American Spine & Orthopaedic Institute, LLC

Patient Registration Information

PATIENT INFORMATION

First Name	M.I.	Last Name	Date of Birth	Age
			/ /	

Street Address	Additional Address	City	State	Zip code

Social Security Number	E-mail	Preferred Phone Number	Secondary Phone Number

Gender	Marital Status	Race	Ethnicity	Preferred Language

CURRENT EMPLOYER

Employer	Phone

Street Address	City	State	Zip code

GUARANTOR INFORMATION

First Name	Last Name	Date Of Birth	Gender
		/ /	

Street Address	Additional Address	City	State	Zip code

SSN	Employer Information

EMERGENCY CONTACT

Name	Phone

PRIMARY INSURANCE INFORMATION

Insurance Name	Address	City	State	Zip code

ID/Certificate Number	Group ID/Number

Policy Holder (Subscriber) Name	Relation To Patient	Date Of Birth	Gender
		/ /	

SECONDARY INSURANCE INFORMATION

Insurance Name	Address	City	State	Zip code

ID/Certificate Number	Group ID/Number

Policy Holder (Subscriber) Name	Relation To Patient	Date Of Birth	Gender
		/ /	

ACCIDENT INSURANCE INFORMATION

Employment	☐ Yes ☐ No	Employer is different than above	City & State	Zip	Injury Date
Auto	☐ Yes ☐ No	Address	City & State	Zip	Injury Date
Other	☐ Yes ☐ No	Address	City & State	Zip	Injury Date

REFERRED TO THIS PRACTICE BY

Primary Care Physician	Phone Number

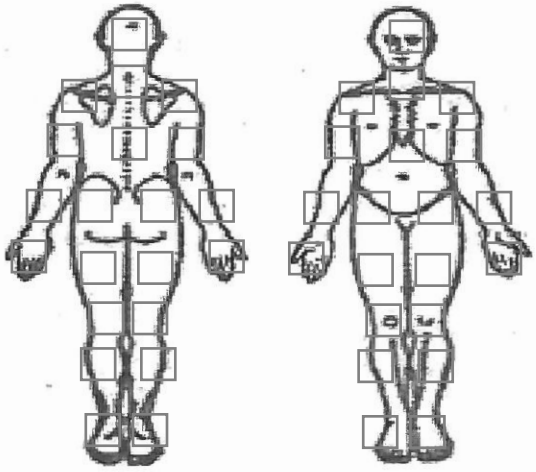
Who Referred you to our office?

I hereby give lifetime authorization for payment of insurance benefits to be made directly American Spine & Orthopaedic, and any assisting physicians for services rendered. I authorize treatment of the above listed patient by a provider at American Spine and Orthopaedic Institute, LLC. I agree that a photocopy of this agreement shall be valid as the original.

Date:_____ Signature: _____

CURRENT CONDITION

USING THE FOLLOWING DRAWINGS, PLEASE INDICATE AREAS F CHIEF COMPLAINTS WHICH YOU ARE SEEKING TREATMENT.



If injured in a CAR ACCIDENT: (circle your answer)

Were you the Driver?	YES	NO	If NO, indicate:____Front Seat ____Back Seat
Did you have your seatbelt?	YES	NO	
Did you lose consciousness?	YES	NO	If YES, how long? _____

DATE OF ACCIDENT: __/__/__

Destination after the accident/injury: _____

When did you go to the hospital?____/____/____Hospital Name: _____

Who drove you to the hospital?_____Were you admitted? _____

Date Discharged:____/____/____ Were x-rays taken? YES / NO Describe: _____

BRIEFLY DESCRIBE THE ACCIDENT:

_____

_____

Has a doctor or dentist ever diagnosed a TMJ disorder prior to the accident? _____

For how long have you hadthis condition?_____Have you had this condition in the past? YES or NO

PROGRESS: WORSE [__] SAME [____] CONSTANT [___] COMES AND GOES [____]

Is this condition interfering with your daily routine? WORK [____] SLEEP [____] DAILY ROUTINE [____]

OTHER: _____

List treatments you have had for this problem and all health professionals that you are currently seeing:

PHYSICIANS	SPECIALTY	TREATMENT PLAN

SIGNATURE:_____**DATE:**_____

American Spine & Orthopaedic Institute, LLC

Please note, items left blank indicate a negative response.

PAST MEDICAL HISTORY ☐ None Indicate **all** medical conditions you have experienced.

☐ Bleeding disorders	☐ High blood pressure	☐ Liver disorder	☐ Osteoporosis
☐ Blood clots/DVT	☐ Heart Disease	☐ Stomach ulcers	☐ Rheumatoid arthritis
☐ Stroke	☐ Arrhythmia	☐ Kidney problems	☐ Gout
☐ Seizures	☐ Anemia	☐ Prostate enlargement	☐ Fibromyalgia
☐ Sleep apnea	☐ Diabetes	☐ Cancer	☐ Birth defects
☐ Asthma/Emphysema	☐ Thyroid disorders	☐ Glaucoma	☐ Other (list in space below)

SURGICAL PROCEDURES: ☐ None Indicate **all** surgical procedures (include approximate dates).

☐ Tonsils	☐ Heart	☐ Uterus	☐ Prostate
☐ Appendix	☐ Colon	☐ Breast	☐ Hernia
☐ Thyroid	☐ Gallbladder	☐ Vascular	☐ Other (list in space below)

FAMILY HISTORY: ☐ None Indicate **all** medical conditions experienced by any parent, sibling, or child

☐ Cancer	☐ High blood pressure	☐ Kidney problems	☐ Osteoporosis
☐ Stroke	☐ Heart disease	☐ Bleeding disorders	☐ Birth defects
☐ Seizures	☐ Diabetes	☐ Blood clots/DVT	☐ Anesthesia complications

SOCIAL HISTORY:

Occupation: ☐ Student ☐ Retired ☐ Disabled (when):

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Living alone: ☐ Yes ☐ No ☐ with spouse ☐ with family ☐ with other:

Tobacco use: ☐ Never ☐ Previous ☐ Currently every day ☐ Currently some days

☐ Cigarettes packs per day: number of yrs: Quit when:

☐ Other: number of yrs: Quit when:

Alcohol use: ☐ None ☐ Occasionally ☐ Weekly ☐ Daily Quit when:

☐ Beer ☐ Wine ☐ Liquor

REVIEW OF SYSTEMS: ☐ None Indicate **all** symptoms that you are presently experiencing.

☐ Fevers/Night sweats	☐ Frequent headaches	☐ Nausea/Vomiting	☐ Rashes
☐ Shaking/Chills	☐ Morning cough	☐ Stomach pain	☐ Severe itching
☐ Recent weight loss	☐ Shortness of breath	☐ Blood in stools	☐ Bruising/Bleeding easily
☐ Bleeding gums	☐ Coughing up blood	☐ Loose stools	☐ Calf cramps
☐ Frequent nosebleeds	☐ Hoarseness	☐ Loss of appetite	☐ Joint pain
☐ Visual problems	☐ Chest pain	☐ Difficulty with urination	☐ Joint swelling
☐ Hearing problems	☐ Abnormal heartbeat	☐ Pain/Burning on urination	☐ Loss of height
☐ Dizziness/Fainting	☐ Ankle swelling	☐ Blood in urine	☐ Irregular periods

MEDICATIONS: ☐ None List **all prescription** and **non-prescription** medications and **supplements**.

Name of medication	Strength/Dose	Frequency

ALLERGIES: ☐ None Indicate **all** allergies you have to **medications** and **foods**.

Include reaction, i.e. nausea, vomiting, itching, rash, swelling, difficulty breathing

☐ Penicillin
☐ Sulfa
☐ Aspirin
☐ Codeine
☐ Morphine
☐ Iodine
☐ Latex
☐ Milk

☐ Other - List below

Print name of patient (or authorized representative)

Signature of patient (or authorized representative)

Date

Name of Provider

Provider Signature

Date

American Spine & Orthopaedic Institute, LLC

Medical History - Page 3

SUPERCONFIDENTIAL INFORMATION: ☐ None Indicate **all** conditions for which you have received treatment.

☐ Mental health conditions (depression, anxiety, etc.)
☐ Substance abuse (alcohol, narcotics, etc.)
☐ Illegal drug use
☐ HIV / AIDS
☐ Sexually transmitted diseases (STD's)
☐ Minor pregnancies (pregnancy under the age of 18)

If you have indicated any of the conditions above, **please initial** the corresponding categories listed below which will authorize **American Spine & Orthopaedic Institute, LLC** to disclose that information to third parties for treatment or payment purposes in the event that it is requested by said third parties or required by law

Initials: _____ Mental health information
Initials: _____ HIV/AIDS information
Initials: _____ Substance abuse information
Initials: _____ STD information
Initials: _____ Illegal drug use information
Initials: _____ Minor pregnancy information

Are you pregnant or could you be pregnant? ☐ No ☐ Yes If yes, due date: _____

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I AM THE PATIENT OR AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE TERMS.

Print name of patient (or authorized representative) | Signature of patient (or authorized representative) | Date

Reason patient is unable to sign and representative's relationship to patient or authority to sign on behalf of patient

Name of Provider | Provider Signature | Date

American Spine & Orthopaedic Institute, LLC

HIPAA CONTACT INFORMATION FORM

In order to assist you in receiving your health information from American Spine, please complete this form:

_____(Initial) American Spine & Orthopaedic Institute, LLC is permitted to share **any and all** medical information with the following individuals listed below, including test results, sensitive information as stipulated by the State of Florida and information disclosed during office visits.

_____(Initial) American Spine & Orthopaedic Institute, LLC is permitted to share **any** medical information with the individuals listed below, including test results, sensitive information as stipulated by the State of Florida, and information disclosed during office visits.

Except: _____

Persons authorized to receive my medical information:
(Include: Full name, relationship, and phone number.)

NAME:	RELATIONSHIP:	PHONE NUMBER:

You may notify me with test results, appointment reminders and other information regarding my health information as follows:

___ Message on answering machine (Phone # _____)

___ Message on work voicemail (Phone # _____)

___ Text message on cell phone (Phone # _____)

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

Printed Name: _____

Signature:_____

DOB: _____

This authorization is **not** valid for the request of printed copies of your medical records. You and only you (or your legal personal representative) must sign a Health information Release form to obtain copies of your medical records.

American Spine & Orthopaedic Institute, LLC

Consent for Electronic Prescribing

American Spine & Orthopaedic Institute, LLC. is enrolled in an electronic prescribing program. This program is meant to help our providers with understanding what medications our patients are currently using and to give them the best possible treatment.

By signing this form, you consent to the American Spine & Orthopaedic Institute, LLC retrieving electronic prescribing information from other providers.

This consent will only be valid for one year. A new consent will be required at that time.

I agree that American Spine & Orthopaedic Institute, LLC may request and use my prescribing medication history from other healthcare providers.

Print name of patient (or authorized representative)	Signature of patient (or authorized representative)	Date

Reason patient is unable to sign and representative's relationship to patient or authority to sign on behalf of patient

Please provide your preferred pharmacy information:

Pharmacy Name: _____

Address: _____

Phone Number: _____

AMERICAN SPINE & ORTHOPAEDIC Institute, LLC

FINANCIAL POLICY

Patient Name: _____ Date: _____

Thank you for choosing American Spine & Orthopaedic Institute. We strive to offer the best healthcare services to our patients. Part of that service is providing transparency regarding any financial responsibilities. If at any time during your visit you have questions or concerns regarding your potential costs of services, please alert one of our team members. Please review the following.

Please review the following:

American Spine & Orthopaedic Institute verifies your benefits with your insurance company prior to each visit. Verification of your benefits with your insurance company is not a guarantee of benefits or payment. You are responsible for paying any out-of-pocket expenses as part of your benefit coverage. Be advised having more than one insurance policy is not a guarantee that all of your out-of-pocket expenses will be covered.

As a courtesy, American Spine & Orthopaedic Institute provides options for you to pay your out-of-pocket expenses for services provided. Estimate of Cost Pay today an estimate of fees owed for your visit. A team member will review your estimated out-of-pocket expenses at the end of your visit today. After your insurance company processes your claim you may have additional out-of-pocket expenses for which you will be billed or you may be due a refund.

Assignment of Benefits: In consideration of the treatment being rendered, you hereby irrevocably assign any and all insurance benefits you have to American Spine & Orthopaedic Institute for services provided to you. You understand you remain personally financially responsible for any services not covered by your insurance benefits or plan.

For Self-Pay patients with no active insurance coverage, American Spine & Orthopaedic Institute offers a flat rate of $250 for the initial office visit and $175.00 for each follow-up office visit. Additional charges apply for services not included in the office visit (examples include DME, MRI, EMG, therapy, surgery). Payment is required prior to services being rendered.

If your balance is not paid or a payment arrangement has not been made after two (2) attempts to collect, a $25 service charge may be assessed as a late fee on your account. Any unpaid balance may be turned over to an outside collection agency.

There will be a **$35 fee** assessed for insufficient funds when paying by check.

A **No Show fee of $50** may be charged for patients who do not cancel or reschedule their appointments prior to 24 hours before their scheduled appointment.

There is a charge for completing individual medical forms, disability, work restriction, employer forms, school forms, etc. Please allow five (5) business days to process all form requests.

There is a cost for other service(s) such as copying x-ray images and medical records.

By signing below, I acknowledge that I have read the financial policy of American Spine & Orthopaedic Institute

_____ _____

Patient or Patient's Representative or Responsible Party Date

AMERICAN SPINE & ORTHOPAEDIC Institute, LLC

Consent for Purposes of Treatment, Payment, and Healthcare Operations

Patient: _____ Date: _____

I consent to medical examination and treatment for myself or for the patient for whom I am the parent or legally authorized representative. (If a patient is a minor, the parent having legal custody, a legal guardian, or a person authorized by them in writing must sign. If a patient is incompetent, a legal guardian or conservator must sign.)

I consent to the use or disclosure of my protected health information by American Spine & Orthopaedic Institute (ASOI) for the purpose of diagnosing and/or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations. I understand that diagnosis and/or treatment of me by ASOI may be conditional upon my consent, as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, and my employer or a health care clearinghouse. This protected health information relates to my past, present, and/or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. ASOI is not required to agree to the restrictions that I may request; however, if ASOI agrees to a restriction that I request then the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that ASOI has taken action in reliance on this consent.

I understand I have the right to review ASOI's Notice of Privacy Practices, which has been made available to me, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, and in the performance of health care operations of the ASOI. The Notice of Privacy Practices for ASOI is also posted at each office location. This Notice of Privacy Practices also describes my rights and ASOI's duties with respect to my protected health information.

ASOI reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

_____ _____

Signature of Patient or Personal Representative Print Name

I hereby authorize the release of my Protected Health Information to the following individuals (Please Print):

Names:	Relationship:	Phone No:

American Spine & Orthopaedic Institute, LLC

To be prescribed opioid and controlled medications from this facility, you will have to agree to the following:

Please initial each to acknowledge you have read them, understand and agree to conform to:

_____ I will be truthful about prior alcohol or drug use or abuse of prescription of illegal drugs (to do otherwise is misleading the doctor and is illegal).

_____ I understand that narcotics may help my pain but are not likely to totally stop it.

_____ I will not alter my written prescriptions in any way and will not reproduce them (this would be illegal to do so).

_____ I will not go to other Physicians to get narcotics (this is illegal).

_____ I will inform the doctor at each visit if I am on any other medications including narcotics and non narcotics (to do otherwise is misleading the doctor and is illegal).

_____ If I have a narcotic related emergency after clinic hours, I will go to the emergency room, calling 911 if necessary. I will inform the doctor there of the medications I take and request he notify my doctor here of any prescriptions or changes in my medications (to do otherwise is misleading the doctor and is illegal).

_____ I will take my medications only as instructed (to do otherwise could cause dependence, addiction, death or withdrawal).

_____ I will not share/sell my medication with/to others, nor will I take/buy other persons medications or illegal drugs (cocaine, heroin, speed, PCP, marijuana, etc.) (this would be illegal to do so).

_____ I understand that, if I overuse my medication, I will run out before my next visit and will not receive more until then. If my medication is lost or stolen, I will not receive more medication until my next visit. Thus, I am likely to go through withdrawal, which can be very unpleasant.

_____ I understand that overusing medication or having it lost or stolen will prevent me from receiving medication at any time in the future from this facility.

_____ I will not overuse alcohol, as combined with narcotics or sedatives, this could be deadly. Coming to the clinic strongly smelling of alcohol or drunk will force the clinic to stop prescribing medication for me.

_____ I will submit to random, observed, urine screening tests for narcotics and illegal drugs to evaluate if medication is being used or abused.

_____ I will file a local police report if my opioids are lost or stolen. (Opioids are controlled substances, US Drug Enforcement Agency).

_____ I will notify my doctor if I am considering PREGNANCY or become PREGNANT.

_____ I will not operate a vehicle or other dangerous equipment if there is any question as to whether my judgment, reflexes, or coordination are impaired by the medications (DUI).

_____ I understand that ingestion of my medications by friends, pets, or children could result in their death.

_____ I give permission to my physician and staff to contact other physicians and pharmacies that have been or will be involved in my medical care concerning my pain medication usage.

I REALIZE BREAKING THE ABOVE AGREEMENT WILL PREVENT ME FROM RECEIVING FURTHER MEDICATION FROM THIS FACILITY.

I have read, understand and agree to abide by the above stated conditions.

Patient printed full name	Patient signature	Date

American Spine & Orthopaedic Institute, LLC

Assignment of Benefits and Direction for Payment

Primary Ins. Co. _____ Secondary Ins. Co. _____

I hereby instruct and direct the above-named insurance company to pay by check made payable to:

American Spine & Orthopaedic Institute, LLC
7824 Lake Underhill Rd, Suite H
Orlando, Florida 32822

for the medical and diagnostic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the Services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to American Spine & Orthopaedic Institute, LLC and I have agreed to pay, in a current manner, any balance of said service charges over and above this insurance payment except to the extent my liability for any such balance is limited by agreement or law applicable to the American Spine & Orthopaedic Institute, LLC.

A photocopy of this assignment shall be considered as effective and as valid as the original. I also authorize the release of any information acquired in the course of my treatment to any insurance company, adjuster or attorney involved in this case.

_____ _____ _____
Print name of patient (or authorized representative) Signature of patient (or authorized representative) Date

_____
Reason patient is unable to sign and representative's relationship to patient or authority to sign on behalf of patient

If you are not represented by an attorney, please got to the next page.

American Spine & Orthopaedic Institute, LLC

Assignment and Lien for Medical Services Rendered

If I, _____, receive or become entitled to receive any monies from any source whatsoever for my injuries, either through a lawsuit, settlement of a lawsuit or claim, award by a court or arbitrator(s), jury verdict, judgment or payment of insurance proceeds, I hereby assign and agree to pay said funds to:

American Spine & Orthopaedic Institute, LLC
7824 Lake Underhill Rd, Suite H
Orlando, Florida 32822

to the extent of any outstanding amounts then owed by me to the American Spine & Orthopaedic Institute, LLC for medical services before any other fees, costs, or expenses are disbursed from any said funds. I further agree and acknowledge that the fee for the services to be performed by the American Spine & Orthopaedic Institute, LLC depends on the treatment rendered and that any amount that I owe to the American Spine & Orthopaedic Institute, LLC shall constitute a lien on any claim or lawsuit I may have as a result of my injuries and any settlement, judgment, jury verdict, or insurance proceeds that I receive or become entitled to receive.

This Assignment and Lien shall be placed in my chart and a copy thereof shall constitute actual notice to my attorney, or any other person, that my medical bills to the American Spine & Orthopaedic Institute, LLC shall be paid first from the proceeds of any such settlement, judgment, jury verdict, insurance proceeds or otherwise. This authorization cannot be modified unless it is in writing and signed by both parties.

I hereby appoint the American Spine & Orthopaedic Institute, LLC or its designee as my attorney-in-fact to sign my name to and file a financing statement under the Uniform Commercial Code to evidence this lien.

I understand that I remain personally responsible for the payment of all fees owed by me to the American Spine & Orthopaedic Institute, LLC and that notwithstanding this Assignment and Lien, the American Spine & Orthopaedic Institute, LLC is not required to look to any other person or entity for payment.

I hereby instruct my attorney to pay directly the American Spine & Orthopaedic Institute, LLC such sums as may be due and owing for medical services rendered to me, and to withhold such sums from any settlement, judgment, jury verdict, or insurance proceeds as may be necessary to adequately protect the American Spine & Orthopaedic Institute, LLC These instructions are irrevocable and may not be changed without the written agreement of the American Spine & Orthopaedic Institute, LLC. I have given authorization to the American Spine & Orthopaedic Institute, LLC to forward this document to my attorney. My attorney hereby acknowledges that in the event I recover money through settlement, judgment, jury verdict, or insurance proceeds from any person or entity in which the law firm and/or attorney is an additional named payee, my attorney agrees to withhold and pay sufficient funds to the American Spine & Orthopaedic Institute, LLC for any outstanding expenses owed to the American Spine & Orthopaedic Institute, LLC in connection with medical services rendered as a result of my injuries.

Print name of patient (or authorized representative)	Signature of patient (or authorized representative)	Date

Reason patient is unable to sign and representative's relationship to patient or authority to sign on behalf of patient

Signature of Attorney	Print name of Attorney	Date

American Spine & Orthopaedic Institute, LLC

Authorization for Obtaining Outside Records and/or Diagnostic Films

If you have had previous medical treatment and/or diagnostic testing for orthopaedic problems, please complete the following release. This will assist us in obtaining these records and/or films for review by our physicians/physician extenders. You understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

Name of Facility: _____

Address of Facility: _____

_____

Phone Number: _____ Fax Number: _____

Description of Information to be released (check all that apply)

☐ Medical data/information as related to: ☐ X-ray films as related to:

- ☐ Specific condition(s) /specific physician(s): _____
- ☐ Specific time frame(s): _____
- ☐ All office notes, test results, and/or films: _____
- ☐ Other: _____

Reason for request: Medical Treatment_____ Legal_____ Other_____

Please send copies of my medical records and/or diagnostic tests/films to:

American Spine & Orthopaedic Institute, LLC

☐ 7824 Lake Underhill Rd Suite H, Orlando FL 32822 Phone 407-792-4152 Fax 407-792-4152

*This authorization expires on [upon]*_____*[Insert applicable date or event,*

i.e. - completion of treatment for this medical condition

I understand that I may inspect or obtain a copy of the information used or disclosed.
I understand that I may revoke this Authorization at any time by notifying the person/organization providing the information in writing, except to the extent that action has been taken in reliance on the Authorization.

By signing below, I acknowledge and agree to the above conditions.

_____ _____

SIGNATURE OF PATIENT (OR AUTHORIZED REPRESENTATIVE*) **PRINT NAME OF PATIENT (OR AUTHORIZED REPRESENTATIVE*)**

Date: _____

*Please explain Representative's relationship to Patient and include a description of Representative's authority to act on behalf of Patient.

_____

_____