Staff Use: Physician Referred By:

____

New Patient Information

Pt #__________________

Doctor:________________

Name____ Date of Birth______________
Last First Middle Initial

Address____SSN________________

Home Phone________________________ Cell Phone__________________________

Primary Care Doctor ______________________Address____________________________

Emergency Contact_____________________________ Relationship___________________

Emergency Contact Phone#_________________ Marital Status: S M D W

You are: Male Female You are: Right Handed Left Handed Height_____ft ____in

Employment Status (please circle one) : Student /Part Time /Full Time / Social Security Disabled / Retired

Preferred Pharmacy & location____

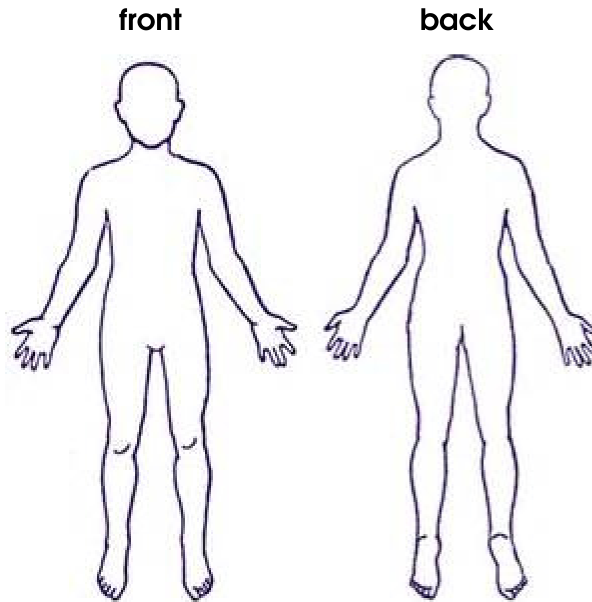
Are you here for a second opinion for treatment? Yes No

What is your main reason for seeking treatment from us today? ___________________________

____

Circle on the body where you are experiencing problems:

front back



Circle your level of pain NOW:

Back Pain: Low 0----1----2----3----4----5----6----7----8----9----10 Extreme

Leg Pain: Low 0----1----2----3----4----5----6----7----8----9----10 Extreme

Neck Pain: Low 0----1----2----3----4----5----6----7----8----9----10 Extreme

Arm Pain: Low 0----1----2----3----4----5----6----7----8----9----10 Extreme

Patient Signature______________________________________Date_____________

I attest all information is accurate.

F.A.S.T.
Florida Advanced Spine and Sports Trauma Centers

Pt #____________________

Dr#____________________

New Patient Information

1. When did your current problem begin? ____

2. Have you had similar pain *or* surgery for this in the past? Circle: Yes No

If yes, please list type of surgery, when/where, name of surgeon: ____________________________

____

3. How would you describe the onset of your pain? (circle all that apply)

Suddenly Lifting Bending Twisting Pulling

Gradually After a fall No apparent cause Date of Accident:_______________

4. What activities intensify your pain? (circle all that apply)

Lying Sitting Exercise(during) Bending forward Twisting

Standing Walking Exercise(after) Bending backward Coughing

5. What reduces your pain? (circle all that apply)

Lying Sitting Exercise(during) Bending forward Twisting

Standing Walking Exercise(after) Bending backward Coughing

6. What treatments have you tried? (circle all that apply)

Physical Therapy, who?______________ Home exercises Acupuncture Decompression

Chiropractic, who?______________ Protective bracing Pain Management, who?____________

Laser Spine Surgery (LSI in Tampa or Dr. Bonati), when?_________________________

7. Have you been seen by any other doctor for this current pain? No prior treatment

Primary Care MD/PA/NP_____________ Emergency Room(date) _______________

Urgent Care(date) _________________ Hospitalized(date)____________________

8. Any of the following tests? No test performed

X-rays(date)_____________ MRI(date)______________ CT Scan(date)______________

EMG/NCS(date)____________ Other____

9. Work related injury? No Yes If yes, when? ________________

10. Are you still working? No Yes If no, last date worked:__________________

11. Is your pain due to an auto accident? No Yes If yes, when?________________________

12. Do you have an attorney involved in your injury? No Yes If yes, please provide name, address, and phone number of attorney____

____

Patient Signature:_____________________________________ **Date:**________________________

I attest all information is accurate.

F.A.S.T.
Florida Advanced Spine and Sports Trauma Centers

Pt #____________________

Dr#____________________

New Patient Information

13. Review of symptoms: (check all that apply)

☐Unexplained weight loss/gain ☐Change in appetite ☐Mood changes
☐Bladder accidents/Incontinence ☐Arm numbness ☐Fatigue
☐Bowel accidents/Incontinence ☐Leg numbness ☐Stiffness
☐Night sweats ☐New swelling(legs or arms) ☐Joint pain
☐Fever ☐Change in handwriting ☐Poor sleep
☐Genital numbness ☐Difficulty walking ☐Rash
☐Severe nighttime pain ☐New balance problems ☐Bruising/Bleeding
☐Recent infections ☐Difficulty buttoning buttons ☐Blurred vision
☐**Other**____

14. Past medical history: (circle all that apply) **None**

Heart Disease High Blood Pressure Diabetes Kidney Disease Osteoarthritis Liver Disease
Ulcers Lung Disease Thyroid Disease Seizures/Epilepsy Psychiatric Illness
Osteoporosis Acid Reflux High Cholesterol Cancer__________________ Fibromyalgia
Rheumatoid Arthritis Other____

15. Past Surgical History: (circle all that apply)

Lumbar(lower back) Heart Stents Lung Kidney Thyroid Breast
Cervical(neck) Bowel Hernia Gall bladder Prostate Arm/Leg, specify:__________________
Other____

16. Allergies:(circle all that apply/include reaction)

Penicillin__________________ Sulfa__________________ Codeine__________________
Iodine__________________ Other____

17.Current Medications: (include dosage)

____

____

____

____

18. Are you taking blood thinner? No Yes If yes, circle all that apply/include dosage:
Aspirin__________ Plavix__________ Coumadin__________ Other__________________

19. Family History: (blood relatives only) Circle all that apply: None
Cancer Bleeding disorder Stroke Diabetes Cardiac Arthritis Back/Neck pain Other__________

20. Social History: (Please answer all questions)
You live: Alone With others:__________________ Retirement Home__________________
Occupation:__________________ Retired Social Security Disability Currently Employed
Job: Sedentary Light Medium Heavy **Have you ever smoked?** No Yes Quit **Packs per day**___ **Yrs**____
Do you drink alcohol? No Yes **What?**____________ **How much per week?**______________
Use illicit drugs? No Yes **What?**______________ **How often?**____________________

Patient Signature____________________________________**Date**__________________

I attest all information is accurate.

F.A.S.T.
Florida Advanced Spine and Sports Trauma Centers

Authorization to Release Medical Records

PATIENT INFORMATION:

Name (Print) **DOB** **SSN**

____ __________________ ____________________

INFORMATION TO BE RELEASED TO:

Name of designated recipient

____

Address **City** **State** **Zip**

____ ________________ __________ _______

INFORMATION TO BE RELEASED: (check one)

_________ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)

_________ All medical records

_________ Specific information (please specify):

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please check all that apply)

________ Attorney ________ Insurance _________Doctor _________Personal

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give me specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial)

______ Drug/Alcohol abuse/treatment & Diagnosis _________ Sexually transmitted disease

______ HIV/AIDS diagnosis/treatment/testing _________ Mental illness or psychiatric diagnosis/treatment

Pt #____________________

Dr#_____________________

ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION, AND AGREEMENT FOR PAYMENT OF SERVICES RENDERED

Benefit Assignment/Release of Information/Financial Policy

I hereby assign all medical and/or surgical benefits, including major health benefits, Medicare, private insurance, and any other health plans or insurance including any insurance authorized by Florida Statutes, including provisions set forth under Fla. Stat. 627.736. Pursuant to this assignment, I hereby assign my insurance benefits and any and all legal and/or equitable causes of action available to me under Florida Law, (and if applicable, Federal Law), and/or my applicable health and/or automobile insurance policy to Florida Advanced Spine, Sports and Trauma Centers, ("F.A.S.T."), the ASSIGNEE herein. I further assign to ASSIGNEE any and all derivative causes of action which may also include attorney fees and costs, extra-contractual or bad faith actions arising out of a dispute for benefits under my health and/or automobile insurance, to the ASSIGNEE. Both the ASSIGNEE and I, the undersigned patient, acknowledge that I am foregoing, and the ASSIGNEE is assuming all of these rights as they relate to the medical services rendered to me by ASSIGNEE under this agreement and thus serves as additional consideration for this assignment of benefits to the ASSIGNEE. In the event my automobile insurance company is obligated to make payments for charges made by ASSIGNEE for services rendered to me and my insurance company refuses to make or reduces such payments, I hereby request and direct the insurance company to comply with §627.736(6)(f) and provide ASSIGNEE notice that the policy limits under this section have been reached within 15 days after the limits have been reached and to set aside and place in escrow an amount equal to the full amount of any such denial or reduction, and to hold that amount in escrow until the dispute is resolved in the appropriate forum. I also acknowledge and affirm that automobile insurance proceeds will be payable and due in Hillsborough County, Florida and that Hillsborough County, Florida will be the most convenient venue for litigation in the event that ASSIGNEE must pursue litigation against an insurer for payment of benefits for services rendered to me. Additionally, I agree that any payments made by my insurance carriers directly to me, my guarantor or my dependants, for services rendered by ASSIGNEE and its physicians and healthcare providers is the property of ASSIGNEE and will be promptly remitted to ASSIGNEE within 30 days of my receipt of such payment. I agree that benefits assigned to ASSIGNEE are for actual services rendered to me by ASSIGNEE. Additionally, I have the right to confirm that those services were performed. I acknowledge that I was not solicited by any person to seek any services from ASSIGNEE. ASSIGNEE bills my insurance carrier as a courtesy to me, although I am responsible for the entire bill when services are rendered. ASSIGNEE requires that arrangements for payment of my estimated portion of the bill be made at the time services are rendered (this estimate is not intended to release me from obligations to remit full payment open on my account balance). If my insurance carrier does not remit payment within 60 days, the balance will be due in full. The only exception to these terms are if I am covered by a Letter of Protection with ASSIGNEE. Additionally, an exception is made if I am a patient covered under the Florida Workers Compensation Act. I also agree to promptly remit payment of any co-payments, co-insurance and deductibles as described by my insurance carrier at the time services are rendered. In any event, I agree to remit payment regarding these services no later than 30 days after said services are billed to me. If any payment is made directly to me by an insurance carrier for services billed by ASSIGNEE, I agree to promptly remit the same to ASSIGNEE. In the event collection action is required to obtain any overdue balance, I agree to pay a 10% penalty to cover said collection fees.

Parent/Guardian: I hereby acknowledge that I have read and understood the information herein, agree with the statements herein, agree to abide by this assignment, release and financial policy, and agree that same are electronically signed by my acceptance of enrollment into ASSIGNEE'S electronic medical record system and I agree to sign original paper agreements in the event that they are requested by any insurance carrier or government bodies.

Patient/Guardian Signature____**Date**__________________

F.A.S.T.
Florida Advanced Spine and Sports Trauma Centers

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may not longer be protected under Privacy laws.

Signature: ________________________________ Date:________________________

(Patient, guardian*, or Authorized Representative)

"This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose." If an oral disclosure is made, the statute requires that an oral notice be provided and followed by the previously mentioned written notice within 10 days of the disclosure.

PATIENT ID:___________

NOTICE OF USE OF PRIVATE HEATH INFORMATION AND CONTRACT AUTHORIZING MEDICAL CARE

Patient Name: _________________________________ **DOB:**___________________ **Date:**_____________

I. DESIGNATION OF CERTAIN RELATIVES, CLOSE FRIENDS AND OTHER CAREGIVERS AS MY PERSONAL REPRESENTATIVE:
I agree that the practice may disclose certain portions of my health information to a personal representative of my choosing; as such person is involved in my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to this person's involvement with my healthcare.

Print Name: ____ Print Name: ___________________________________
Print Name: ____ Print Name: ___________________________________

II. REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS:
As provided by Privacy Rule Section 164.522(b), I hereby request that the practice make all communications with me by the alternative means I have listed below:

HOME / CELL PHONE NUMBER: HOME:___________________________**CELL:**______________________________
◯ Ok to leave message w/ detailed information ◯ Leave Message with call back number only ◯ Ok to Text Confirmation
WORK PHONE NUMBER: _______________________________________
◯ Ok to leave message w/ detailed information ◯ Leave Message with call back number only **WRITTEN COMMUNICATION ADDRESS OR EMAIL:** ____
◯ Ok to mail / email detailed information

III. ACKNOWLEDGEMENT OF PRACTICE'S HIPAA PRIVACY NOTICE:
By subscribing my name below, I acknowledge that FASTMD, Florida Advanced Spine and Sports Trauma Centers, has provided me with a copy of the HIPAA Privacy Notice, and that I have read (or had the opportunity to read if I so chose), and understand my rights and ask questions regarding my rights and receive answers to my satisfaction and agree to its terms

____ ____
PRINT NAME SIGNATURE

Patient ID:__________

Follow Up Intake Questionnaire

Date:__________

Name:____ **DOB:**________

Last First Middle

1. **Please circle on the line below how bad your pain is NOW.**

Back Pain	0 ----- 1 ----- 2 ----- 3 ------ 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Worst
Leg Pain	0 ----- 1 ----- 2 ----- 3 ------ 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Worst
Neck Pain	0 ----- 1 ----- 2 ----- 3 ------ 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Worst
Arm Pain	0 ----- 1 ----- 2 ----- 3 ------ 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Worst

2. **Current problem is ◯ Changed or ◯ Unchanged from your last visit. (Please check one)**

3. **What medication(s) and how much of over the counter or prescription medication are you currently taking?**____

____

____

4. **How many sessions of therapy have you had since the last office visit?** ______________ **◯ N/A**

5. **Medical History: ◯ Not Changed ◯ Changed on** _______________ **Date**
   Describe below:

____

____

____

6. **Are you currently working? ◯ Yes ◯ No**

____ ________________________________

Patient Signature **Date**