REFERRAL QUESTIONAIRE

Patient Primary Care Physician: ______________________________

Please mark below how you were referred to the Florida Spine Institute?

☐ Referring Physician: ______________________________
(please specify)

☐ Attorney: ______________________________
(please specify)

☐ Brochure
☐ Coast Guard
☐ Drive By
☐ Emergency Room / Hospital
☐ Friend / Word of Mouth
☐ Florida Spine Institute employee
☐ Florida Spine Institute website
☐ Insurance
☐ Internet
☐ Newspaper
☐ Phone Book
☐ Seminar
☐ Television
☐ Workman's Compensation
☐ Other: ______________________________
(please specify)

Patient name: Chart #:

Florida Spine Institute
Excellence With Compassion

PATIENT FINANCIAL POLICY & GUARANTY

This is an agreement between Spinecare Associates, LLC d/b/a Florida Spine Institute ("Florida Spine") and the Patient, Guarantor and if applicable, Patient's Legal Guardian or Spouse (sometimes collectively referred to as "Responsible Parties").

1. **Payment**: By executing this agreement, the Responsible Parties agree to pay Florida Spine for all services and supplies that are received including any applicable finance charges, without deduction or set-off. In addition, Responsible Parties agree that that they will be jointly and severally liable for any amounts due to Florida Spine.

2. **Assignment, Lien and Authorization:** Patient and his or her Legal Guardian, if applicable, hereby irrevocably assign to Florida Spine, Patient's right to benefits under any insurance policy and direct his or her insurance carrier and/or attorney, to pay directly to Florida Spine ("Assignee") such sums as may be due and owing Assignee for services rendered to the Patient, and to withhold and pay such sums to Assignee from any disability benefits, medical payments, No-Fault benefits funds from any settlement or judgment or any other insurance benefits owed to Patient or on behalf of Patient. The Patient and his or her Legal Guardian, if applicable, hereby grants to Assignee a security interest in and lien on and against any and all such insurance benefits and any and all proceeds of any settlement, judgment or verdict which may be paid to Patient or on behalf of Patient as a result of the injuries or illness for which Patient has been treated by Assignee.

3. **Billing Statement**: Florida Spine will send the Patient a billing statement. It will show separately any previous balance, any new charges on account, and any payments or credits applied to the account at any time during the month. Responsible Parties may receive a separate bill for Clearwater Ambulatory Surgery Center ("CMED") for facility charges as they are a separately owned and operated facility.

4. **Payment Options**
   a. **Payment Options If Patient Does Not Present Verifiable Health Insurance**:
   Payment must be made in full on the day that treatment is rendered. Responsible Parties may pay by cash or credit card. Payment for the seventy-two hour evaluation program is due prior to any service being performed.

   b. **Payment Options if Patient Has Verifiable Health Insurance**:
   Health Insurance: Insurance is a contract between Patient and the Insurer. In most cases, Florida Spine is NOT a party to this contract. Florida Spine may bill Patient's primary and secondary insurance company, if applicable, as a courtesy. In order to properly bill the insurance company(s), Florida Spine requires disclosure of all current insurance information including primary and secondary insurance and complete verification of the following:

   Patient Name: **Insurer:**___________________________
   Responsible Party: ___________________________ **Policy No.:**___________________________
   Relationship: ___________________________ **Group No.:**___________________________
   (If not Patient) **Phone no. of Insurer:**___________________________
   Signature: ___________________________ **Date:** ___________________________

   (i) Responsible Parties agree to pay any deductible, co-pay and any out-of-pocket portions at the time of service by cash, check, or credit card.
   (ii) If the Responsible Parties choose to pay for all treatment in full at time of service, Florida Spine will issue a refund or credit balance after claims adjudication by the insurance carrier.
   (iii) Each physician, physician assistant, CRNA and/or the facility/surgery center and physical therapy provider may not be under contract with the insurance carrier. Such services must be paid by the Responsible Parties at the time services are provided.

   Failure to provide complete insurance information may result in denial of your insurance benefits. Although we may have an estimate of what the insurance company may pay, it is the insurance company that makes the **final determination** of your eligibility and benefits. If your insurance company is not under contract with us, you agree to pay any portion of the charges not covered by your insurance, including but not limited to those charges that are above the usual customary allowance. If Florida Spine is out of network for your insurance company and your insurance pays Responsible Parties directly, Responsible parties are responsible for payment and agree to forward the payment to Florida Spine upon receipt. **If your insurance company requires a referral and or pre-authorization, Patient is responsible for obtaining such referral and/or preauthorization**. Failure to obtain the referral and or pre-authorization may result in denial of payment from the insurance company. **While we may submit Your bill to Your insurance company, You remain at all times fully responsible for payment of the bill in full. Payment in full is due thirty (30) days from the date services are rendered, regardless of any pending insurance claim.**

   c. **Medicare/Medicaid**: Florida Spine participates with Medicare Part B. Florida Spine does not participate with Medicaid. Florida Spine agrees to bill and accept contractual adjustments for Medicare. Patient must present a Medicare card at the time services are rendered. There may be services and supplies rendered that are not covered by Medicare and therefore require an Advanced Beneficiary Notice (ABN) to be signed by the Patient. By signing the ABN, Responsible Parties understand that they are financially responsible as set forth herein for payment of those services and/or supplies that are not covered by Medicare.

_____________ *Patient Initials*

d. **Workers Compensation**: Florida Spine will treat injuries covered by Workers Compensation without payment being due at the time services are rendered. However, if Patient's claim is denied, Responsible Parties shall be liable for payment in full upon billing as set forth herein.

5. **Returned Checks:** Florida Spine will charge a service fee of $25.00 on any check returned by the bank and Florida Spine will proceed with legal action for collection of such sums owed, which will result in additional service fees.

6. **Past Due Accounts:** If Patient's account becomes past due, Florida Spine may cease providing any additional services to Patient and will take all necessary steps to collect on the account including legal action. Interest may be charged on the outstanding balance of any past due account at the rate of 18% per annum ("Finance Charge")

7. **Waiver of Confidentiality:** We have the option to report Patient's account status to any attorney, collection agency, credit reporting agency such as a credit bureau, or for court litigation; and the fact that Patient received treatment by Florida Spine may become a matter of public record as allowed under Treatment, Payment and Operations under federal HIPAA guidelines.

8. **Transferring of Records:** Copies must be requested in writing and Patient will be required to pre-pay a reasonable copying fee. In order to forward Patient's records to another doctor, Florida Spine requests that Patient complete a Release of Records forms.

9. **Personal Injury, Auto and Third Party:** Florida Spine may elect to enter into a Letter of Protection ("LOP") with Patient's attorney upon terms acceptable to Florida Spine. However, Florida Spine reserves the right to void the LOP at any time. Florida Spine will not provide any information to Patient's attorney without a signed LOP on file. An LOP shall not release Responsible Parties from liability for any outstanding bills unless payment is made.

10. **Attorney's Fees:** In any action or legal proceeding between the Responsible Parties and Florida Spine relating to collection of monies owed or interpretation or enforcement of this Agreement, the prevailing party shall recover reasonable attorneys' fees and court costs including in the legal proceeding post-judgment on appeal or in bankruptcy.

11. **Entire Agreement:** This agreement constitutes the entire and exclusive agreement between and amount the parties hereto on the matters set forth herein, and supersedes any and all prior or contemporaneous agreements, understandings, promises, representations, warranties and covenants, whether written or oral and whether express, implied, or apparent with respect to the subject matter hereof.

12. **Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force effect.

13. **Severability.** In the event that any one or more of the provisions of this Agreement shall be held invalid, illegal, or unenforceable, then such invalidity, illegality or unenforceability shall not affect any other provision hereof, and this Agreement shall be considered by disregarding the invalid, illegal, or unenforceable provision or provisions.

14. **Arbitration and Waiver of Right to Trial by Jury:** Responsible Parties and Florida Spine agree that any disputes between them ("Dispute") will be resolved by final and binding Arbitration by the American Arbitration Association under Florida Rules of Arbitration. The Responsible Parties and Florida Spine waive any right to adjudicate the Dispute in any other court or forum. The Arbitration will be held in Pinellas County and shall be governed under the laws of the State of Florida. Responsible Parties and Florida Spine also waive any right they may have to a trial by jury.

Witness: ____________________ Patient Signature: ____________________

Print: ____________________ Date: ____________________

Witness: ____________________ Patient's Spouse: ____________________

Print: ____________________ Date: ____________________

Witness: ____________________ Legal Guardian: ____________________

Print: ____________________ Date: ____________________

Witness: ____________________ Guarantor: ____________________

Print: ____________________ Date: ____________________

Patient name: Chart #:

So that we may keep your family physician or referring physician informed of your progress under our care, please list the name and address of that physician.

Name: ____________________

Address: ____________________

____

Phone #: ____________________

Fax #: ____________________

____________________ ____________________
PATIENT SIGNATURE DATE

For office use only:

UPIN # ____________________

ME # ____________________

Florida Spine Institute
Excellence With Compassion

PAIN MANAGEMENT

Patient: Chart #: Date:

Referring Physician: ______________________ Patient Age: ___________

Please circle where your pain is:

Head Upper Back Right Arm Right Leg Right Hip Right Shoulder Other: ________

Neck Lower Back Left Arm Left Leg Left Hip Left Shoulder

Vitals:

Height _____________

Weight _____________

B/P ________________

Onset of the pain was:
☐ Acute ☐ Sudden ☐ Gradual ☐ Variable
☐ following motor vehicle accident ☐ following incident at work

You have had the pain for (please write in number and mark increment):
_____ ☐ minutes ☐ hrs ☐ days ☐ weeks ☐ months ☐ years

The pain occurs in what kind of pattern:
☐ Intermittent ☐ Persistent
☐ Episodic: Each episode lasts: _____ ☐ minutes ☐ hrs ☐ days ☐ weeks ☐ months

The pain is:
☐ Increasing ☐ Worsening ☐ Gradually worsening ☐ Rapidly worsening
☐ Gradually improving ☐ Rapidly improving ☐ No change

Severity of the pain is:
☐ Mild ☐ Mild to moderate ☐ Moderate ☐ Moderate to severe ☐ Severe

Date	*Previous treatment for pain (in order)*	*Result*

Current Medication	*Dosage*	*How long?*

How would you rate your pain? (Please circle)

0 1 2 3 4 5 6 7 8 9 10
Least Worse

Doctors Notes:

____

____

____

____

____

Gait: ____________ Toe Walking ☐ Heel Walking ☐

Trunk: Flexion ☐ Extension ☐ Bending I ☐ C ☐

Neck: Flexion ☐ Extension ☐ Bending I ☐ C ☐

SLR Rt ☐ Lt ☐

Spurling Rt ☐ Lt ☐

Patrick Test ☐ Bilat Hip Compression ☐

Gluteal ☐ Piriformis ☐

Other _____________ ☐ SI ☐

Lumbar Paraspinal Rt ☐ Lt ☐

Thoracic Paraspinal Rt ☐ Lt ☐

Cervical Paraspinal Rt ☐ Lt ☐

Trapezius Rt ☐ Lt ☐

Occipital Rt ☐ Lt ☐

Supra Scapular Rt ☐ Lt ☐

Sensory: ________________ Motor: ________________ Reflexes: _______________

Other: ____

____

Patient: Chart #: Date:

FLORIDA SPINE INSTITUTE
NEW PATIENT INFORMATION

Date Patient Name Chart #

DOB Age ______ Sex Weight __________ Height __________

Is your problem related to: ☐ Job injury Date ______________ ☐ Right handed
☐ Car accident Date ______________ ☐ Left handed
☐ Other Date ______________

Briefly describe your main problem/complaint. Also, describe the injury that caused these symptoms, if applicable.

____
____
____
____

How long have you had this problem?

____

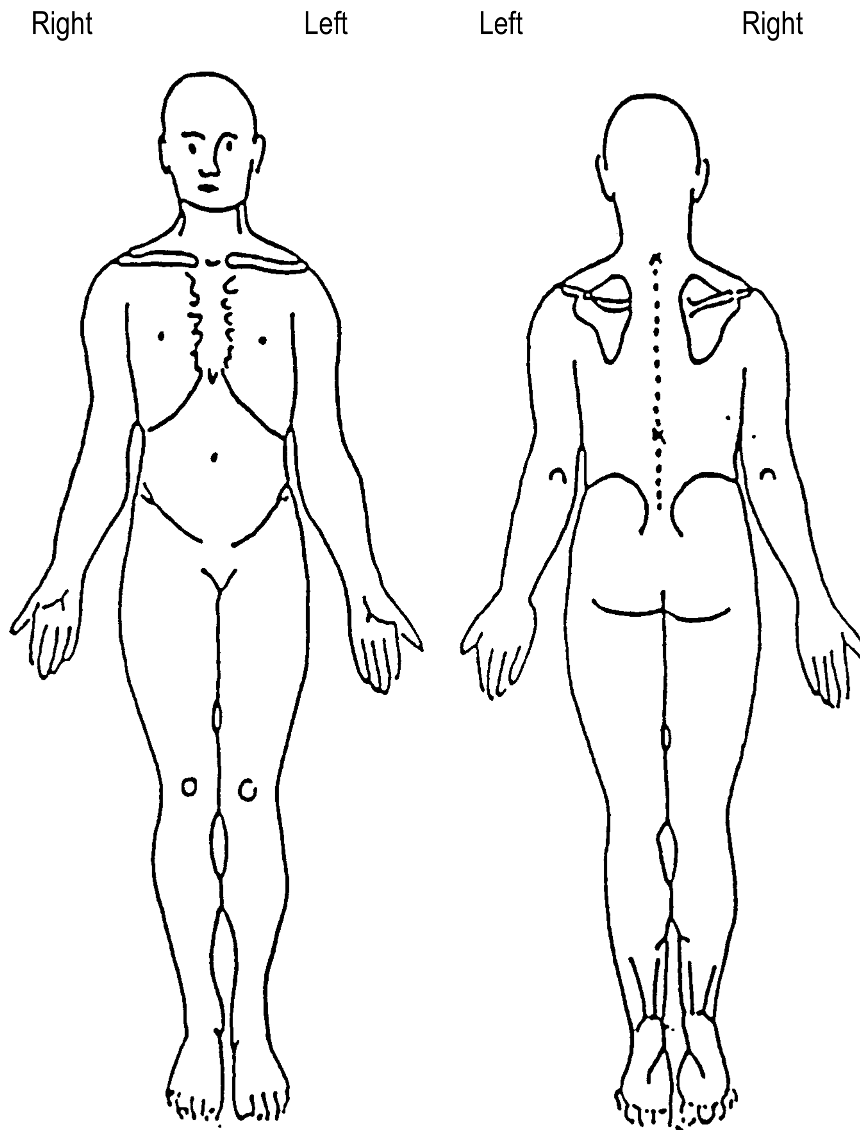
PLEASE CONTINUE COMPLETING ALL PAGES ATTACHED → →

FOR PHYSICIAN USE ONLY – HISTORY OF PRESENT ILLNESS
(These are preliminary notes; refer to dictation for more details)

____
____
____
____
____
____
____
____
____

Using the symbols below, please draw in the location of your symptoms on the diagrams.

X = Pain
0 = Numbness
/ = Aching
* = Pins & Needles



If you have **NECK PAIN**, what percentage of your pain is _______% Neck and ________% Arm (Total 100%)

If you have **BACK PAIN**, what percentage of your pain is _______% Back and ________% Leg (Total 100%)

Patient name: Chart #:

Mark an **X** on the line indicating the usual Degree of the Pain (0 meaning No Pain, 10 meaning Worst pain)

0______1______2______3______4______5______6______7______8______9______10
LEAST WORST

What position/activity makes the pain worse/better?

	Worse	Better	Comments
Bending			
Bowel Movement			
Coughing			
General Activity			
Home Remedies			
Lying Down			
Sitting			
Standing			
Walking			

How long can you **STAND** with no or minimal pain ____________ minutes.

WALKING DISTANCE with no or minimal pain
0-50ft ______ 50-200 ft ______ 200-500 ft ______ 500+ ft ______ ½ mile+ ______

Do you need **SUPPORT** to help you walk? ______ Yes ______ No
If yes, what kind of support? ____

Do you wear a back or neck **BRACE**? ______ Yes ______ No
If yes, what kind of brace? ____

List below the **PREVIOUS PHYSICIANS** (MD, DO, Chiropractor) you have seen for your main complaint/problem.

Physician	Specialty	Dates	Treatment

Indicate which **DIAGNOSTIC TESTS** you have had in evaluation of your main complaint/problem (include dates).

Test	Date	Test	Date	Test	Date
Plain X-ray		EMG/NCV/SSEP		CT Scan	
Bone Scan		Arthrogram		Dexa Scan	
Myelogram		MRI		Diskogram	
Other: ________					

Please check with **TREATMENTS** you have had for your main problem/complaint and indicate whether they were helpful.

Treatment	✓	Helpful?	Treatment	✓	Helpful?	Treatment	✓	Helpful?
Electrical Stimulation			Massage			Whirlpool		
T.E.N.S.			Pool Exercises			Injections		
Ultrasound			Home Exercises			Acupuncture		
Hot Packs			Manipulation			Cold		
Other: _________			Botox					

PAST MEDICAL HISTORY Check below if you have had any of the following

	✓	Comments		✓	Comments
Bowel disorders			Osteoporosis		
Cancer (where?)			Pacemaker		
Depression			Polio		
Diabetes			Psoriasis		
Heart disease			Rheumatoid arthritis		
High blood pressure			Seizures		
High cholesterol			Serious infection		
Kidney disease			Stroke		
Lung disease			Thyroid		
Multiple myeloma			Ulcers		
Other: __________			Coronary Artery Disease		

List any **SURGERY(S)** you have had.

Type	Date	Outcome

Patient name: Chart #:

DRUG ALLERGIES

Drug	Type of Reaction

List **ALL CURRENT MEDICATIONS** as follows

Name	Dose (milligrams, grams)	How Often (how many times a day)	How Long

Have you taken any of the following drugs previously?

Medication	✓	Helpful?	Medication	✓	Helpful?	Medication	✓	Helpful?
Aspirin			Kadian			Skelaxin		
Bextra			Lortab			Soma		
Celebrex			Mobic			Topamax		
Clinoril			Motrin			Tylenol		
Darvocet			Naprosyn			Tylenol #3		
Demerol			Neurontin			Tylox		
Dilaudid			Oxycontin			Valium		
Dolobid			Parafon Forte			Vicodin		
Duragesic			Percodan			Vioxx		
Elavil			Prednisone			Zanaflex		
Flexeril			Prozac					
Ibuprofen			Relafen					

SOCIAL HISTORY & HABITS

Occupation ____________________ Marital Status _________ Highest Education Level __________

WORK STATUS

☐ Full Duty ☐ Light Duty ☐ Off Duty per Physician ☐ Unemployed ☐ Retired

If you are **NOT** working full duty, how long have you been off work? ___________________________

Have you had a work capacity assessment? ______ Yes ______ No

Are you disabled through Social Security? ______ Yes ______ No

Patient name: Chart #:

TOBACCO USE

Do you currently use Tobacco products? _____ Yes _____ No Started Age/Year ______ Stopped ____

If yes, indicate the quantity per day:

Cigarettes ______________ Cigars ___________________ Chewing Tobacco (snuff) ____________

ALCOHOL USE

Do you currently consume alcoholic beverages? ______ Yes ______ No

If yes, indicate the quantity per day:

Beer ________________________ Wine _______________________ Distilled spirits _____________________

Have you ever had a history of drug or alcohol abuse? ______ Yes ______No

REVIEW OF SYSTEMS

Check if you have experienced any of the following

Constitutional	✓	**Eyes/Ear/Nose/Throat**	✓	**Respiratory**	✓	**Cardiovascular**	✓
Weight gain-last 6 months		Recent changes in vision		Short of breath		Chest pain	
Weight loss-last 6 months		Recent changes in hearing		Cough		Palpitations	
Night sweats		Recent changes in smell		Sputum		Shortness of breath w/exercise	
Chills		Recent changes in taste		History of Tuberculosis		Heart murmur	
Fever		Dizziness		Wheezing		Feet edema	
Gastrointestinal	✓	**Genito-urinary**	✓	**Central Nervous System**	✓	**Musculoskeletal**	✓
Nausea		Blood in urine		Poor appetite		Cramps	
Vomiting		Urinary tract infections		Problem sleeping		Attack of weakness	
Diarrhea		Unable to control bladder		Numbness/tingling feet		Joint pain/swelling	
Indigestion		Unable to control bowel		Numbness/tingling hands		Morning stiffness	
Abdominal pain		Rushing to go		Crying spells		Back pain	
Bloody/dark stools		Need to go frequently		Convulsions		Backache	
				Headaches			
Skin	✓			**Spine/Neck**	✓		
Easy bleeding				Neck mass		Neck swelling	
Any rashes				Neck pain		Swollen glands	
Easy bruising				Neck stiffness			

Patient name: Chart #:

FAMILY HISTORY – Describe current health, age, cause of death, illness, diabetes, cancer, hypertension, etc

	Age	Alive	Deceased	Medical history or Cause of death
Father				
Mother				
Sibling 1				
Sibling 2				
Sibling 3				
Sibling 4				
Sibling 5				
Sibling 6				

FEMALE PATIENTS

	Date		Date
Abnormal vaginal bleeding		History of breast biopsy	
History of nipple discharge		History of endometriosis	

Date of last **MENSTRUAL PERIOD** __________________ Date of last **MAMMOGRAM**? _____________________

MALE PATIENTS

	Date		Date
History of Prostatitis		Difficulty urinating	

Date of last **PROSTATIC EXAM** ____________________ Date of last **COLONOSCOPY**? _____________________

Rectal test ______ Yes ______ No Results ____

PSA (Prostate blood test) ______ Yes ______ No Results _____________________________________

RACE

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ White

ETHNICITY

☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Refused to report/Unreported

PREFERRED LANGUAGE

☐ English ☐ Spanish ☐ French ☐ American Sign Language

The preceding patient information packet has been reviewed and discussed with my patient.

PHYSICIAN SIGNATURE ____ DATE ____________________

Dear Patient:

The completion of informational/insurance forms represents an administrative service to our patients above and beyond the provision of medical care. Recent changes in health care have resulted in the tremendous increase in the volume of information requests to our practice. The time and effort involved in providing this detailed information results in significant costs especially when multiplied over the large number of patients our practice services. The refusal of insurance companies and requesting agencies to cover the costs requires us to institute a policy of charges for the completion of forms as follows:

NO CHARGE

- Workers Compensation requested Disability and Work Status forms
- Auto Insurance Carrier requests for Work Status and Treatment plans

$10.00: Disabled Parking Applications

$25.00 per form for completion of the following:

- Credit card deferment forms
- Private Disability Insurance forms
- School Educational Disability or Limitation forms

$35.00: Family Medical Leave Act forms

$150.00 – $300.00

- For completion of any dictated letter describing medical care and limitations.

- For any narrative report detailing diagnosis, treatment and future medical care including work capacity statements. Functional capacity evaluation testing maybe necessary prior to or in addition to the narrative report. The fee for the FCE test is determined by the facility that the testing is completed at.

____________________________________ ______________________

Patient Signature Date

Patient name: Chart #:

C-Med Ambulatory Surgery Center

2238 Drew Street
Clearwater, FL 33765
Phone: (727) 724-5653

C-Med Ambulatory Surgery Center is designed exclusively for outpatient surgery. Therefore, we are able to offer patients a convenient, comfortable, and generally less costly alternative to the hospital. The Center's warm surroundings and the increased level of individual attention, from our staff, minimize the stress often associated with surgery. The Center has a highly skilled team of registered nurses and medical technicians' specially trained in surgical and recovery care.

C-Med is Medicare certified and fully accredited by Accreditation Association for Ambulatory Healthcare, Inc (AAAHC). Medicare Conditions for Coverage require that we inform the patient or the patient's representative of the following information in advance of the date of a procedure in the ASC.

C-Med has established the Patient Rights and Responsibilities below with the expectation that observance of these rights will contribute to more effective patient care, greater patient satisfaction and positive outcomes for the patient. Patients and or their representatives shall have the following rights without regard to age, race, sex, national origin, religion, cultural, or physical handicap, personal value and/or belief systems or whether or not they have an advance directive.

PATIENT RIGHTS

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to expect confidential treatment of their medical records and is given the opportunity to approve or refuse their release except when required by law.

A patient has the right to know to the highest degree possible, complete information concerning their diagnosis, evaluation, treatment, and prognosis.

A patient has the right to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her own care.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the healthcare provider or the Center accepts the Medicare assignment rate.

A patient has the right to formulate an Advance Directive.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a hard copy of reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to know if medical treatment is for the purpose of experimental research and to give his or her consent or refusal to participate in such experimental research.
A patient has the right to express grievances regarding any violation of his or her rights by notifying the Surgery Center Administrator @ 727-724-5653 and/or The Office of the Attorney General, State of Florida, The Capitol

PL-01, Tallahassee, FL, 32399-1050 at (850) 414-3300 or Florida Toll Fee at (866) 966-7226 and/or to The Office of the Medicare Beneficiary Ombudsman @ 1-800-MEDICARE or visit the website at www.medicare.gov/ombudsman/resources.asp

PATIENT RESPONSIBILITIES

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or the Center.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following the Center rules and regulations affecting patient care and conduct.

ADVANCE DIRECTIVES

This section has been designed to help you understand Federal and State laws and the Surgery Center's policy on advance directives. Florida State Advance Directive information is available upon request.

The 1990 Patient Self-Determination Act is a federal law that requires most health care facilities to provide the patient with their decision-making rights and the facility's policy with respect to advance directives. This law is intended for inpatient hospital, nursing homes and health care agencies.

Florida law says that a health care facility shall provide to each patient written information concerning the individual's rights concerning advance directives and the health care facility's policies respecting the implementation of such rights, and shall document in the patient's medical records whether or not the individual has executed an advance directive. The health care facility may not require a patient to execute an advance directive or to execute a new advance directive using the facility's or provider's forms. The patient's advance directives shall travel with the patient as part of the patient's medical record.

The physicians and staff of C-Med Ambulatory Surgery Center respect your rights to participate in decisions regarding your health care. The policy of the Surgery Center is that all patients undergoing surgical procedures will be considered eligible and will receive life sustaining emergency treatment. If you are transferred to a hospital your Advance Directive with be sent with you as part of your medical record.

DISCLOSURE OF OWNERSHIP

The following physicians have financial interest or ownership in C-Med Ambulatory Surgery Center.

Kenneth P Botwin, MD	Constantine G. Bouchlas, MD	Luis G Figueroa, MD
Ashraf F. Hanna, MD	Francisco M. Torres, MD	Scott A. Webb, DO

For more information about C-Med Ambulatory Surgery Center visit: www.cmedsurgerycenter.com

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

Patient name: Chart #:

I understand that as a part of my healthcare Florida Spine Institute originates and maintains health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatments. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can identify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that the practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the practice is not required to agree to restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

Notification of Family Members:

Please share information with:

____________________ ____________________

____________________ ____________________

I request the following restrictions to the use or disclosure of my health information:

____

____

Signature of Patient or Legal Representative	Print Name	Date
Witness Signature	Print Name	Date

Dear

Thank you for choosing Florida Spine Institute for your healthcare needs. It has been our pleasure to serve you and the community for over 20 years.

Recently, CMS (Centers for Medicare/Medicaid Services) has issued initiatives for physicians to demonstrate meaningful use of their Electronic Medical Records in order to enhance and improve patient communication with their physicians through technology. Study after study has shown a link between engaged communication and better health outcomes. Engaged and informed patients are more likely to adhere to medical advice, keep appointments, and monitor their conditions, which make the patient and important addition to the healthcare team.

In an effort to provide the best possible patient experience in the most effective and efficient manner, Florida Spine Institute will begin utilizing technology to make or remind patients of their appointments, notify our patients of test results, and provide other educational communications to our patients. We are therefore requesting you to complete the bottom portion of this letter, providing Florida Spine Institute with your email address and cell phone number. By returning this signed and completed form to our office, you are agreeing to allow Florida Spine Institute to contact you either via email or text message. ***Florida Spine Institute, in no way will distribute your private contact information to any third party, and will only utilize this information for notification from Florida Spine Institute.***

We appreciate your cooperation, and look forward to continuing to provide you the highest quality of care.

Sincerely,

Florida Spine Institute
Physicians and Staff

- -

Email Address: ______________________________@ _______________________._____

Email Address: ______________________________@ _______________________._____

Cell Phone: (______) _______-__________

Patient Name: ____
(Please Print)

______________________________________ ______________

Patient Signature Date

Assignment, Lien and Authorization
Insurance Benefits

To Whom It May Concern:

I, _______________, hereby authorize and direct you, my insurance carrier and/or my attorney, to pay directly to SpineCare Associates, LLC (Assignee) such sums as may be due and owing Assignee for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due Assignee, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits or any other insurance benefits obligated to reimburse me or form any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee. I hereby further give a lien to said Assignees against any and all insurance benefits named herein 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 Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided**. Further, I hereby instruct the insurance carrier to request that, in the event the subject medical services and/or benefits are disputed for any reason, the amount of benefits being claimed by SpineCare Associates, LLC are to be held in escrow and not be disbursed until the dispute is resolved.**

In the event my insurance company obligated to make payment to me upon the charges made by Assignee for their services refused to make such payments, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or in Assignee name and further authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I authorize Assignee to release any information pertinent to my case to any insurance carrier, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above-mentioned Assignee be given Special Power of Attorney to endorse/sign my name on all checks and claim forms for payment of my bill.

Dated:

_______________________________   _______________________________

Claimant   Witness