SPINEUGENIX LLC
Minimally Invasive Pain Procedures

Today's Date: _____

Patient Legal Name: _____ MI: _____ Last: _____

Date of Birth: _____ SS#_____ Male/Female

Cell # (_____)_____ Home # (_____) _____Work# (_____)_____

Main number you would like us to use: Cell Home Work

Patient Billing Address: _____

City: _____ ST: _____ Zip: _____

Primary Care Doctor: _____ Who referred you to us? _____

Marital Status: Single Married Divorced Legally Separated Widowed

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Declined to Specify

Race: White African American Asian American Indian Alaska Native Hawaiian Native Other

Primary Language: _____

Patient Employment Status: Full Time/ Part Time/ Self Employed/ Not Employed/ Disabled

Employer: _____ Retired (Date): _____

Veteran: Yes/ No Active Duty: Yes/ No Student: Yes/ No

Primary Insurance Carrier: _____

Policy #: _____Group #: _____

Secondary Insurance Carrier: _____

Policy #: _____ Group #: _____

Guarantor information (If other than Patient)

Name: _____ Date of Birth: _____

Address: _____

City: _____ ST: _____ Zip: _____

Relationship to patient: _____

Preferred Pharmacy: _____

Location: _____

Phone #: _____

HPAA PATIENT CONTACT CONSENT

I give permission to share the following information with:

Emergency contact 1: _____Relation: _____

Cell#: (_____) _____Home#: (_____) _____

This person is granted full access to my personal medical health information: YES or NO

Picking up medications: YES or NO

Appointment information: YES or NO

Billing information: YES or NO

Emergency contact 2: _____Relation: _____

Cell#: (_____) _____Home#: (_____) _____

This person is granted full access to my personal medical health information: YES or NO

Picking up medications: YES or NO

Appointment information: YES or NO

Billing information: YES or NO

Expiration or termination of authorization – This authorization will remain in effect until terminated by patient's personal representative, or another individual of legal entity authorized to do so by court order or law.

Right to revoke or terminate – As stated in our Notice of Privacy practices, you have the right to revoke or terminate authorization by submitting a written request to our Privacy Manager.

PRACTICE POLICIES AND GUIDELINES AGREEMENT

Welcome! We are so glad that you have decided to become a part of our practice. Our goal is to provide you with excellent healthcare in a friendly and compassionate environment. Please take a moment to become familiar with our office's policies and guidelines, then sign the acknowledgement at the bottom of this page and return it to our office. Thank you for your cooperation.

First Time Visit: Please arrive at least 10 – 15 minutes prior to your appointment time and bring your insurance cards and a photo ID. A medical assistant will go over your past medical history. Please bring a complete list of all medications you are currently taking. If you have co-pay or have not yet met your deductible, please be prepared to pay it when you check in at the front desk. If you are a self-pay patient, payment will be collected before you see the doctor. Payment is due at the time of service.

Follow-Up Visits: Please arrive 5 – 10 minutes before your schedule appointment time. It is our goal for you to be ready to see your physician on time. Follow-ups are scheduled based on the particular needs of specific disease processes. If you have multiple chronic illnesses, you may be scheduled for multiple follow-up visits.

Late Arrivals: We all run late sometimes. In the event that you are late for your appointment, we will try our best to work you back in to the schedule. Depending on how busy we are, you may be required to reschedule your appointment.

Appointment Cancellations: We understand that sometimes plans change. We ask that you reschedule appointments *at least* 24 hours in advance so that we may give that time to someone else. If you do not call the office 24 hours prior to your appointment or "no show" you will be charged a $55.00 fee.

Sick Visits: Established patients who need acute care should call as early in the day as possible so that we can accommodate you. Patients are seen by appointment only.

Medication Refills: For non-emergency, and routine medication refills, please allow 72 hours and ask your pharmacy to send us a refill request. Also, please let a nurse or physician know if you need a 90 day prescription. Narcotic medications will only be written for a 30 day supply at a time. Additional refills to the original prescription will be at the doctor's discretion. Early refills will not be given. You may also be asked for a follow-up appointment for certain refill requests.

AFTER HOURS * If you have a life threating emergency, call 911 or go to the nearest emergency room.

Special Forms or Letter Requests: There is a $35.00 charge for al medical forms or letters of any kind to be completed by our practice. Please allow 7 to 10 days for completion.

Financial policy: SPINEUGENIX participates with most major insurance carriers. Please consult the provider list for in network savings with your insurance company. If a referral is needed for your insurance this must be obtained prior to your visit. If is the patient's responsibility to make sure correct referrals are obtained. It is imperative the office always has your correct insurance information on file. It is ultimately your responsibility to know the benefits provided under your insurance plan. As a courtesy to our patients, we file insurance claims for those insurances with which we participate. Accounts with outstanding balances greater than 90 days will be considered in collection status. All costs associated with sending the patient to collections will be the responsibility of the guarantor. Payment plans can be arranged by speaking with the front desk.

Please remember that your appointment is to focus on your medical needs. If your family member, who is also our patient, has any medical needs (including medication refills), we will be happy to schedule an appointment for them at the conclusion of your office visit.

As a courtesy, please turn off or silence your cell phone during your office visit.

I have read and understand the above office policies and agree to abide by them.

_____ _____

Signature Date

Assignment of Insurance Benefits

Medicare, Supplemental and Commercial Insurances

If applicable, I authorize any holder of medical information about me to release to the Centers for Medicare& Medicaid Services ("CMS") and its agents and/or any supplemental insurance companies any information needed to determine benefits or the benefits payable for related services. I request that payment of authorized benefits be made to SPINEUGENIX ("The Practice") on my behalf for any services furnished me by or in The Practice, including physician services. I authorize The Practice to act as my agent to help me assure payment from Medicare and any supplemental insurance companies. As part of my treatment, The Practice may prescribe testing procedures to be performed here. I understand, and have been advised that according to Florida Law, I am under no obligation to use this facility. I understand that I am responsible for full payment of any charges, including non-covered services, deductibles, and/or co-payment due. Regarding Commercial Insurance if applicable, I authorize the release of medical information that is necessary to process claims. I understand that some, and perhaps all, of the services may be non-covered services and may not be considered medically necessary under my insurance contract. SPINEUGENIX request that payment of authorized benefits be made on my behalf to ("The Practice") for any services provided by The Practice physicians. I understand that I am responsible for payment of any charges, including non-covered services, deductibles, and/or co-payment due. I further understand that I am responsible to notify this office of any preauthorization or precertification required by my insurance company. It is my responsibility to ensure that an authorization is on file with The Practice prior to having my procedure performed. When applicable, I understand that I am responsible for full payment of all charges in the absence of an authorization.

_____ _____

Signature of patient/parent or legal guardian Date

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by SPINEUGENIX ("The Practice") for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of The Practice. I understand that diagnosis or treatment of me by The Practice may be conditioned upon my consent as evidenced by my signature on this document.

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. The Practice is not required to agree to the restriction that I may request. However, if The Practice agrees to a restriction that I request, the restriction is binding on The Practice.

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

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present 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 a right to review The Practice's Notice of Privacy Practices prior to signing this document. The Practice's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures if my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of The Practice. The Notice of Privacy Practices for The Practice is also provided in the waiting room. This Notice of Privacy Practices also describes my rights and The Practice's duties with respect to my protected health information.

The Practice reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of patient/parent or legal guardian Date

ALLERGIES

PLEASE LIST ANY ALLERGIES TO MEDICATION OR FOOD:

MEDICATION NAME	SYMPTOMS/REACTION

MEDICATIONS

LIST CURRENT MEDICATIONS, OVER THE COUNTER, HERBS & SUPPLEMENTS:

NAME	STRENGTH/FREQUENCY	NAME	STRENGTH/FREQUENCY

SOCIAL HISTORY

DO YOU CURRENTLY USE OR HAVE YOU EVER USED TOBACCO? YES NO
IF YES, PLEASE CIRCLE THE TYPE: CIGARS CIGARETTES PIPE CHEWING TOBACCO
HOW MANY YEARS? HOW MUCH PER DAY? YEAR YOU QUIT-
ALCOHOL USE: YES NO IF YES, HOW MANY DRINKS/HOW OFTEN?
CAFFEINE USE: YES NO IF YES, PLEASE CIRCLE THE TYPE: COFFEE TEA SODA
HOW MANY DRINKS/HOW OFTEN?

FAMILY HISTORY

RELATIONSHIP	LIVING YES/NO	AGE	MAJOR MEDICAL PROBLEMS/CAUSE OF DEATH
FATHER			
MOTHER			
SIBLING(S)			
CHILDREN			

HAVE YOU HAD ANY OF THE FOLLOWING PROCEDURES (CHECK ALL THAT APPLY)

PROCEDURE	YEAR	PROCEDURE	YEAR
□ APPENDIX REMOVED		□ HYSTERECTOMY	
□ ABDOMINAL ANEURYSM REPAIR		□ KNEE JOINT REPLACEMENT L/R/BIL	
□ BRAIN SURGERY		□ LEG ARTERY BYPASS	
□ BREAST CANCER SURGERY		□ PACEMAKER/DEFIBRLLATOR	
□ CARDIAC CATHETERIZATION		□ PROSTATE CANCER SURGERY	
□ CAROTID ARTERY SURGERY		□ PTCA (ANGIOPLASTY)	
□ GALLBLADDER REMOVED		□ SPINE SURGERY NECK/BACK	
□ HEART SURGERY		□ STEROID/EPIDURAL/SPINE INJECTIONS	
□ HEART VALVE REPLACEMENT		□ STRESS TEST	
□ HERNIA SURGERY		□ TONSILLECTOMY	
□ HIP JOINT REPLACEMENT L/R/BIL		□ VASCULAR SURGERY STENT	
□ OTHER:		□ OTHER:	

PERSONAL HEALTH HISTORY (CHECK ALL THAT APPLY)

□ ABNORMAL ELECTROCARDIOGRAM	□ HEART MURMUR
□ ADDICTION ISSUES	□ HEART STENTS
□ ALLERGIES/SINUS DIFFICULTIES	□ HERNIA
□ ANEMIA	□ HIGH BLOOD PRESSURE
□ ARTHRITIS OF:	□ HIGH CHOLESTEROL
□ ASTHMA/ BREATHING DIFFICULTIES	□ KIDNEY PROBLEMS
□ BLEEDING DISORDER	□ LIVER PROBLEMS
□ BLOOD CLOTS	□ MENTAL ILLNESS
□ BOWEL/DIGESTIVE PROBLEMS	□ OSTEOPOROSIS/OSTEOPENIA
□ CANCER OF:	□ PALPITATIONS
□ C.O.P.D/EMPHYSEMA/CHRONIC BRONCHITIS	□ PNEUMONIA
□ DEPRESSION/ANXIETY	□ REFLUX DISEASE
□ DIABETES – DIET/PILLS/INSULIN	□ RHEUMATIC FEVER
□ DIALYSIS TREATMENTS	□ SEIZURES
□ FIBROMYALGIA	□ STROKE/TIA
□ GALLBLADDER PROBLEMS	□ THYROID PROBLEMS
□ GOUT	□ URINARY TRACT INFECTIONS
□ HEADACHES/MIGRAINES	□ ULCERS

INITIAL PAIN ASSESSMENT

HISTORY OF PAIN:

WHEN DID YOUR PAIN BEGIN? MONTH YEAR

HOW DID YOUR PAIN BEGIN? (CHECK ONE) _____ _____

□FOLLOWING SURGERY □ FOLLOWING ILLNESS

□UNKNOWN CAUSE OF ONSET □ACCIDENT AT WORK □ACCIDENT AT HOME

OTHER ACCIDENT (PLEASE DESCRIBE OTHER ACCIDENT IF APPLICABLE: _____

_____

PAIN AND TREATMENT: *WHAT TREATMENTS HAVE YOU RECEIVED IN THE PAST AND WHICH ONES ARE YOU CURRENTLY RECEIVING?*

	PAST	CURRENT	HAS THE TREATMENT BEEN SUCCESSFUL?
NARCOTICS	□	□	YES NO
PSYCHIATRIC MEDICATIONS	□	□	YES NO
PSYCHOTHERAPY/COUNSELING	□	□	YES NO
CHIROPRACTIC CARE	□	□	YES NO
PHYSICAL THERAPY	□	□	YES NO
MASSAGE THERAPY	□	□	YES NO
OCCUPATIONAL THERAPY	□	□	YES NO
ACUPUNCTURE	□	□	YES NO
HYPNOSIS	□	□	YES NO
STEROID/EPIDURAL/SPINE INJECTIONS	□	□	YES NO
SURGERY	□	□	YES NO

DESCRIPTION OF PAIN: *WHAT DOES YOUR PAIN FEEL LIKE? (CIRCLE ALL THAT APPLY)*

ACHING BEATING BURNING CRAMPING DULL FLICKERING NUMB PIERCING PINCHING POUNDING PRESSING PULLING PULSING QUIVERING SHARP SHOOTING STABBING STINGING SQUEEZING TENDER THROBBING TINGLING

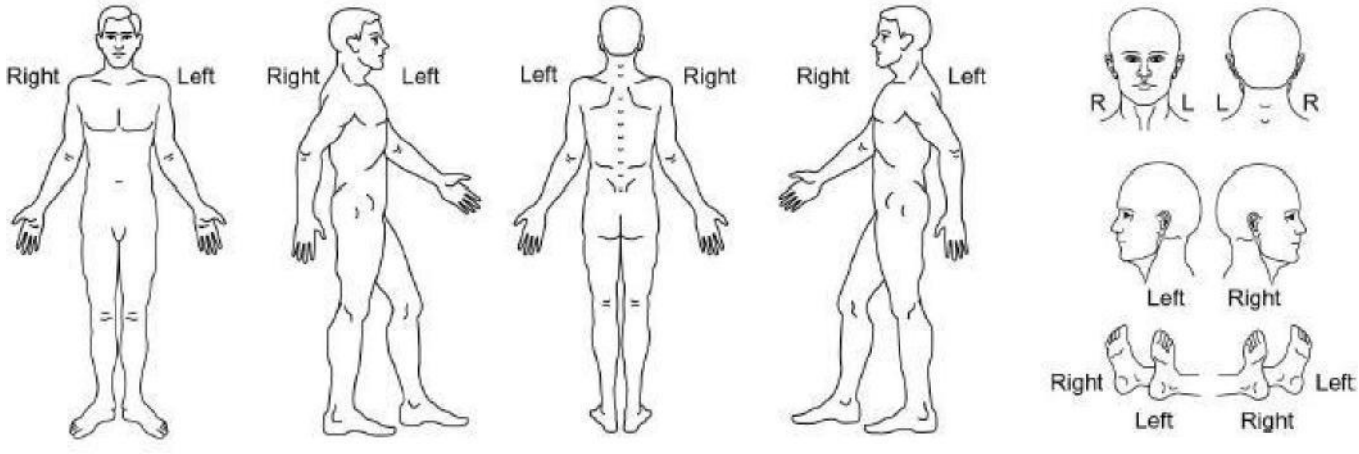
INTENSITY OF PAIN: *(PLACE A MARK ON THE LINE BELOW TO INDICATE INTENSITY OF YOUR PAIN THE MAJORITY OF THE TIME)*

0_____ **10**

NONE MINIMAL MODERATE SEVERE UNBEARABLE

LOCATION OF PAIN:

(CIRCLE ALL AREAS OF THE BODY ON THE IMAGES BELOW THAT ARE CAUSING YOU PAIN)



PATTERN OF PAIN:

WHAT HAPPENS TO YOUR PAIN? (CHECK APPROPRIATE BOXES BELOW)

	INCREASES	DECREASES	STAYS THE SAME
WHEN WALKING?	□	□	□
WHEN STANDING?	□	□	□
WHEN SITTING?	□	□	□
WHEN LAYING DOWN?	□	□	□
AS THE DAY PROGRESSES?	□	□	□

DURATION OF PAIN:

HOW LONG DOES YOUR PAIN LAST? (CHECK ONE WORD GROUP BELOW)

□CONTINUOUS, STEADY CONSTANT □RHYTHMIC, PERIODIC,

INTERMITTENT□ BRIEF, MOMENTARY, TRANSIENT

ALLEVIATION OF PAIN:

WHAT DO YOU DO TO ALLEVIATE YOUR PAIN? (CHECK ALL THAT APPLY)

□TAKE MEDICATION □IGNORE THE PAIN □EXERCISE

□REST AND RELAX □DISTRACT YOURSELF□OTHER:

_____