ANCHOR SPINE & JOINT

PATIENT INFORMATION:					
PATIENT:	LAST NAME:	FIRST NAME:	M.I.	DATE OF BIRTH:	SEX:
					☐ MALE ☐ FEMALE

ADDRESS:	STREET:	CITY/STATE:	ZIP CODE:	LAST 4 OF SOCIAL:
				— — — —

HOME PH #:		CELL PH #:		E-MAIL:	

RACE:	☐ CAUCASIAN	☐ HISPANIC	☐ ASIAN	☐ OTHER
	☐ AFRICAN AMERICAN	☐ NATIVE AMERICAN	☐ REFUSED TO DISCLOSE	

REFERRAL INFORMATION:			
PRIMARY CARE PHYSICIAN:		REFERRING PHYSICIAN:	

EMERGENCY CONTACT INFORMATION:					
NAME:		PHONE NUMBER:		RELATIONSHIP:	

COMMERCIAL HEALTH INSURANCE INFORMATION:			
PRIMARY INS. NAME:		SECONDARY INS. NAME:	
POLICY ID:		POLICY ID:	
GROUP ID:		GROUP ID:	
POLICY HOLDER NAME:		POLICY HOLDER NAME:	
POLICY HOLDER DOB:		POLICY HOLDER DOB:	
RELATIONSHIP:		RELATIONSHIP:	

INSURANCE INFORMATION:			
IS YOUR PAIN DUE TO AN AUTO ACCIDENT? Y N		PERSONAL INJURY CASE? Y N	WORKMAN'S COMPENSATION CASE? Y N
DATE OF INJURY:		CLAIM NUMBER:	
INSURANCE COMPANY:		POLICY HOLDER NAME/DOB:	
ADJUSTER NAME:		ADJUSTER PHONE #:	
ATTORNEY NAME:		ATTORNEY PHONE #:	

HOW MAY OUR OFFICE CONTACT YOU?: (CIRCLE ONE)	HOME PH: YES OR NO CELL PHONE: YES OR NO
MAY OUR OFFICE LEAVE A MESSAGE ON YOUR HOME PHONE?:	YES OR NO
MAY OUR OFFICE LEAVE A MESSAGE ON YOUR CELL PHONE?:	YES OR NO
NOTICE OF PRIVACY PRACTICES, WOULD YOU LIKE A COPY?:	YES OR NO

I understand that the physicians and staff of Anchor spine and Joint will only be evaluating my condition as it relates to my pain. Any condition which is not specifically pain-related must be followed and evaluated by my primary care physician.

I understand that the procedures and medications which may be prescribed can potentially have adverse effects on the status of one's fertility as well as a developing fetus. I will notify my physician if there is any change in my fertility status or pregnancy status.

I understand that it may be at times difficult to obtain prompt consultation with the physicians or staff. If there is ever a significant deterioration on my function or progression of symptoms, I will seek prompt medical attention elsewhere.

I acknowledge that I may request at anytime a copy of notice of privacy practices of this office, which outlines how confidential patient information will be used, disclosed, and protected.

Patient or Legal Representative Printed Name:	Date:
Patient or Legal Representative Signature:	

PATIENT NAME:		DATE OF BIRTH:	

PAIN DESCRIPTION:

PAIN LEVEL:	MILD	MILD-MODERATE	MODERATE	MODERATE-SEVERE	SEVERE
My pain is: (Circle)	Constant	Intermittent	Improving	Worsening	
Onset of Pain:		**Due to MVA:** YES	NO	**Due to Injury:** YES	NO
Describe your pain:	☐ Dull/Aching	☐ Sharp/Stabbing	☐ Hot/Burning	☐ Pins/Needles/Tingling	
	☐ Cramping	☐ Squeezing	☐ Throbbing	☐ Shooting/Radiating	
What activities makes pain WORSE:	☐ Prolong Sitting	☐ Prolong Walking	☐ Prolong Standing	☐ Reaching	
	☐ Lifting	☐ Bending	☐ Range of Motion	☐ Other: _____	
What activities makes pain BETTER:					

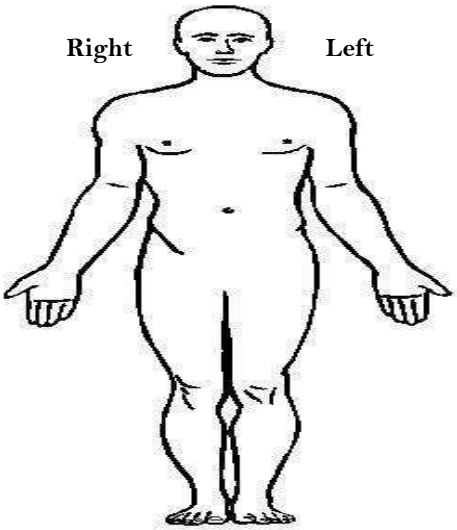
ASSOCIATED SYMPTOMS: Currently Experiencing (Circle)

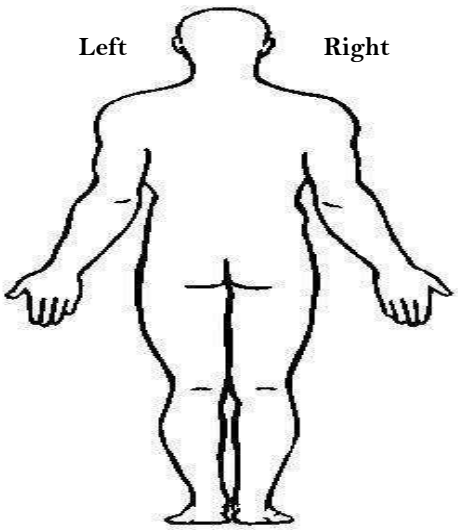
Numbness/Tingling Location:			
Weakness Location:			
Joint Swelling	Stiffness	Leg Swelling	Leg Pain
Difficulty Walking	Balance Problems	Bowel Incontinence	Bladder Incontinence
Fatigue	**Other:**		

AUTO ACCIDENT INJURY

Date of Injury:				
Have you had previous injuries?			YES	NO
Have you seen other providers?			YES	NO
The patient was the:			DRIVER	PASSENGER
Patient was wearing seat belt:			YES	NO
Patient was holding the steering wheel:			YES	NO
Patients' air bags deployed:			YES	NO
Patient hit head/Suffered a head trauma:			YES	NO
Patient reports loss of consciousness:			YES	NO
Patients' vehicle was:			STOPPED	MOVING
Type of accident:		REAR END	T-BONE	HEAD ON
Post-Accident, the patient went where:		HOME	HOSPITAL	URGENT CARE
Type of Treatment:				

Circle Pain Area:





PRIOR TREATMENTS				
IMAGING COMPLETED				
X-RAY: Where?_____	MRI: Where?_____	CT SCAN: Where?_____	EMG/NCV(NERVE STUDY)	
INJECTIONS:	BETTER	WORSE	NO CHANGE	TYPE:
SPINE SURGERY:	BETTER	WORSE	NO CHANGE	TYPE/YEAR?

PHYSICAL THERAPY:	BETTER	WORSE	NO CHANGE	LAST SESSION:
CHIROPRACTOR:	BETTER	WORSE	NO CHANGE	LAST SESSION:
ACUPUNCTURE	BETTER	WORSE	NO CHANGE	LAST SESSION:
BRACE:	BETTER	WORSE	NO CHANGE	OTHER:
TENS UNIT:	BETTER	WORSE	NO CHANGE	OTHER:
HEAT/ICE:	BETTER	WORSE	NO CHANGE	OTHER:
MASSAGE THERAPY:	BETTER	WORSE	NO CHANGE	OTHER:

CURRENT MEDICATIONS:

NAME:	DOSE/DIRECTIONS:	NAME:	DOSE/DIRECTIONSl
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

PRIOR MEDICATIONS:

ANTI-INFLAMMATORY:	HELPED:	PAIN MEDICATIONS:	HELPED:
Naproxen (Aleve)	YES NO	Hydrocodone	YES NO
Ibuprofen (Advil,Mortin)	YES NO	Oxycodone	YES NO
Diclofenac (Voltaren)	YES NO	Tramadol	YES NO
Celebrex	YES NO	Tylenol w/ Codeine	YES NO
Lido/Flector Patch	YES NO	Tylenol (Acetaminophen)	YES NO
MUSCLE RELAXANT:	**HELPED:**	**NERVE MEDICATIONS:**	**HELPED:**
Cyclobenzarprine (Flexeril)	YES NO	Gabapentin	YES NO
Skelaxin (Metaxolone)	YES NO	Lyrica	YES NO
Methocarbarmol (Robaxin)	YES NO	Cymbalta	YES NO
Tizanidine (Zanaflex)	YES NO	Amitriptyline	YES NO

ALLERGIES

ANY KNOWN ALLERGIES?:			
Have you ever had an allergic reaction to:	CONTRAST: YES NO	IODINE: YES NO	SHELLFISH: YES NO
Dental Numbing Medications: YES NO	Latex: YES NO		
Have you ever had a bad reaction to anesthesia?: YES NO			

PAST MEDICAL HISTORY

High Blood Pressure	Diabetes	Heart Attack	Heart Disease	Stroke
Rheumatoid Arthritis	Gout	Kidney Disease	Liver Disease	Cancer
Anxiety Disorder	HIV/AIDS	Osteoporosis	Hepatitis (A , B , C)	Depression
Peptic Ulcer Disorder	Bipolar Disorder	Attention Deficit	Schizophrenia	Anemia
OTHER:				

PAST SURGERIES: LIST ANY AND ALL SURGERIES

SOCIAL HISTORY			
Occupation:		RETIRED	DISABLED
Tobacco Usage:	YES NO	What age did you START:	
If YES : How many packs per day:		What age did you QUIT:	
Alcohol Consumption:	YES NO	Do you drink alcohol socially?	YES NO

FAMILY HISTORY			
Alcohol Abuse	YES NO	Diabetes	YES NO
Illegal Drug Use	YES NO	Heart Disease	YES NO
Prescription Drug Abuse	YES NO	Hypertension	YES NO
Stroke	YES NO	Cancer	YES NO
Other:			

REVIEW OF SYSTEMS								
GENERAL:			**ENDOCRINE:**			**EARS/NOSE/THROAT:**		
Loss of Appetite	YES	NO	Thyroid Disease	YES	NO	Hoarseness	YES	NO
Recent Weight Loss	YES	NO	Heat Intolerance	YES	NO	Trouble Swallowing	YES	NO
Fever or Chills	YES	NO	Cold Intolerance	YES	NO	Hearing Loss	YES	NO
RESPIRATORY:			**CARDIOVASCULAR:**			**HEMATOLOGIC:**		
Shortness of Breath	YES	NO	Chest Pain	YES	NO	Easy Bruising	YES	NO
Chronic Cough	YES	NO	Palpitations	YES	NO	Easy Bleeding	YES	NO
KIDNEY/BLADDER:			**EYES:**			**PSYCHIATRIC:**		
Painful Urination	YES	NO	Blurred Vision	YES	NO	Depression	YES	NO
Blood in Urine	YES	NO	Double Vision	YES	NO	Suicidal Thoughts	YES	NO
Kidney Problems	YES	NO	Loss of Vision	YES	NO	Drug/Alcohol Abuse	YES	NO
NEUROLOGICAL:			**SKIN:**			**GASTROINTESTINAL:**		
Headaches	YES	NO	Frequent Rashes	YES	NO	Constipation	YES	NO
Seizures	YES	NO	Blood Clots	YES	NO	Heartburn	YES	NO
Dizziness	YES	NO	Lumps	YES	NO	Nausea/Vomiting	YES	NO

VITALS			
Pain Level:	RR:	Oxygen:	HR:
BP:	Weight:	Height:	Temp:

Patient or Legal Representative Printed Name:	Date:
Patient or Legal Representative Signature:	

MEDICAL RECORDS RELEASE AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	M.I.		DATE OF BIRTH:

ADDRESS:	STREET:	CITY/STATE:	ZIP CODE:

INFORMATION TO BE RELEASED: (CHECK ALL ITEMS TO BE RELEASED)

☐ Entire Record
☐ Discharge Letter
☐ Last 3 Office Notes
☐ Operative Reports
☐ Last 3 Procedure Notes
☐ MRI/XRAY/CT SCAN/EMG STUDY
☐ Last 3 UDS Results
☐ Other: _____

Period From: _____

Special Records: I understand that protected health information related to my diagnosis or treatment for AIDS/HIV, psychiatric care treatment, treatment for drug and alcohol abuse may be released as part of my health information. Please check appropriate boxes below.

AIDS/HIV Information:	☐ YES, disclose	☐ NO, do not disclose
Psychiatric Care/Treatment:	☐ YES, disclose	☐ NO, do not disclose
Treatment for Drug/Alcohol Abuse:	☐ YES, disclose	☐ NO, do not disclose

PURPOSE/USE OF REQUESTED INFORMATION: Continuation of Treatment

RELEASE INFORMATION TO:

Anchor Spine and Joint
10726 Ketchum Valley Drive, Riverview, FL 33579
110 S. MacDill Ave, Suite 300, Tampa, FL 33609
7800 66th Street N, Suite 305, Pinellas Park, FL 33781
13543 State Road 54, Suite B, Odessa, FL 33556
Phone: 813-331-4465 Fax: 813-280-4855

AUTHORIZATION:

For personal requests: There will be a charge of $1.00 per page from 1-25, and $.25 per page 26+ fee for all requests on paper (plus the cost of postage and envelope).

For Doctor to Doctor requests: There will be no fee. By default , the past two (2) years of pertinent information will be sent.

- I understand that my authorization will automatically expire on one (1) year after the date of signature on this form.
- I understand that I may revoke this authorization at any time, by notifying Anchor Spine and Joint in writing.
- I understand the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under applicable law, the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer subject to the protections of the privacy standard.
- My refusal to sign this authorization will not affect enrollment, eligibility for benefits, payment, or my ability to receive treatment.
- I understand that I may inspect or copy the information that is used or disclosed.

Patient or Legal Representative Printed Name:	Date:
Patient or Legal Representative Signature:	

AUTHORIZATIONS FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

By signing below, I authorize Anchor Spine and Joint, its agents and employees ("provider"), to use and/or disclose any and all of my protected health information ("records") on my behalf, of any kind and description, to the following ("recipient"):

Recipient Name:	Relationship:
	Attorney
	Car Insurance
	Relative/Friend/Spouse
	Relative/Friend/Spouse

I also authorize provider to release my protected health information to my insurance, primary care provider, referring provider, hospitals, diagnostic centers, and/or laboratories that may require this information for continued care and authorize provider to transmit this information through electronic means.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION INCLUDING HIV & AIDS RELATED INFORMATION:

I understand that neither provider nor recipient may condition treatment, payment, enrollment or eligibility for the benefits on whether I sign this authorization. In addition, I understand the recipient may redisclose the records and that the records may no longer be protected by the federal privacy regulations.

I acknowledge and agree that the protected health information authorizes to be disclosed under this authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnoses or treatment for HIV, HIV related diseases and communicable disease related information. With respect to any communicable disease related information protected by state confidentiality rules and disclosed under this authorization, recipient is prohibited from making any further disclosure of this information unless future disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

I understand I have the right to refuse to sign this authorization, writing, at any time and that I do not have to sign this authorization to receive treatment at Anchor Spine and Joint. When my information is used of disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal health insurance portability and accountability act (HIPPA). I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer whose address is Anchor Spine and Joint, Attn: Privacy Officer, 10726 Ketchum Valley Drive, Riverview, FL 33579.

Further, with respect to any drug and alcohol abuse treatment information disclosed under this authorization, this information has been disclosed from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42. C.F.R. part 2. A general authorization for the release of medical or other information is NOT enough for the purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This authorization will remain effective until one year following the dates set forth below, or, if no date is set forth below, the date Anchor Spine and Joint receives executed authorization, at which time this authorization will be used, disclosed, and protected.

Patient or Legal Representative Printed Name:	Date:
Patient or Legal Representative Signature:	

PATIENT FINANCIAL AGREEMENT:

AUTHORITY TO TREAT AND GUARANTEE OF PAYMENT FOR MEDICAL SERVICES

Re: Patient Printed Name: _____ (hereinafter "Patient")

Date of Birth:_____

Date of Incident: _____

Initial:

1. Anchor Spine and Joint (hereinafter "the Practice") has agreed to provide medical care to the Patient.

2. Because the Patient is being seen at this medical practice due to injuries received as a result of a traumatic event, this document becomes reasonable and necessary. The Practice will bill any and all applicable insurance coverages and/or governmental benefit programs which are accepted by the Practice for any services rendered, unless otherwise directed in the Advanced Beneficiary Notice of Billing and Service Options. However, often times, standard insurance coverages and/or governmental benefit programs will not pay all of the medical bills incurred and/or for the services rendered for one or more reasons. Any balance for medical services which are not paid by the patient's insurance coverage or accepted governmental benefits shall remail the responsibility of the patient.

3. Presently, the Patient is not a subscribing member of any group or individual commercial health insurance policy and/or does not participate in any government sponsored health insurance plans (Medicare, Medicaid, Tricare, etc.) OR the Patient does possess valid health insurance or a sponsored health plan but requires medical care which may not be fully reimbursable under said policy or program.

4. The Patient does not want to pay any out-of-pocket costs associated with his/her medical care and as a result, has requested an alternate payment arrangement with the practice. The Practice agrees to provide medical care and to defer collection of his/her medical charges including, but not limited to, co-pays, deductibles and/or patient responsibilities until the conclusion of any liability claim/claims being made as a result of his/her traumatic incident.

5. As one potential payment source, the Practice has the right to seek payment for the medical services provided from the proceeds of the Patient's settlement or jury verdict in his/her liability claim/claims. The Patient hereby agrees and directs his/her Attorney to pay for his/her medical treatment out of the proceeds of any settlement or verdict the Patient may receive from the patient's case.

6. In consideration for this Patient Financial Agreement/Authority to Treat and Guarantee of Payment, the Practice agrees to defer attempts to collect payment until the conclusion of the Patient's legal claim/claims for this incident.

7. The Patient understands that this type of Patient Financial Agreement/Authority to Treat and Guarantee of Payment is vastly different from the traditional contractual relationship between the practice and a commercial insurance carrier or government sponsored insurance plan. In that instance, there is a predictable certainty in the contractual relationship wherein the contract defines the responsibility of each respective party. The parties pre-emptively agree upon terms such as: utilization/pre-authorization, reimbursement rates, billing practices, aging of receivables and the appeals process for denials. Conversely, this arrangement covered by this agreement has an unpredictable outcome which presents certain risks to the Practice. The consequence of uncertainty in litigation matters requires compliance with the terms of this agreement in order to adequately reflect such risks as well as to account for the additional costs and responsibilities which this medical practice will be required to undertake.

8. Regardless of the outcome of any liability claim/claims which is/are the subject of the traumatic incident that has required the need for the medical services, the below signed Patient understands and agrees that he/she is personally responsible for any unpaid balance that remains unpaid at the conclusion of the liability claim/claims.

I have read this document carefully and I have been given an opportunity to ask any questions and/or have this agreement reviewed by an attorney of my choice prior to signing this agreement. I understand and agree with this document as evidenced by my voluntary signature below.

Patient or Legal Representative Printed Name:	**Date:**
Patient or Legal Representative Signature:	
Medical Provider Signature:	**Date:**

ADVANCED BENEFICIARY NOTICE OF BILLING AND SERVICE OPTIONS

By my signature below, I, _____ (print name), hereby acknowledge and understand that Anchor Spine and Joint (hereinafter "the Practice"), have offered to provide medical treatment related to my liability incident dated _____. I have fully read this notice to make an informed decision about the payment for my medical care. I further acknowledge that I have been given the opportunity to ask any questions I may have and to consult with an attorney of my choice to discuss my rights and responsibilities prior to choosing my option and signing this form.

(INITIAL ONLY ONE BOX. WE CANNOT CHOOSE A BOX FOR YOU.)

_____ OPTION 1 - Due to the time and nature of treatment to be rendered by the practice, in addition to the risk in undertaking my medical treatment of either underpayment or nonpayment by my health insurance carrier, I want the medical services prescribed by the practice but do not want my health insurance to be billed. I do not want to pay out-of-pocket for my co-pays, deductibles, co-insurance, or other patient responsibility costs related to these medical services. I understand that by choosing this option, I will remain personally liable for the payment of all medical services rendered but I am being offered the ability to pay for those medical services at a later time and with no additional interest on the amount owed. I understand that the term "health insurance carrier" includes health insurance, Medicare, Medicaid and/or managed healthcare of any kind.

_____ OPTION 2 - I hereby agree that the practice will bill my health insurance carrier, Medicare, Medicaid, or other applicable carrier for the medical services by the practice, but I will be required to pay in full all co-pays, deductibles, co-insurance, or patient responsibility estimated to be payable as a result of the rendering of these medical services prior to receiving any medical treatment.

By signing below, I hereby acknowledge that I have read and understand this notice and have freely made my own decision as to which option to choose. Any questions I have about this document have been answered to my satisfaction by the Practice and I have had an opportunity to consult my attorney if needed.

Patient or Legal Representative Printed Name:	**Date:**
Patient or Legal Representative Signature:	

FINANCIAL POLICY

Our financial policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide the highest quality medical care for our patients.

Appointments: Missed appointments and late arrivals: if you are more than 15 minutes late, we reserve the right to reschedule your appointment. If you are more than 60 minutes late, no show for an appointment, or do not give cancellation notice at least 24 hours in advance, you will be responsible for a missed appointment fee. The first missed appointment occurrence will not be charged a fee. Any additional missed appointments will result in a missed appointment fee as follows: Missed office visits are subject to a $100 charge, missed procedure are subject to a $250 charge. These charges are your responsibility and will not be billed to any insurance carrier. It is at the provider's discretion to determine whether you will be dismissed from the practice due to missed appointments.

INSURANCE PAYMENTS

Financial responsibility: Your insurance policy is a contract bet ween you and your insurance carrier. You are ultimately responsible for payment in full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.

Coverage changes and timely submission: It is your responsibility to in form us in a timely manner of any changes to your billing or insurance information. There is a time limit with in which Anchor Spine and Joint must submit a claim on your behalf to your insurer. If we are unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.

Self-pay: If you have no health insurance or governmental sponsored program and are not tr eating under an ABN or authority to treat, you will be considered a self-pay patient. Your payment may be made pursuant to a time of service discount negotiated with the practice and paid prior to receipt of any service.

BENEFITS AND AUTHORIZATION

Insurance plan participation: We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out of net work charges may have higher deductibles and co-payments.

Prior authorization and non-covered services: Anchor Spine and Joint may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefit s and authorized by your insurer. As a courtesy to our patients, Anchor Spine and Joint makes a good faith effort to determine if services are covered by your insurance plan, and , if so, whether prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf. Please be aware some and perhaps all the services provided may be "non-covered" services and not considered reasonable and necessary under the Medicare program and/or other medical insurance. Our practice is committed to providing the best treatment possible for our patients, and we charge what is usual and customary for the area.

Out of network payments: If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to Anchor Spine and Joint, immediately.

ACCOUNT BALANCES AND PAYMENTS

Reassignment of balances: If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.

Returned check: Returned checks will be subject to a $38 returned check fee.

I have read and understand the financial policy of Anchor Spine and Joint, and I agree to abide by its terms. I understand that this financial policy is binding upon me, my estate, executors and/or administrators, if applicable. I hereby authorize Anchor Spine and Joint, to release any medical information necessary to process all claims for reimbursement on my behalf. I hereby assig n all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to Anchor Spine and Joint or named physicians or affiliates for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to cross-over Medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above named entity. I understand that I am financially responsible for all services I receive from Anchor Spine and Joint. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.

Patient or Legal Representative Printed Name:	**Date:**
Patient or Legal Representative Signature:	