FLORIDA SPINE CARE & PAIN CENTER

Dr. Bao T. Pham, DO
Specialist in Interventional Pain Management
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FLORIDASPINEPAIN.COM

patient information *(please print)*

PATIENT NAME *(last, first, middle)*	SOCIAL SECURITY #	SEX M F	RACE	DATE OF BIRTH

ADDRESS	CITY / STATE / ZIP	COUNTY	MAIDEN NAME

MARITAL STATUS	HOME PHONE # ( )	CELL / PAGER # ( )	MAY WE CONTACT YOU BY EMAIL? YES NO	PRIMARY LANGUAGE

EMPLOYER *(if retired, please indicate here)*	OCCUPATION	EMAIL ADDRESS

EMPLOYER ADDRESS	EMPLOYER CITY / STATE / ZIP	WORK PHONE # ( )	EMPLOYMENT STATUS

spouse information

SPOUSE NAME *(last, first, middle)*	SOCIAL SECURITY #	DATE OF BIRTH

ADDRESS	CITY / STATE / ZIP	HOME PHONE # ( )

EMPLOYER *(if retired, please indicate here)*	OCCUPATION	WORK PHONE # ( )

emergency contact 1

NAME *(last, first, middle)*	RELATIONSHIP: FATHER MOTHER BROTHER SISTER SON DAUGHTER FRIEND OTHER SPOUSE

HOME PHONE # ( )

WORK PHONE # ( )

emergency contact 2

NAME *(last, first, middle)*	RELATIONSHIP: FATHER MOTHER BROTHER SISTER SON DAUGHTER FRIEND OTHER SPOUSE

HOME PHONE # ( )

WORK PHONE # ( )

account guarantor

GUARANTOR OF ACCOUNT *(responsible party)*	RELATIONSHIP SPOUSE PARENT OTHER	SOCIAL SECURITY #

ADDRESS	CITY / STATE / ZIP	COUNTY

EMPLOYER *(if retired, please indicate here)*	SEX M F	DATE OF BIRTH	HOME PHONE # ( )

EMPLOYER ADDRESS	OCCUPATION	WORK PHONE # ( )

EMPLOYER CITY / STATE / ZIP	EMPLOYMENT DATE	CELL / PAGER PHONE # ( )

primary & secondary insurance *(copy of the front & back of insurance cards)*

PRIMARY INSURANCE COMPANY NAME	SUBSCRIBER NAME	SUBSCRIBER D.O.B.	SOCIAL SECURITY #

GROUP NAME	GROUP #	MEMBER ID / POLICY #	RELATIONSHIP SPOUSE PARENT CHILD OTHER	EFFECTIVE DATE

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER CITY / STATE / ZIP	COPAY

SECONDARY INSURANCE COMPANY NAME	SUBSCRIBER NAME	SUBSCRIBER D.O.B.	SOCIAL SECURITY #

GROUP NAME	GROUP #	MEMBER ID / POLICY #	RELATIONSHIP SPOUSE PARENT CHILD OTHER	EFFECTIVE DATE

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER CITY / STATE / ZIP	COPAY

I certify that the information provided by me in applying for payment under Title XVIII of the Social Security Act is correct.

authorization for release of information

I authorize FLORIDA SPINE CARE AND PAIN CENTER to release to my insurance carrier or its designated agents any information concerning medical care (physical and/orpsychological), advice, treatment or supplies provided to me for purposes of administration, review, investigation or evaluation of claim coverage and utilizationof services. I authorize that a copy of this information to be as valid as the original. I will notify FLORIDA SPINE CARE AND PAIN CENTER in writing of any information I do not want released.

X _____

SIGNATURE DATE

FLORIDA SPINE CARE & PAIN CENTER

1560 Kingsly Ave Suite #3, Orange Park, FL 32073

POWER OF ATTORNEY AND MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER, WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these present does hereby make, constitute and appoint FLORIDA SPINE CARE AND PAIN CENTER, and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said FLORIDA SPINE CARE AND PAIN CENTER, at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows FLORIDA SPINE CARE AND PAIN CENTER or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these present does give and grant the said FLORIDA SPINE CARE AND PAIN CENTER as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes, as the undersigned might or could do personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of the same to FLORIDA SPINE CARE AND PAIN CENTER or any insurer providing coverage to me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

PATIENT INITIALS _____

ASSIGNMENT OF BENEFITS

I, _____, hereby authorize_____ the assignment of benefits

Name of Injured/Patient Name of Insurance Company/Carrier

payable to FLORIDA SPINE CARE AND PAIN CENTER and/or its designee for physician services and supplies by government and/or any other private third party payer. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles, non-covered services and services deemed not medically necessary by the agents given above. In the event I receive payment from my insurance carrier I agree to endorse any payment I have over to my physician for which these fees are payable. PATIENT INITIALS _____

FINANCIAL DISCLOSURE POLICY

As a result of the changes to the 2003 Florida No Fault Statute, it is a third degree felony for any provider to agree to waive a deductible or to reduce or waive your co-pay as a routine business practice. We therefore require payment of any balances due after all attempts by us (including litigation) to collect from the Florida No Fault coverage who's right to collect, you have assigned to us. (Two exceptions are allowed by statutue involving financial inability in individual cases). PATIENT INITIALS _____

AUTHORIZATION FOR TREATMENT

I agree to any examination, treatment and procedures that may be performed during office visits, including emergency treatment considered necessary by the physician and/or his/her providers.

BY SIGNING BELOW I AGREE TO ALL THE HEADINGS ABOVE, FOR WHICH I HAVE ALREADY INITIALED.

X _____ | _____

PATIENT NAME PATIENT SIGNATURE DATE

X _____ | _____

WITNESS NAME WITNESS SIGNATURE DATE

FLORIDA SPINE CARE & PAIN CENTER

1560 KINGSLEY AVE SUTIE #3, ORANGE PARK, FL 32073

PAIN MANAGEMENT AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines.

In this case, my doctor will taper off this medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also a drug dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medications with anyone.

I will not attempt to obtain any controlled medicines, including opiate pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. **No refills will be available during evenings or on weekends**.

I agreed to use _____Pharmacy

Located at _____

Telephone number _____, for filling prescriptions for all of my pain medicine.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my Pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

I agree that I will use my medicine at a rate no greater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused pain medicine to every office visit

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me. This Agreement is entered into on this _____ day of _____.

Patient Signature _____ Physician Signature_____

Witnessed by _____

FLORIDA SPINE CARE & PAIN CENTER

PROVIDER'S LIEN NOTICE OF PROTECTION

I DO HEREBY AUTHORIZE AccMed Healthcare Systems, (Dr. Bao T Pham, or it's authorized representative) to furnish your any attorney, with a full report of this examination, diagnosis, prognosis, etc. of myself in regard to the accident I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said provider such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said provider. I hereby further give a Lien on my case to said provider against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event that another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said provider for all

Medical bills submitted by him for services rendered me and that this agreement is made solely for said provider's additional protection and in consideration of him awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fees or charges. I authorize AccMed or its authorized representatives to sign my name to any check written in both our names, when such a check is in payment for his services regarding my condition.

Please acknowledge this letter by signing below and returning it to the provider's office. I have been advised that if my attorney does not wish to cooperate in protecting the provider's interest, the provider will not await payment but may declare the entire balance due and payable immediately.

If this amount is assigned to any attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Date _____ _____

Patient's Signature

_____

Print Patient's Name

This undersigned being attorney of record for the above patient do hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect said provider above named. Attorney further agrees that in the event the Lien is litigated, the prevailing party will be awarded fees and costs.

Date _____ _____

Attorney's Signature

_____

Print Attorney's Name

FLORIDA SPINE CARE & PAIN CENTER

HIPAA PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and disclosures of health information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax or other methods.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We provide information when otherwise required by law, such as for enforcement in specific circumstances. In any other situation we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make significant change in our policy, we will change notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights

In most cases you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of instance where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes and other than when you explicitly authorized it. If you believe that information in your record is incorrect or if information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices and follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice.

Privacy Representative

Shelby Faulkner, Practice Administrator 904-264-2677

Please Print Name here _____

Please Sign and Date here _____

FLORIDA SPINE CARE & PAIN CENTER

STATEMENT OF POLICIES

The following policies are established for mutual convenience and benefits. Please read them carefully and sign at the bottom to indicate your agreement of this statement of policies.

I. FLORIDA SPINE CARE AND PAIN CENTER strictly provides spine and pain services only. Patients are expected to have or arrange for a Primary Care Physician.

II. Deductibles and Copays are payable at the time of service. Any previous balance is to be paid at the time of service.

III. Patients are responsible for obtaining referrals and authorizations for services rendered at FLORIDA SPINE CARE AND PAIN CENTER.

IV. If you are unable to keep a scheduled clinic appointment, please call during normal business hours, at least 24 HOURS in advance to cancel the appointment. Patients are to call the *office* at 904.264.2677 to cancel or reschedule appointments. Failure to do so will incur a **$30** charge to your account for the missed appointment.

V. Procedure appointments require a 48 HOUR notice and will incur **$50** charge to your account for the cancellation fee.

VI. There is a **$25** fee for all disability, FMLA and other forms/paperwork that you need to have completed by the physician. Keep in mind that many forms may require you to make an appointment. Forms will take approximately **2-3** weeks to be completed. Fees are required in advance.

VII. There is a fee for my reports or records requested by attorney's insurance companies, disabilities, etc. This charge will be determined by the information requested.

VIII. Prescription Policies:

a. *NO* refills will be given unless seen by a physician.

b. *NO* pain medication will be prescribed/refilled/given via the telephone or facsimile.

c. Our physicians DO NOT replace lost or stolen prescriptions.

d. ALL patients are expected to adhere to FLORIDA SPINE CARE AND PAIN CENTER pain management agreement.

IX. I realize that if my insurance company fails to pay my balance in full, or there is no payment made within 90 days, it is my responsibility to pay my services directly to FSCPC.

X. I understand that that FLORIDA SPINE CARE AND PAIN CENTER obtains benefit coverage as a *courtesy* only and is in no means liable for any misinformed information given by the insurance company. Furthermore, I understand that I am responsible for verifying insurance coverage myself.

I acknowledge that I have carefully read and understand the Statement of Policies and agree to abide by them.

Print Patient Name:_____ Date of Birth:_____

Signature:_____ SSN:_____