TAMPA BAY
ORTHOPEDIC & SPINE
GROUP

Patient Intake Information

First Name: ___________________________________Last Name________________________________ Middle Initial______

Address: ____City&State_______________Zip______

Home Phone _________________________Cell Phone ________________Email______________________________________

May we leave messages regarding your appointment or medical condition at the number listed above? □Yes □ No

DOB___/____/____ SS#:_____/______/____ Marital Status: *Married / Single / Widow*

Do you have a DNR on file? Yes/ No -Do you have Advanced Directives in place? Yes / No If yes, may we have a copy? Yes/ No

Occupation: __________________________________Employer____________________________Work#__________________

Emergency Contact Name: ____Phone#___________________________

Family/Referring Dr______________________________________Phone_________________________Fax________________

Health Insurance

Insurance Company: ___________________________________Subscriber ID#:____________________Group#_____________

Are you the primary insured on this policy? □*YES* □*NO* If No, Insured Name: ________________________ Relation__________

Address if different then above__________________________City/St_____________Zip____________Phone______________

SS#_____/_____/_______DOB_____/_____/_____ Do you have secondary insurance? *YES / NO*

Pharmacy: ____

Auto Insurance

Date of accident ___/_____/____ Insurance Company Name: ______________________________Phone#__________________

Policy Number: __________________________________Claim Number: ____

Adjuster Name________________________________Phone#________________________Fax#_________________________

If you do not have auto insurance, do you live with anyone who does? *YES / NO*

If yes, Name of Insured: ____________________Address:___________________________City/St___________Zip________

Relation to insured ______________Insurance Company: ___________________Policy Number: _______________________

Workers Compensation

WC Insurance Company: ____Date of injury_____/______/______

Employer: ______________________Phone#___________________________________Claim#________________________

Nurse Case Manager: __________________________________Phone#_________________________Fax#_________________

Attorney Information

Do you have an attorney? *YES / NO*

If yes, Office Name____ Attorney Name____

Address____Phone__________________________Fax__________

I authorize the release of a full report of examination of findings, diagnosis, treatment programs, etc., to any referring or treating physician or dentist. I additionally authorize the release of any medical information to the insurance companies for legal documentation to process claims. I understand that I am responsible for all charges for the treatment rendered to me regardless of the insurance coverage. I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that ***Tampa Bay Orthopedic & Spine Group****. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to* ***Tampa Bay Orthopedic & Spine Group*** *will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will me immediately due and payable.*

Patient/ Guardian Signature____***Date***__________

Medical Complication Questionnaire

Date: ___________
Patient Name: ______________________________ Age: ______ Sex: *Male* *Female*
Dominant Hand**:** *Right /Left /Ambidextrous* Height: ________ Weight: __________

Please mark/circle your answers to questions that pertain to your medical complaint. You may select more than one answer.

☐ Headaches	*Globally*	*Frontal*	*Temporal Right/Left*	*Occasionally*	*Constant*	*Other*_________
☐ Neck	*Sharp*	*Stabbing*	*Burning*	*Dull*	*Ache*	*Pins & Needles*
☐ Upper Back	*Sharp*	*Stabbing*	*Burning*	*Dull*	*Ache*	*Pins & Needles*
☐ Lower Back	*Sharp*	*Stabbing*	*Burning*	*Dull*	*Ache*	*Pins & Needles*
☐ Leg *Right/Left*	*Sharp*	*Stabbing*	*Burning*	*Dull*	*Ache*	*Pins & Needles*
☐ Arm *Right/Left*	*Sharp*	*Stabbing*	*Burning*	*Dull*	*Ache*	*Pins & Needles*
☐ Shoulder/Elbow *Right/Left*	*Sharp*	*Dull/Ache*	*Swelling*	*Clicking/Popping*	*Instability*	*Pain w/Movement*
☐ Wrist/Hand *Right/Left*	*Sharp*	*Dull/Ache*	*Swelling*	*Clicking Popping*	*Instability*	*Pain w/Movement*
☐ Hip/Knee *Right/Left*	*Sharp*	*Dull/Ache*	*Swelling*	*Clicking/Popping*	*Instability*	*Pain w/Movement*
☐ Ankle/Foot *Right/Left*	*Sharp*	*Dull/Ache*	*Swelling*	*Clicking/Popping*	*Instability*	*Pain w/Movement*

If you checked more than one region which one is more problematic? ___________________________________

Are you experiencing any of the following: ☐ *Weakness* ☐ *Numbness* ☐ *Tingling*

Please, describe where you are experiencing the sensations(s) ____

When did this pain start? _____________ Have you had and previous neck or back problems? ☐ *Yes* ☐ *No*

If yes please explain____

Since the pain began has it ☐ *Improved* ☐ *Worsened* ☐ *Stayed the same* ☐ *Comes and goes*

What time of day is the pain most intense: ☐ *Morning* ☐ *Afternoon* ☐ *Evening* ☐ *While Sleeping* ☐ *All Day*

What aggravates your pain? ☐ *Walking* ☐ *Standing* ☐ *Sitting* ☐ *Laying* ☐ *Bending/Lifting* ☐ *Other*_________

What makes your pain feel better? ☐ W*alking* ☐ *Standing* ☐ *Sitting* ☐ *Laying* ☐ *Stretching* ☐ Other_________

Do you have difficulty walking*?* ☐ *Yes* ☐ *No* If yes, how far you can walk till you feel pain____________________

Does your pain awaken you from sleep? ☐ *Never* ☐ *Occasionally* ☐ *Frequently* ☐ *Always*

Have you had any problems with bowel, bladder, or sexual functions since this condition began? ☐ *Yes* ☐ *No*

If yes, please explain____

Do you exercise regularly? ☐ *Yes* ☐ *No If yes how often?* ____________________________

Does this pain affect your daily living? ☐ *Yes* ☐ *No If yes explain*________________________

Is your pain the result of some sort of auto accident or a traumatic incident?

☐ *Yes* *If yes, please fill out the accident /injury description*

☐ *No* *If no, please skip to the next section.*

Patient/ Guardian Signature____***Date***__________

ACCIDENT/INJURY DESCRIPTION

When did the accident or injury occur? Date: ____________Location:_____________________________________
What type of accident or injury occurred? (Circle)

☐ *Motor Vehicle* Were you the: ☐ *Driver* ☐ *Front Seat Passenger* ☐ *Rear Seat Passenger* ☐ *Pedestrian*

Seatbelt: ☐ Yes ☐ No Airbag: ☐Yes ☐ No

☐ *Work related* ☐*Motorcycle* ☐*Struck by vehicle* ☐*Slip and Fall* ☐*Sports/Recreation* ☐*Other*_______________

Briefly describe the accident/Injury in your own words:
____
____
____
____
____
____

Did you go to the hospital/urgent care? ☐ Yes ☐No *If Yes, where?* ___________________________________

Have you had an ☐MRI ☐X-rays ☐CT ☐Other_________ If so where? __________________________________

What treatments have you received for this condition?

☐Medication (list):____

☐Physical therapy (how many weeks/months): ____

☐Chiropractic care (how many weeks/months): ____

☐Injections (trigger point, epidural, etc.): How many? ________ When was the last? __________________

Surgical History

Have you had any previous surgical operations including spine ☐Yes *If yes please list below* ☐No

Date	Physicians Name	Treatment Type

Family Health Information

Many health problems are the result of hereditary spinal weakness, thus information about your family member will give us a better picture of your total health picture. Please list any information you may know about your family members

Father: ____

Mother: ____

Siblings:____

SOCIAL HISTORY

Are you pregnant? ☐YES ☐ NO ☐MAYBE If yes, how far along___________ Number of children______________

Smoke: ☐No, when did you quit smoking? ______ ☐ Yes; pack per day? _____Smoking time length (yrs): ___

Other (cigars, smokeless tobacco, etc.): ____________________

Alcohol per week: ☐None ☐less than 6 drinks ☐ 6-12 drinks ☐ 12-24>drinks

Do you us recreational drugs? ☐No ☐Yes If yes, type/how often____

Occupation: ____

Current work status:

☐Full time employment ☐Full time with restrictions; explain____

☐Part time ☐Part time due to condition; explain: ____

☐Part time with restrictions ☐ unemployed ☐unemployed looking for work ☐ Retired

☐Currently not working due to medical reason; explain: ____

☐Student

Patient/ Guardian Signature____***Date***__________

Medical History

Please check the following conditions you currently have, or have had in the past.

Artificial Implant
_ Heart pace maker
_ Breast augmentation
_ Insulin pump
_ Heart valve
_ Joint Replacement __________
_ Other_____________________

Arthritis
_ Gout
_ Osteoarthritis
_ Rheumatoid Disease
_ Other_____________

Blood
_ Anemia
_ Leukemia
_ Hemophilia
_ HIV/AIDS
_ Sickle Cell Anemia
_ Other__________________

Endocrine
_ Diabetes Type 1
_ Diabetes Type 2
_ Thyroid Disease
_ Hypoglycemia
_ Parathyroid Disease
_ Other____________________

Eye
_ Glaucoma
_ Hypoglycemia
_ Other:_________________

Lung/Respiratory
_ Asthma
_ Emphysema
_ Lung Cancer
_ COPD
_ Shortness of Breath
_ Tuberculosis
_ Other_________________

Nerve /Other
_ Cerebral Palsy
_ Epilepsy
_ Neuralgia
_ Multiple Sclerosis
_ Parkinson's Disease
_ Stroke
_ Headaches /Migraines
_ Dizziness
_ Vertigo
_ Anxiety
_ Depression
_ Bipolar Disorder
_ Other_______________

Stomach/Intestinal
_ Ulcerative Colitis
_ Gallbladder issues
_ IBS
_ Other:_______________

Heart/Circulatory
_ Arteriosclerosis
_ Congenital Heart Disorders
_ Parathyroid Disease
_ Heart attack
_ Coronary Artery Disease
_ Heart Murmur
_ High/Low Pressure
_ Rheumatic fever
_ Congestive Heart Failure
_ Poor circulation
_ Heart palpitations
_ Other_______________

Kidney/Urinary
_ Bladder Infection
_ UTI
_ Blood in Urine
_ Kidney Disease
_ Sugar in urine
_ Other:_________________

Liver Disease
_ Cirrhosis of the liver
_ Hepatitis A
_ Hepatitis B
_ Other:_________________

Review of Systems

Have you **RECENTLY** experienced any of the following?

General/Constitutional
__Fever
__Fatigue
__Chills
__ Night Sweats
__Weight Gain
__Weight Loss

Skin
__*Change in moles*
__ *Breast Lumps*
__*Lesions*

Eyes
__*Loss of vision*
__*Double Vision*

ENT
__*Hearing loss*
__*Nose Bleeds*
__ *Difficulty Swallowing*

Gastrointestinal
__*Decrease appetite*
__*Nausea*
__ *Vomiting*
__ *Change in Bowel*
__ *Heartburn*

Respiratory
__Shortness of breath
__ Coughing Blood
__ Wheezing
__Difficulty Breathing

Cardiovascular
__Chest Pain
__Palpitations
__Fainting
__High Blood Pressure
__*Swelling in the Legs*
__Emboli (clots)

Genitourinary
__Frequent Urination
__ Difficulty with Urination
__Blood In Urine
__Unable to hold Urine
__Sexual difficulties

Musculoskeletal
__*Muscle/Joint Weakness*
__*Muscle/Joint Pain*
__*Joint Swelling*

Psychiatric
__*Depression*
__*Suicidal thoughts*
__*Anxiety*
__*Memory Loss*

Patient/ Guardian Signature____ ***Date***__________

Physician Signature: ____ ***Date:***__________

Consent for Treatment

I hereby authorize your practice and whomever the doctor may designate as his/her assistant to perform examination, physiotherapy, and physical therapy and to perform non-invasive diagnostic tests. This may include any unforeseen condition that arises in the course of the procedures which may call for judgment for procedures in addition to or different from those non-complicated. I further request and authorize this office to perform whatever my treating doctor deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications have been fully explained to me. I acknowledge that no guarantee has been made to me as to the result that may be obtained.

Patient/ Guardian Signature___________________________________Date___________________________

Authorization for Medical Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-rays, physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the auto personal injury protection law. (Chapter 71-252f)

Patient/ Guardian Signature____Date___________

Summary of the Florida Patient's Bill of Rights and Responsibilities

Florida law requires that your healthcare provider or healthcare facility recognize your rights while you are receiving medical care and that you respect the healthcare provider's or healthcare facility's right to expect certain behavior on the parts of patients. You may request a copy of the full text of this law from your healthcare provider or health facility. A Summary of your rights and responsibilities are as follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his/her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his/her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his/her conduct.
- A patient has the right to be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his/her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the healthcare provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive a copy of a reasonable clear and understandable, itemized bill and upon request, to have the charges explained.
- A patient has the right to receives, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for the purpose of experimental research and to give his/her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his/her rights, as states in Florida law, through the grievance procedure of the healthcare provider or healthcare facility which served him/her and to the appropriate states licensing agency.
- A patient is responsible for providing to the healthcare provider, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health.
- A patient is responsible for reporting unexpected changes in his/her condition to the healthcare provider.
- A patient is responsible for reporting to the healthcare provider whether he/she comprehends a contemplated course of action and what is expected for him/her.
- A patient is responsible for following the treatment plan recommended by the healthcare provider.
- A patient is responsible for keeping appointments and, when he/she is unable to do so for any reason, for notifying the healthcare provider for healthcare facility.
- A patient is responsible for his/her actions if he/she refuses treatment or does not follow the healthcare provider's instructions.
- A patient is responsible for assuring that the financial obligations of his/her healthcare are fulfilled as promptly as possible.
- A patient is responsible for following healthcare facility rules and regulations affecting patient care and conduct.

***I have read and understand the summary of the Florida patient's bill of rights and responsibilities*.**

Patient/guardian Signature____Date_______________

HIPAA Privacy Authorization Form

This is an authorization for use or Disclosure of Protected Health Information.(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

This is an authorization for release of health information that covers all past, present, and future periods of my medical record. I, ___________________________ ____/_____/________ _______/____/______
Patient Name *Date of Birth* *SS#*
authorize the use or disclosure of the health information as described below to the following person or organization____ __________________________
Name /Facility *City/St*

- ☐ Entire Medical Record
- ☐ ER Record
- ☐ Operative Reports
- ☐ Diagnostic Imaging
- ☐ Demographic Information
- ☐ Consultations
- ☐ Laboratory results
- ☐Other_________________

I authorize the disclosure of the following information marked above to the following organization:

Tampa Bay Orthopedic & Spine Group
☐ 1100 W. Kennedy Blvd Tampa Fl 33607 | P:813.463.2815 |F:813.463.2857

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that the information in my medical record may include information relating to mental healthcare, and treatment of alcohol or drug abuse. I also understand that the information may include information relating to sexually transmitted disease, AIDS or HIV. I also understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apply to my insurance policy. Unless otherwise revoked, this authorization will expire in one year.

Patient /Guardian Signature: ____**Date**_________
*If signed by Legal Rep., relation to Patient*_________________________
Witness____**Date**_________

Irrevocable Lien of Insurance &
Settlement Proceeds

To the extent for the bill of services rendered by ***Tampa Bay Orthopedic & Spine Group,***

I, _________________________hereby consent that this agreement constitutes an irrevocable lien against any recovery of proceeds paid by and insurance carrier from whatever source, including, but not limited to, PIP coverage, bodily injury coverage, health insurance coverage, uninsured/underinsurance motorist coverage, medical payments coverage, general liability coverage, or any other coverage that may be available to pay me for my medical bills or my damages stemming from the accident occurring on _________________. Further, and to extent of bills incurred, the undersigned agrees that this agreement shall constitute an irrevocable lien against any recovery resulting from the aforementioned accident, or any judgment or verdict obtained in the pursuit of my claim for damages stemming from said accident.

This lien is provided to me by ***Tampa Bay Orthopedic & Spine Group,*** in consideration *of* ***Tampa Bay Orthopedic & Spine Group's*** agreement to refrain from any collection efforts against me, the patient, until my claim for damages stemming from the above referenced accident is settled, resolved in litigation, or abandoned. The undersigned agrees that it has a duty to keep ***Tampa Bay Orthopedic & Spine Group,*** informed of the status of the patients' claim for damages by immediately advising ***Tampa Bay Orthopedic & Spine Group,*** of any settlement reached, or any verdict or judgment rendered, whether favorable or not. The undersigned agrees that it had the duty to advise ***Tampa Bay Orthopedic & Spine Group,*** should the patient choose to abandon its claims for damages. The claimant further recognizes, that should his/her claim for damages results in no recovery, or in an amount insufficient to pay this provider's medical bill in full, that it shall remain obligated to pay outstanding balance owed to ***Tampa Bay Orthopedic & Spine Group.***

I hereby authorize any attorney I choose to represent me in my personal injury claim/case, to discuss my case, or provide ***Tampa Bay Orthopedic & Spine Group,*** with any and all information necessary to assist in the payment of medical bills incurred with Gulf Coast Injury Center. I further authorize and irrevocably instruct said attorney(s) to with hold such sums from any insurance payments made, from any settlement reached, or from any verdict or judgment paid, and pay Gulf Coast Injury Center and to deposit any disputed amount in the registry of the *Court of Hillsborough County, Florida*. The parties agree that ***Tampa Bay Orthopedic & Spine Group,*** is an interested party in the outcome of my claim for damages, and shall remain an interested party, until the balance owed by me, *to* ***Tampa Bay Orthopedic & Spine Group,*** is paid in full. I acknowledge my understanding that this lien shall remain in force, and effect, even if I should decided to substitute consul or represent myself.

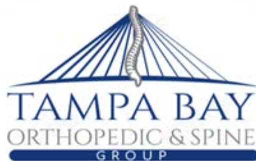
Patient/guardian Signature____***Date***______________

Office use only:

Law Firm: ____

Attorney Name: ____**DOA:**____/____/_____

Insurance Company: ____



Letter of Protection

I, ____________________, hereby authorize and direct my attorney, _______________to pay
(Patient Name) (Attorney Name)
proceeding payable to the directly from any client and received throughout the efforts of the law office of ___________________ and any deductible, applicable co-pay or any outstanding
(Law Firm Name)
balance due to ***Tampa Bay Orthopedic & Spine Group,*** for reasonable services rendered to me in connection with injuries I received as a result of __________________accident, which
(Type of Accident)
occurred on ________/_________, 20________ in the state of_________________
(Date) (Year) (State)
This Letter of Protection is a subordinate to any applicable attorney's fees and cost.

____
Patient Signature

____
Attorney Signature

____
Scott Drummond for Tampa Bay Orthopedic & Spine Group
Richard Galloway For Tampa Bay Orthopedic & Spine Group

Date this ______Day of ___________, 20________

1100 W Kennedy Blvd Tampa FL 33606 P: 813.463.2815 F: 813.463.2857
Toll Free: 877.703.7171

Patient Name: ____DOB___________________

Address: _____________________________________City/St________________Zip____________

Date of Loss: _____________ Insurance Carrier ___________________Claim#__________________

Assignment of Benefits

I hereby assign from any and all automobile policies which provide medical benefits or no-fault benefits, all rights, title and interest ***to Tampa Bay Orthopedic & Surgery Group LLC D/B/A Tampa Bay Orthopedic & Spine Group*** ("Assignee") for payment for services rendered unto me both by reason of accident or illness. In the event my insurance company fails to pay Assignee the full amount owed to Assignee after proper statutory notice, I hereby also assign by this instrument, all rights and causes of action in tort, in contract and the laws of Florida, against the personal injury protection carrier for the above named insured/patient, for its failure to pay for services rendered unto Assignee in relation to my accident or illness. This assignment may only be rescinded /reassigned by the mutual constant of the patient/insured/assignor and the healthcare provider/assignee.

Reservation of Benefits

Please be advised that I am here by placing you on notice pursuant to Florida case law that should you deny, reduce or fail to pay either part or an entire bill, which was submitted on my behalf from this healthcare provider. I am requesting you reserve, or hold aside, that same amount until this dispute is resolved. Additionally, should the remaining amount of my benefits approach an amount where there would be insufficient funds to pay the amount you reduced, denied or failed to pay, or if my benefits should become exhausted, please notify me and this healthcare provider of the fact immediately.

Direction of Payment/Release of Information

I hereby authorize any insurance company or attorney to pay direct to *Assignee* the amount of this and/or any future bills for services rendered unto me. I also agree to pay in a current manner any difference between the total charges and the amount pain by the insurance company directly to the *Assignee.* I hereby authorize *Assignee* to release any information requested that is pertinent to my case to any insurance company or attorney involved in this case. *Pursuant to FS 627.4137*, I hereby request a copy of this PIP payment log and any available policy insurance or declaration sheet, which reflects the applicable policy limits available at the time of this accident, to be provided by the insurance company to the *Assignee.* I hereby authorize *Assignee* permission to request and receive a current copy of my PIP payment log periodically as they deem necessary. A photocopy of this assignment shall be considered as valid and effective as the original

Patient/Guardian Signature____***Date***_________