Institute. Implants & techniques may be used during your care, specifically during a surgical procedure, which are provided by a company that your physician or surgeon may have financial interest in. If you have any questions or concerns regarding this disclosure, please feel free to have a discussion with your medical provider.

Delinquent Accounts: Delinquent accounts may be turned over to an outside collection agency or attorney if balances remain unpaid for a period of 90 days unless arrangements are made with our facility. You are responsible for all fees and charges incurred from the collection agency and/or legal process regarding the settlement of your account.

PATIENT NAME: ___________________________________ **PATIENT DATE OF BIRTH:** _____________

Thomas M Sweeney II, MD, PhD, PA, dba Southeastern Spine Center & Research Institute

Financial Policy and Acknowledgement of Notice of Privacy Practices

Medication Renewal Policy: Renewing prescriptions must be done during regular office hours which are Monday through Friday, 8:30 a.m. to 4:00 p.m. To expedite the renewal of prescription medication, call your pharmacist first. They will then place a call to our office for renewal authorization. Prescription renewals are always called in at 5:00 p.m., once we complete office hours.

We realize that emergencies arise that cannot be anticipated. 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 office 48 hours in advance. Renewals called in to our office after 3:00 p.m. will be handled the next business day.

Appointment Cancellation Policy: Our office has implemented a policy regarding appointment cancellations. If you are unable to make your scheduled appointment, please notify us within 24 hours so your appointment can be cancelled or rescheduled. Failure to cancel or reschedule your appointment 24 hours in advance may result in your account being charged a fee or $25.00. This fee is charged directly to you, as your insurance carrier does not reimburse this fee. We are sorry for any inconvenience this may cause. Thank you in advance for your cooperation.

Medical Records Requests: When a patient, physician or other party is requesting medical records, the office may require 10-20 working days for completion of this request, due to the many other office responsibilities to other patients

Patient Acknowledgement of Thomas M Sweeney II, MD, PhD, PA, dba Southeastern Spine Center & Research Institute's "Notice of Privacy Practices":

I understand that Thomas M Sweeney II, MD, PhD, PA, dba Southeastern Spine Center & Research Institute has a detailed document posted in the office for all to read. Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications of alternative location. I understand that I may request a written copy of this document at any time.

I HAVE THOROUGHLY READ AND UNDERSTAND THE ABOVE LISTED DISCLOSURES AND POLICIES AND BY SIGNING BELOW I INDICATE THAT I UNDERSTAND THESE POLICIES AND AGREE TO THEM.

I ALSO ACKNOWLEDGE RECEIVING THE NOTICE OF PRIVACY PRACTICES.

Please review this document as well as our Privacy Policy which you will locate on the Home Page of our website (www.southeasternspinecenter.com). Upon arrival in our office you will be supplied with a copy of this page and requested to sign acknowledgement of receipt of this document.

We would like to take this opportunity to welcome you to our practice.

Thomas M Sweeney II, MD, PHD, PA, dba Southeastern Spine Center & Research Institute
5922 Cattlemen Lane, Suite 201, Sarasota, Florida 34232
AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.
- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, mobile voice mail, email or with a household family member.

[ ] Please check here **if you do not want** us to leave messages on your answering machine or with a household family member.
[ ] Please check here **if you do not want** us to leave a message on your mobile voice mail.
[ ] Please check here **if we can** call you at work. .

- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.

- If you choose, please list **by name and relationship** the persons with whom we may share your healthcare or payment information:

Name: ______________________ **Relationship** ;______________

Name: ______________________ **Relationship**: ______________

Name:______________________ **Relationship:** ______________

- You may request a copy of and you have the right to read our "*Notice of Patient Privacy Practices*" prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Name (please print):______________________ Date of Birth: ______________

______________________ ______________________ ______________

Signature | Print name of person signing if other than patient | **Date**

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have a **Healthcare Power of Attorney** for the patient. Yes [ ] No [ ] RELATIONSHIP______________________

FOR OFFICE USE ONLY
Patient refused to sign the form. Reason: ______________________ Date: ______________