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
NEW PATIENT INFORMATION

Date Patient Name Chart #

DOB «PDOB» Age ______ Sex Weight __________ Height __________

Is your problem related to:
- ☐ Job injury Date ______________
- ☐ Car accident Date ______________
- ☐ Other Date ______________

Briefly describe your main problem/complaint.

____

____

____

____

____

Describe the injury, in detail that caused the above symptoms: ☐ No Injury

____

____

____

____

____

____

Describe any previous injuries and/or treatments to this area: ☐ No previous injury/treatment

____

____

____

____

____

____

PLEASE CONTINUE COMPLETING ALL PAGES ATTACHED → →

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

____

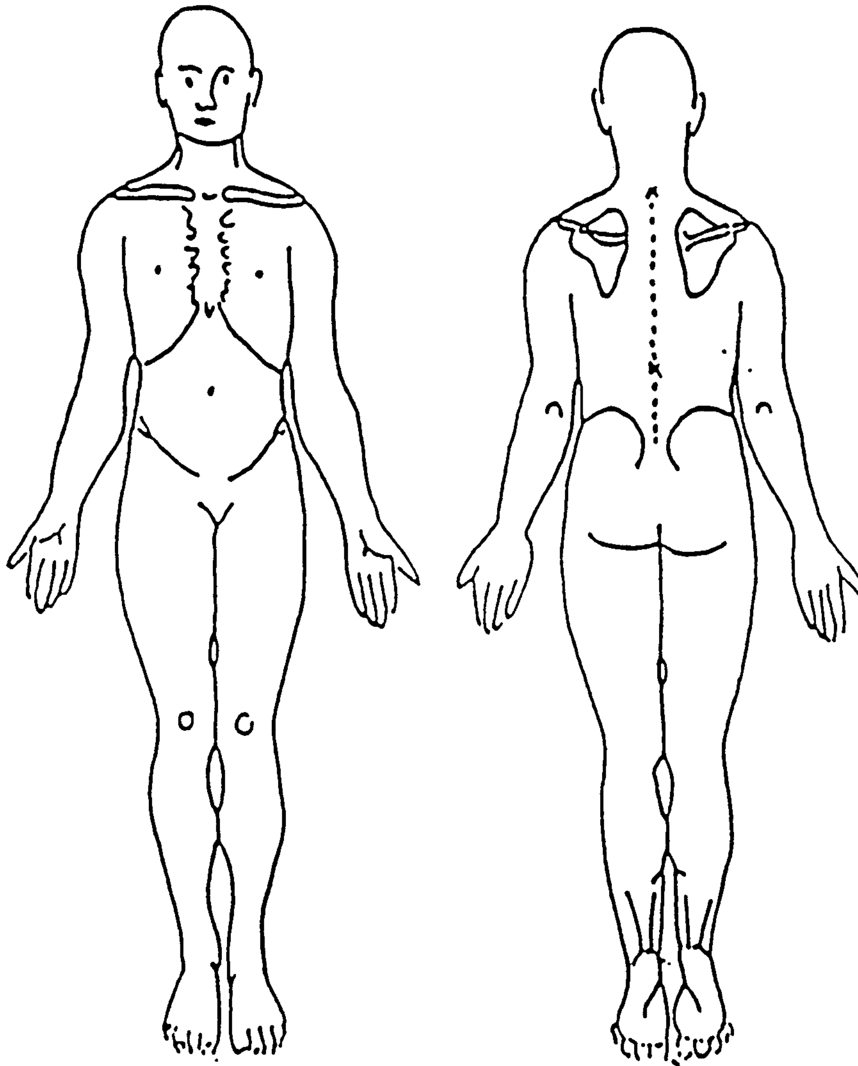
____

____

____

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			Physical Therapy		

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 ☐ **No Known 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			Lyrica			Topamax		
Clinoril			Mobic			Tylenol		
Darvocet			Motrin			Tylenol #3		
Demerol			Naprosyn			Tylox		
Dilaudid			Neurontin			Valium		
Dolobid			Oxycontin			Vicodin		
Duragesic			Percocet			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	✓
Weight gain – last 6 months		Recent changes in vision		Short of Breath	
Weight loss – last 6 months		Recent changes in hearing		Cough	
Night Sweats		Recent changes in smell		Sputum	
Chills		Recent changes in taste		History of Tuberculosis	
Fever		Dizziness		Wheezing	
GASTROINTESTINAL		**GENITO-URINARY**		**CENTRAL NERVOUS SYSTEM**	
Nausea		Blood in urine		Poor appetite	
Vomiting		Urinary tract infections		Problem sleeping	
Diarrhea		Unable to control bladder		Numbness/tingling feet	
Indigestion		Unable to control bowel		Numbness/tingling hands	
Abdominal pain		Rushing to go		Crying spells	
Bloody or dark stools		Need to go frequently		Convulsions	
CARDIOVASCULAR		**MUSCULOSKELETAL**		**SKIN**	
Chest pain		Cramps		Easy bleeding	
Palpitations		Attack of weakness		Any rashes	
Shortness of breath with exercise		Joint pain/swelling		Easy bruising	
Heart murmur		Morning stiffness			
Feet edema					

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 ________________________

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 # ______________

Dear

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 #:

Florida Spine Institute
Excellence With Compassion

HEALTH STATUS SURVEY

Appt Date: Patient: Chart #:

*This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Respond to every question by marking the answer as indicated, unless there have been no changes (see below). **If you are a New Patient to Dr. Webb, please start at #3.** If you are unsure about an answer, please give the best answer you can.*

☐ **I HAVE BEEN SEEN BY DR WEBB IN THE LAST 60 DAYS AND THERE ARE NO CHANGES TO MY CONDITION.** Patient Initials _______

1. Have you had any changes in your medications since your last office visit? ☐ Yes ☐ No
   If yes, list medications: ____

2. Have you been hospitalized or gone to the emergency room since your last office visit? ☐ Yes ☐ No

3. In general, would you say your health is:
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

4. **Compared to one year ago**, how would you rate your health in general now?
   ☐ Much better ☐ Somewhat better ☐ About the same ☐ Somewhat worse ☐ Much worse

5. The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	1	2	3
Lifting or carrying groceries	1	2	3
Climbing **several** flights of stairs	1	2	3
Climbing **one** flight of stairs	1	2	3
Bending, kneeling or stooping	1	2	3
Walking **more than a mile**	1	2	3
Walking **several blocks**	1	2	3
Walking **one block**	1	2	3
Bathing or dressing yourself	1	2	3

6. During the **past 4 weeks**, have you had any of the following health problems with your work or other regular daily activities **as a result of your physical health**?

	Yes	No
Cut down on the **amount of time** you spent on work or other activities	1	2
Accomplished less than you would like	1	2
Were limited in the **kind** of work or other activities	1	2
Had **difficulty** performing the work or other activities (i.e. it took extra effort)	1	2

7. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

	Yes	No
Cut down the **amount of time** you spent on work or other activities	1	2
Accomplished less than you would like	1	2
Didn't do work or other activities as **carefully** as usual	1	2

8. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

9. How much bodily pain have you had during the **past 4 weeks**?

☐ None ☐ Very mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

10. During the **past 4 weeks** how much did pain interfere with your normal work (including both work outside the home and housework)?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

11. These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time **during the past 4 weeks**…..

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Did you feel full of pep?	1	2	3	4	5	6
Have you been a very nervous person?	1	2	3	4	5	6
Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
Have you felt calm and peaceful?	1	2	3	4	5	6
Did you have a lot of energy?	1	2	3	4	5	6
Have you felt downhearted and blue?	1	2	3	4	5	6
Did you feel worn out?	1	2	3	4	5	6
Have you been a happy person?	1	2	3	4	5	6
Did you feel tired?	1	2	3	4	5	6

12. During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc)?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

13. How TRUE or FALSE is each of the following statement for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
I seem to get sick a little easier than other people	1	2	3	4	5
I am as healthy as anybody I know	1	2	3	4	5
I expect my health to get worse	1	2	3	4	5
My health is excellent	1	2	3	4	5

14. Gender ☐ Male ☐ Female

PATIENT INITIALS: ____________ DATE: ________________

Florida Spine Institute
Excellence With Compassion

ACTIVITY LIST

Appt Date: Patient: Chart #:

☐ **I HAVE BEEN SEEN BY DR WEBB IN THE LAST 60 DAYS AND THERE ARE NO CHANGES TO MY CONDITION.** Patient Initials _______

Please mark all activities in which you are able to perform.

- ☐ Attend movies, plays, church events or sports activities
- ☐ Bicycle 1 mile
- ☐ Bicycle 1 mile (nonstop)
- ☐ Bicycle 2 miles
- ☐ Bicycle 2 miles (nonstop)
- ☐ Calisthenics or aerobic dancing (5 minutes nonstop)
- ☐ Carry light load of groceries
- ☐ Carry heavy load of groceries
- ☐ Carry large suitcase or bowling (one game)
- ☐ Carry out garbage
- ☐ Clean windows
- ☐ Climb 12 steps
- ☐ Climb 12 steps (nonstop)
- ☐ Climb 24 steps
- ☐ Climb 24 steps (nonstop)
- ☐ Climb 36 steps
- ☐ Climb 36 steps (nonstop)
- ☐ Climb 50 steps (2 ½ floors)
- ☐ Climb 50 steps (nonstop)
- ☐ Climb 6 steps
- ☐ Climb 6 steps (nonstop)
- ☐ Climb 9 steps
- ☐ Climb 9 steps (nonstop)
- ☐ Cook my own meals
- ☐ Dance (social)
- ☐ Dine at a restaurant
- ☐ Dress or undress (no rest or break needed)
- ☐ Dress or undress (without assistance)
- ☐ Dusting/polishing furniture or polishing a car
- ☐ Get clothes from drawers or closets
- ☐ Get in and out of chairs or bed (without assistance)
- ☐ Get in or out of the car (without assistance)
- ☐ Ironing or folding clothes
- ☐ Kneel or squat to do light work
- ☐ Listen to the radio
- ☐ Make bed (including changing sheets)
- ☐ Make bed (not changing sheets)
- ☐ Mow lawn (power mower, but not a riding mower)
- ☐ Painting (interior/exterior)
- ☐ Play basketball/soccer (game play)
- ☐ Play cards/table games
- ☐ Play tennis or racquetball
- ☐ Put groceries on shelves
- ☐ Put on shoes, stockings or socks (no rest or break needed)
- ☐ Read books, magazines or newspapers
- ☐ Run 110 yards (100 meters) or play softball/baseball
- ☐ Run or jog ¼ mile
- ☐ Run or jog ¼ mile (nonstop)
- ☐ Run or jog ½ mile
- ☐ Run or jog ½ mile (nonstop)
- ☐ Run or jog 1 mile
- ☐ Run or jog 1 mile in 12 minutes or less
- ☐ Run or jog 2 miles
- ☐ Run or jog 2 miles in 20 minutes or less
- ☐ Run or jog 3 miles
- ☐ Run or jog 3 miles in 30 minutes or less
- ☐ Scrub (floors, walls or cars)
- ☐ Shop (by yourself)
- ☐ Shovel or dig
- ☐ Shovel or dig (5 minutes nonstop)
- ☐ Shower
- ☐ Stand (for more than 1 minute)
- ☐ Stand (for more than 5 minutes)
- ☐ Sweep
- ☐ Sweep (5 minutes nonstop)
- ☐ Swim 25 yards
- ☐ Swim 25 yards (nonstop)
- ☐ Take a bath (without assistance)
- ☐ Use public transportation or drive a car (99 miles or less)
- ☐ Use public transportation or drive a car (100 miles or more)
- ☐ Vacuum carpets
- ☐ Vacuum carpets (5 minutes nonstop)
- ☐ Walk ½ block on level ground
- ☐ Walk ½ block on level ground (nonstop)
- ☐ Walk ½ block uphill
- ☐ Walk ½ block uphill (nonstop)
- ☐ Walk 1 block on level ground
- ☐ Walk 1 block on level ground (nonstop)
- ☐ Walk 2 blocks on level ground
- ☐ Walk 2 blocks on level ground (nonstop)
- ☐ Walk 6 blocks on level ground
- ☐ Walk 6 blocks on level ground (nonstop)
- ☐ Walk 1 mile
- ☐ Walk 1 mile (nonstop)
- ☐ Walk 2 miles
- ☐ Walk 2 miles (nonstop)
- ☐ Walk 3 miles (nonstop)
- ☐ Walk 3 miles or golf 18 holes without riding a cart
- ☐ Walk 30 yards (27 meters)
- ☐ Walk 30 yards (nonstop)
- ☐ Wash or dry dishes
- ☐ Work at a desk or table
- ☐ Write (letters, notes)

Florida Spine Institute
Excellence With Compassion

BACK PAIN QUESTIONNAIRE

Appt Date: Patient: Chart #:

☐ **I HAVE BEEN SEEN BY DR WEBB IN THE LAST 60 DAYS AND THERE ARE NO CHANGES TO MY CONDITION.** Patient Initials _______

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer all sections and mark only one line in each section which best applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the one line which most closely describes your problem.

Section 1 – Pain Intensity
☐ I can tolerate the pain I have without having to use pain killers
☐ The pain is bad but I manage without taking pain killers
☐ Pain killers give complete relief from pain
☐ Pain killers give moderate relief from pain
☐ Pain killers give very little relief from pain
☐ Pain killers have no effect on the pain and I do not use them

Section 2 – Personal Care (Washing, Dressing, etc)
☐ I can look after myself normally without causing extra pain
☐ I can look after myself normally but it causes extra pain
☐ It is painful to look after myself and I am slow and careful
☐ I need some help but manage most of my personal care
☐ I need help every day in most aspects of self care
☐ I do not get dressed, wash with difficulty and stay in bed

Section 3 – Lifting
☐ I can lift heavy weights without extra pain
☐ I can lift heavy weights but it gives extra pain
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table
☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
☐ I can lift only very light weights
☐ I cannot lift or carry anything at all

Section 4 – Walking
☐ Pain does not prevent me walking any distance
☐ Pain prevents me walking more than 1 mile
☐ Pain prevents me walking more than ½ mile
☐ Pain prevents me walking more than ¼ mile
☐ I can only walk using a stick or crutches
☐ I am in bed most of the time and have to crawl to the toilet

Section 5 – Sitting
☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than 1 hour
☐ Pain prevents me from sitting more than ½ hour
☐ Pain prevents me from sitting more than 10 minutes
☐ Pain prevents me from sitting at all

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:

   PatientName: **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 #:

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 #: «PNumber»

______________________________________ _______________
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