# FLORIDA SPINE CARE
## Dr. Bao T. Pham, DO
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FLORIDASPINECAREJAX.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? | PRIMARY LANGUAGE |
|---|---|---|---|---|
| | ( ) | ( ) | YES NO | |

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

X _____

SIGNATURE

# New Patient Information

**Date:** _____ **SSN:** _____

**LAST NAME** | **FIRST NAME** | **DATE OF BIRTH** | **CURRENT AGE**

**PRIMARY CARE PHYSICIAN** **PHONE #**

**REFERRING PHYSICIAN** **PHONE #**

## REASON FOR VISIT (CHECK THE ONE THAT APPLIES TO YOU)

**Work comp injury:**_____ **Automobile accident:**_____ **Slip and Fall :**_____ **Chronic Pain :**_____

If a specific personal injury was indicated above, please complete this section. (If not skip to next section)
date of injury:_____ state or place of injury: _____ attorney representation: yes or no

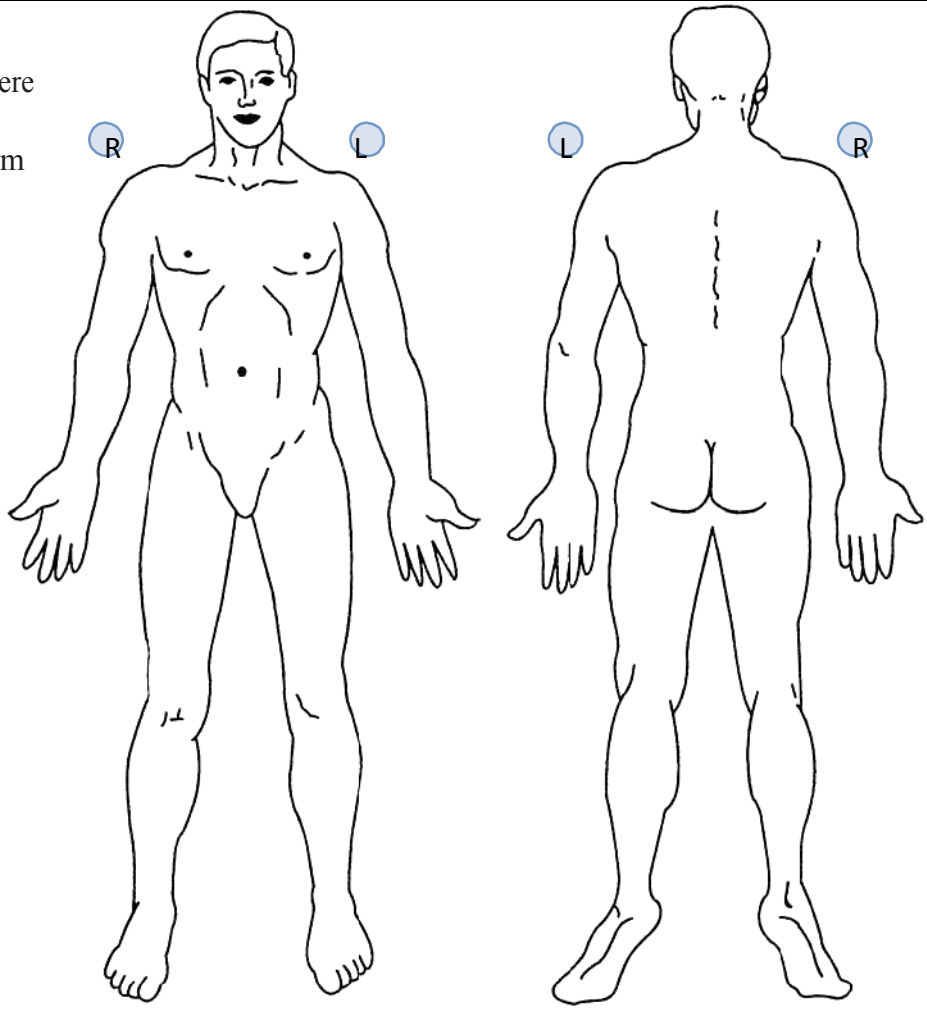
## PRIMARY REASON FOR THIS VISIT (DESCRIBE LOCATION OF PAIN)

## FACTORS OF COMPLAINT Explain how your pain or problem began and how it happened and how long you have had it

## ORTHO PAIN CHART

Mark the areas on your body where you feel the described sensations using the appropriate symbol from the list below.

| | |
|---|---|
| numbness | = = = |
| pins & needles | o o o |
| burning/aching | x x x |
| stabbing | / / / |



**PATIENT NAME:** **DOB:**

The Spine Center
OF DUPAGE MEDICAL GROUP

## FAMILY HISTORY

**WHAT ILLNESSES RUN IN YOUR CLOSE FAMILY (CHECK ALL THAT APPLY)**

**____ Scoliosis ____Spine Disease ____Arthritis ____Cancer ____Other:_____**

## TESTS & TREATMENT YES OR NO

Any previous tests (examinations) or treatments for your current condition you are being seen for today
*(If yes, please complete the following, if no, please skip to "medical history" section)*

## PREVIOUS TREATMENTS FOR THIS CONDITION

### *MEDICATIONS*

| | | | | |
|---|---|---|---|---|
| **Anti- Inflammatories** | _____ | **Temporary relief** | **Lasting relief** | **No relief** |
| **Muscle relaxants** | _____ | **Temporary relief** | **Lasting relief** | **No relief** |
| **Pain medications** | _____ | **Temporary relief** | **Lasting relief** | **No relief** |
| **Other(s)** | _____ | **Temporary relief** | **Lasting relief** | **No relief** |

### *THERAPIES*

| | | | | |
|---|---|---|---|---|
| **Chiropractic care** | _____ | **Temporary relief** | **Lasting relief** | **No relief** |
| **Physical therapy** | _____ | **Temporary relief** | **Lasting relief** | **No relief** |
| **Other(s)** | _____ | **Temporary relief** | **Lasting relief** | **No relief** |

### *INJECTIONS*

**(i.e. epidural steroid injections, nerve-root blocks)**

| | | | | | |
|---|---|---|---|---|---|
| **Date** _____ | **Injection type** _____ | **Temporary relief** | **Lasting relief** | **No relief** |
| **Date** _____ | **Injection type** _____ | **Temporary relief** | **Lasting relief** | **No relief** |

**Previous treating doctors** _____

**Specialty(s) (i.e. surgeon)** _____

## SPINE IMAGING HISTORY

PLEASE INDICATE WHETHER YOU HAVE HAD ANY OF THE FOLLOWING STUDIES AND WRITE WHEN & WHERE THE MOST RECENT WAS

| | | | | | | |
|---|---|---|---|---|---|---|
| **Yes** | **No** | **Regular x-ray of spine** | **When** | _____ | **Where** | _____ |
| **Yes** | **No** | **CT scan of spine** | **When** | _____ | **Where** | _____ |
| **Yes** | **No** | **EMG** | **When** | _____ | **Where** | _____ |
| **Yes** | **No** | **Bone scan** | **When** | _____ | **Where** | _____ |
| **Yes** | **No** | **Myelogram** | **When** | _____ | **Where** | _____ |
| **Yes** | **No** | **Discogram** | **When** | _____ | **Where** | _____ |
| **Yes** | **No** | **MRI of spine** | **When** | _____ | **Where** | _____ |

**PATIENT NAME:** **DOB:**

The Spine Center
OF DUPAGE MEDICAL GROUP

## MEDICAL HISTORY

**PLEASE CHECK ALL CURRENT & PAST MEDICAL CONDITIONS**

| | | | |
|---|---|---|---|
| ___No medical problem | __High Blood Pressure | __Heart attack | __Lung disease |
| ___Cancer *where?* _____ | __Asthma | __Bronchitis | __Stroke |

## SURGICAL HISTORY

**PLEASE CHOOSE ALL SPINAL SURGERIES YOU HAVE HAD**

Spine-neck Type of surgery _____ Date(s) _____

Spine-lower back Type of surgery _____ Date(s) _____

Other _____ Type of surgery _____ Date(s) _____

## Current medications *(may attach a list)*

| NAME | DOSE | # PER DAY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Allergies *(may attach a list)* ☐ No known medical allergies

| SUBSTANCE | REACTION |
|---|---|
| | |
| | |
| | |
| | |

# FLORIDA SPINE CARE
## 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 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, 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 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 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 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 assign all rights, under any insurance policy, which provides coverage for my
Name of Patient/Insured

treatment, to Accmed Healthcare Systems d/b/a Florida Spine Care. 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 agent(s) 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 statute 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 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 _____, 20____.

Patient Signature _____ Physician Signature_____

Witnessed by _____

# FLORIDA SPINE CARE

## 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 Pham, Practice Administrator 904-527-3135

Please Print Name here _____

Please Sign and Date here _____

# FLORIDA SPINE CARE

## 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 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.

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 904.527.3135 to cancel or reschedule appointments. Failure to do so will incur a **$50** 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 **$35** 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 **4-6** 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 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 FSC.

X. I understand that that FLORIDA SPINE CARE 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:_____

Signature:_____