



Patient Demographics

Date: _____

Last Name		First Name		Middle	
Birth Date		Age	Sex: M F	Email:	
Street Address		City		State	Zip
Social Security #		Home Phone		Cell Phone	
Employer		Work Phone			
Emergency Contact		Emergency Contact #			
Relationship of Emergency Contact					
Primary Care Physician		Phone #			
Referring Physician		Phone #			

Primary Insurance Company			Phone #		
Insured Person Name		Insured Person Birth Date			
Relationship to Insured Person		Group #		Policy / ID #	
Secondary Insurance Company			Phone #		
Insured Person Name		Insured Person Birth Date			
Relationship to Insured Person		Group #		Policy / ID #	

Race: American Indian/ Alaska Native Asian Black/African American Hawaiian/Pacific Islander White

Ethnicity: Hispanic or Latino Not Hispanic or Latino



Pharmacy Name:	Phone #
Address:	

Do you have an Advance Directive? Yes No

* Please complete sections below **ONLY** if your visit is related to injury sustained by automobile accident or worker's compensation*

Auto Injury	Date of Injury:		
Adjuster Name:	Phone #	Fax #	
Attorney Name:	Phone #	Fax #	
Worker's Compensation Injury	Date of Injury:		
Adjuster Name:	Phone #	Fax #	

MEDICAL INTAKE FORM

What is the reason for today's visit? _____

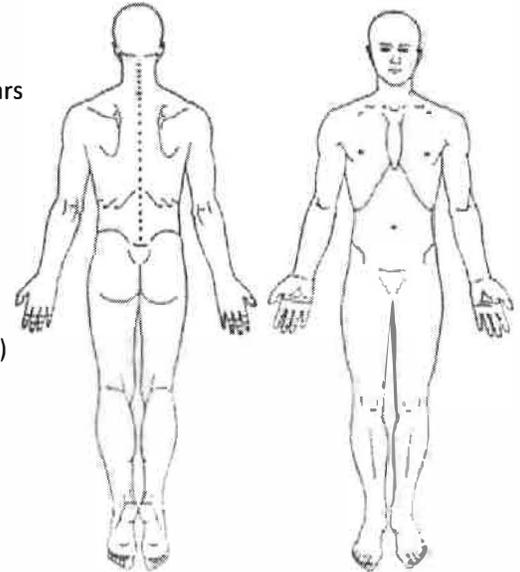
If appropriate, please draw where your symptoms are located on the human diagram →

How long have you had your symptoms? _____ weeks / months / years

Are you RIGHT or LEFT handed? (circle)

Past treatments for symptoms: *please check ALL that apply*

- Over the counter medications: _____
- Prescribed medications: _____
- Physical Therapy: _____ (Date)
- Spinal Injections: _____ (Physician & Date)
 - Epidural
 - Facet Blocks
 - Facet Rhizotomies
 - Trigger Point Injections
 - SI Joint
 - Other Injection(s): _____
- Other Treatments: _____



Have you seen any other specialists or had additional testing for the above symptoms? *please describe*

- CT
- MRI
- DEXA / Bone Density
- EMG/Nerve Conduction

Medical History: *check ALL that you have been diagnosed or treated for*

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Crohns Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Depression | <input type="checkbox"/> Murmurs |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Peripheral Neuropathy |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Brain Aneurysm / AVM | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Brain Mass | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> IBS | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Kidney Disease | |

Surgical History: *list ALL major surgeries & dates*

I have not had any surgeries

Family History: *list all pertinent family history*



The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information) and patient medical record information by Orlando Neurosurgery (the "Practice" in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for more complete description of the potential uses and disclosures of such information, and the patient has the right to review such Notice prior to signing this consent form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Practices, Patient may obtain a copy of the revised notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice as it pertains to the patient only.

Patient acknowledges and agrees that the Practice may disclose Patient's protected health information and patient medical record information to the following individuals who are either the Patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient: (list names below)

The patient agrees that the Practice may disclose the following types of information contained in the Patient's medical record below, unless otherwise indicated (please initial only IF YOU DO NOT WISH to disclose):

- HIV / AIDS Information
- Mental Health Information
- Substance Abuse Information
- Sexually Transmitted Disease Information
- Pregnancy Information (If patient under age of 18)

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action in reliance on the Consent.

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Signature of Patient (or Authorized Representative*)

Date

Please Print Name

*Authorized Representative's relationship to Patient



Office Policies

Medical Consent: I consent to all care, treatment, diagnostic imaging, laboratory testing and other medical procedures performed or prescribed by a physician of Orlando Neurosurgery and his/her designees.

Right of Refusal of Treatment: I understand that I have the right to make informed decisions regarding all aspects of my care. I should ask my health care provider to further clarify and explain anything I do not understand. I have the right to refuse treatment.

Acknowledgement of Receipt of Patient Rights & Notice of Privacy Practices: I have acknowledged that I have received both notices, Notice of Patient Rights/Responsibilities and HIPPA Notice of Privacy Practices.

Release of Medical Information: I authorize Orlando Neurosurgery to release any information necessary to facilitate healthcare processing of claims, or audit of payments in relation to my care and treatment. I also consent to the release of any information needed to other facilities, agencies or healthcare providers as per Orlando Neurosurgery's discretion. This order will remain in effect until revoked by me in writing.

Financial Policy: I certify that the insurance information I have provided to Orlando Neurosurgery is accurate, complete and current. I certify that no other coverage of insurance exists. It is my responsibility to understand the terms and benefits of my insurance plan. I understand I am financially responsible for charges not paid by my insurance. I may be required to pay co-payments, co-insurance or deductibles at the time of service unless other arrangements have been made in advance. Orlando Neurosurgery will make every attempt to notify me in advance if a service is not covered. If my insurance company has not paid my bill in full within 60 days, I will be expected to pay the remaining balance within 30 days. In the event of a large balance due from an operation, Orlando Neurosurgery may be able to arrange a payment plan suitable for all parties concerned.

Forms & Medical Records: If you require our office to complete any forms, there is a charge of \$15 per form. Forms will be completed within 10-14 business days. If you require a copy of your medical records, you must sign a Medical Records Release form and a payment of \$1.00/page for the first 25 pages, then \$0.25/page after that will be due upon receipt of your request. Your request will be completed within 10-14 business days.

Appointment No Show / Cancellations: If it is necessary to cancel/reschedule your appointment, please do so 24 hours PRIOR to the time of your scheduled appointment. If you do not cancel an appointment or no show, you will be responsible for a \$25.00 charge. The fee of \$25.00 is to be paid by the patient and is not billable to any insurance.

Surgery Cancellations: If you must cancel a scheduled surgery, please notify our office by 12:00PM ten (10) business days (Monday – Friday) prior to your surgery to avoid a cancellation fee of \$250.

Dispensing of Opioid (Narcotic) Pain Medications: In response to the "Opioid Crisis", The State Legislature of Florida passed the Controlled Substances Bill (CS/CS/HB 21) which regulates the prescribing of Schedule II and Schedule III pharmaceuticals. These regulations affect the prescriptions your providers are allowed to prescribe you after surgery. Schedule II narcotics are limited to a three (3) day supply for "acute pain exception". A seven (7) day supply can be provided under special circumstances. Our office will limit dispensing schedule II and III prescriptions to 14 days post-op. It is important to understand that Orlando Neurosurgery does not manage chronic pain. If you need chronic pain management, we are happy to provide a referral to a pain management specialist.

Return of Imaging CDs/Films: It is important for our providers to review your images for proper diagnosis and treatment; however, our office does not have the capacity to store these films. A copy of your images will be downloaded to our system at your appointment. Your images will be returned to you at the end of your appointment. If you leave your images for any reason past your appointment date, we will store them for 90 days as a courtesy. During this 90 days, you have the option to pick them up on the office at no charge, or we can ship them to you for a \$10 service and handling fee. After 90 days, any remaining CDs/films will be disposed per HIPAA guidelines.

Patient Signature

Printed Name

Date



Records Release

Authorization to Use and Disclose Confidential Information

Information may be disclosed <i>from</i> :	Information may be disclosed <i>to</i> :
<hr/> Person/Facility	<hr/> Person/Facility
<hr/> Address	<hr/> Address
<hr/> Phone	<hr/> Phone
<hr/> Fax	<hr/> Fax

The following information to be released:

- | | |
|--|--|
| <input type="checkbox"/> ANY/ALL MEDICAL RECORDS
<input type="checkbox"/> Office Notes
<input type="checkbox"/> History and Physical
<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Problem list/Medication List | <input type="checkbox"/> Operative Reports
<input type="checkbox"/> Consultations
<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> Lab/Pathology Reports |
|--|--|

- I understand that the information may include the release of information about mental health, substance and/or alcohol use, HIV/AIDS, and STDs.
- This authorization will remain in effect for one (1) year or until I revoke it in writing.
- I have the right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The facility, it's employees, officers, and physicians are hereby released from any liability for the disclosure of the above information to the extent indicated and authorized therein.
- I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.
- I am aware that I may be charged a fee for this request as allowed by law, which may include up to \$1.00 per page for Paper Records and fees associated with supplies and postage. Fees are waived when information is released to a health care provider for treatment purposes.

Patient Printed Name

Date of Birth

Patient Signature

Date

Signature of Parent/Guardian or Legal Representative

**This page only needs a signature*