ORLANDO NEUROSURGERY

PATIENT DEMOGRAPHICS

LAST Name:	**FIRST Name:**		**MIDDLE:**
Birth Date:	Age:	Sex:	SS#:
EMAIL:			
Address:	City:	State:	Zip:
Cell #	Home #		
Emergency Contact:	Emergency Contact #:		
Relationship to Patient:			
Primary MD:	Primary MD #:		
Referring MD:	Referring MD #		
Do you have an **Advanced Directive**? ☐ Yes ☐ No			
Primary Insurance:	Member ID #	Group #	
Secondary Insurance:	Member ID #	Group #	
Employer:			

Is this injury related to auto accident/slip and fall ? Yes _____ No______
Is this related to Work Comp? Yes_____ No______
Are you involved in Litigation? 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 Accident:*	
Adjuster Name:	*Phone #*	*Fax #*
Attorney Name:	*Phone #*	*Fax #*
WORK COMP INJURY	*Date of Injury:*	
Adjuster Name:	*Phone #*	*Fax #*

PATIENT ACKNOWLEDGMENT AND AGREEMENT OF OFFICE POLICIES

Financial Policy: I certify that the insurance information I have provided 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, Orlando Neurosurgery may be able to arrange a payment plan suitable for all parties concerned.

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 three (3) business days (Monday – Friday) prior to your surgery to avoid a cancellation fee of $250.

Consent to Treatment: 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. 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.

Notice of Privacy Practices (HIPAA): I have acknowledged that I have received and/or been offered the Notice of Privacy Practices, which describes how my health information may be used and disclosed. This notice is posted at the front desk and available on the practice website.

Patient Code of Conduct: I acknowledge that I have received and/or been offered the Patient Code of Conduct policy. This policy is posted at the front desk and available on the practice website. I understand that if I do not follow this policy, I may be discharged from the practice.

Communication Consent: I give permission to the office to contact me by phone, voicemail, email, or text message regarding appointments, billing, and medical information.

Forms & Medical Records: Forms (ex. FMLA, school/work, or personal forms) will be completed within 10-14 business days. The charge is $15 per form. 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.

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. Schedule II narcotics are limited to a three (3) to seven (7) day supply for "acute pain exception". Our office will limit dispensing schedule II and III prescriptions to 14 days post-op. 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.

____

PATIENT SIGNATURE **PRINTED NAME** **DATE**

Orlando Neurosurgery
Phone 407-975-0200 – Fax 407-975-0209

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

Release of Medical Information: I hereby authorize Orlando Neurosurgery to release or use any identifiable health 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. I should review Orlando Neurosurgery's Notice of Privacy Practices for a more complete description of the potential release of such information. Orlando Neurosurgery reserves the right to change the terms of the Notice of Privacy Practices at any time. You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restrictions(s), such restrictions are then binding on the Practice.

I acknowledge and agree that Orlando Neurosurgery may disclose my protected health information and medical record information to the following individuals who are family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

Name: ____ Contact #: _________________________________

Name: ____ Contact #: _________________________________

Name: ____ Contact #: _________________________________

I agree that Orlando Neurosurgery may disclose the following types of information contained in my medical record below, unless otherwise indicated (please initial)

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

At all times, I retain the right to revoke this consent. Such revocation must be submitted to Orlando Neurosurgery in writing. The revocation shall be effective except to the extent that Orlando Neurosurgery 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

RECORDS RELEASE

* THIS SECTION MAY REMAIN BLANK UNTIL RECORDS ARE REQUESTED *	
Information may be disclosed *by*:	**Information may be disclosed *to*:**
______________________________ Person/Facility ______________________________ Address ______________________________ Phone ______________________________ Fax	______________________________ Person/Facility ______________________________ Address ______________________________ Phone ______________________________ Fax

The following information to be released:

☐ **ANY/ALL MEDICAL RECORDS**

☐ Office Notes
☐ History and Physical
☐ Progress Notes
☐ Problem list/Medication List
☐ Operative Reports
☐ Consultations
☐ Radiology Reports
☐ 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, its 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.

____ ______________
Signature of Patient (or Authorized Representative*) Date

____
Please Print Name

____
*Authorized Representative's relationship to Patient

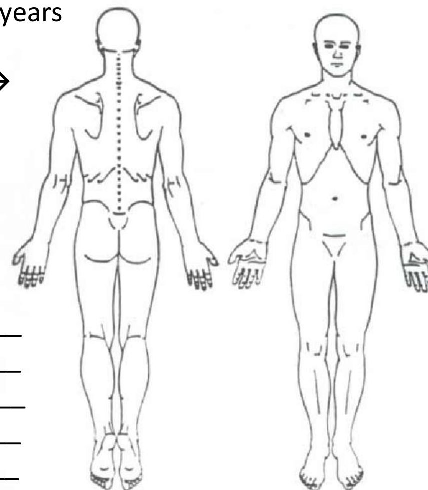
PHARMACY:	Pharmacy #
Pharmacy Address:	

MEDICAL HISTORY

Chief Complaint: (*reason for today's visit*?) ____
____
____

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

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



PAIN SCALE: (*1= least, 10= worst*): 0--1—2—3—4—5—6—7—8—9—10 (*circle*)

Are you RIGHT or LEFT-handed? *(circle)*

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

☐ Medications: ____
____

☐ Physical Therapy (*location/date last performed*) ____________________________
____

☐ Spinal Injections: (*MD/date last performed*) _______________________________
____

☐ Other Treatments: ____

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

☐ Atrial Fibrillation
☐ Autoimmune Disease:
☐ Bleeding Disorders
☐ Blood Clots / DVT or PE
☐ Brain Aneurysm
☐ Brain Mass / Tumor
☐ Cancer:
☐ Cardiovascular/Heart Disease
☐ COPD
☐ Diabetes
☐ HIV/AIDS
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Liver Disease
☐ Osteopenia
☐ Osteoporosis
☐ Peripheral Neuropathy
☐ Rheumatoid Arthritis
☐ Seizures
☐ Stroke
☐ Thyroid Disease
☐ Other

Medication List: *list ALL medications / supplements below OR provide copy of list*

Medication Name	Dosage and Frequency	What is it for?

Allergies: *list ALL drug / food allergies*

____

____

Surgical History: *list ALL major surgeries & dates:*

____

____

Family History: *list all pertinent family history:*

____

____

Social History:

Occupation: ____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Do you **smoke**? ☐NO ☐YES ☐ Former/ Quit ________ (*year*)
If YES, I smoke ________ pack(s) per day. I started smoking in ________ (*year*)

Do you drink **alcohol**? ☐NO ☐ YES
If YES, how often? ☐Never ☐Monthly or less ☐2-4 times a month ☐2-3 times a week ☐4 or more times a week
If YES, how many drinks do you have on a typical day? ☐1-2 ☐ 3-4 ☐5-6 ☐7-9 ☐10 or more
If YES, how often do you have 6+ drinks on ONE occasion? ☐Never ☐Less than monthly ☐Monthly ☐Weekly ☐Daily

Have you had any recent **falls**? ☐NO ☐ YES
If YES, how many falls in the past year? _______; did the fall result in injury? ☐NO ☐ YES

Review of Systems (ROS): *please check all that apply*

Constitutional:
- ☐ Body Aches
- ☐ Fever

ENT:
- ☐ Visual Loss
- ☐ Difficulty Swallowing
- ☐ Hearing Loss

Cardiovascular
- ☐ Irregular Heart Beats
- ☐ Leg Swelling

Endocrine
- ☐ Breast Discharge (Galactorrhea)
- ☐ Irregular Periods

Gastrointestinal
- ☐ Nausea / Vomiting
- ☐ Abdominal Pain

Genitourinary
- ☐ Urgency
- ☐ Retention
- ☐ Incontinence

Musculoskeletal
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Leg Pain

Neurologic
- ☐ Muscular Weakness
- ☐ Numbness / Tingling
- ☐ Seizures
- ☐ Loss of Balance / Falls
- ☐ Memory Difficulties

Psychiatric
- ☐ Anxiety
- ☐ Depression

Respiratory
- ☐ Shortness of Breath
- ☐ Cough