Welcome!

You may return the forms in person, fax, or email to info@nsatb.com. Some of the attached forms are informational only and are yours to keep.

******TO AVOID CANCELATION, THESE FORMS AND ANY RELATED SCANS MUST BE COMPLETED AND SUBMITTED ONE WEEK PRIOR TO YOUR APPOINTMENT. ******

Please write in black ink only. If you are completing this electronically, please type, save and email to our secure office email at info@nsatb.com.

In order to provide the best possible care we require that all scans be no older than six months from the date of your appointment.

Please be advised that our physicians are trauma surgeons and may be called to an emergency at any time. Therefore, your appointment may be canceled or delayed without notice.

Also note, we cannot prescribe medications for you until you are an established patient. If you need a prescription filled prior to your appointment, you will have to contact your primary care physician.

Free parking is available in the West Parking Garage which is attached to our building. Valet and metered parking are also available.

To better serve your needs, please make note of the following phone numbers:

Appointment Coordinator: 727-828-8403/727-828-8404
Billing/Insurance: 727-828-8405
Nurse/Surgical Coordinator: 727-828-8402

We look forward to offering you the best possible care and appreciate your patience and understanding!
Patient Demographics/Insurance (Please Print Clearly)

Demographics

First Name: _______________________ Middle Initial: _______ Last Name: ___________________ Maiden: _________
Date of Birth: _______ /______ /______  S.S. #:____ - ____ -_______ Marital Status: ____________________
Race: __________________   Ethnicity: ______________________ Language: ______________________
Address: ________________________________________ City: ___________________ State/Zip: __________________
Phone: Home: _________________________ Cell: ________________________ Work: ___________________________
Email: ________________________________________________
Out of Town Address: __________________________ City: ___________________ State/Zip: ________________
Emergency Contact: _______________________Emergency Phone: ________________ Relationship: _________________
Primary care Physician: ___________________________ Phone: _______________________
Referring Physician: _________________________ Phone: _______________________

Primary Insurance                      Secondary Insurance
Insurance Co.:___________________________________ Insurance Co.:_________________________________
Policy#:_______________________ Group#:__________ Policy#:______________________ Group#:__________
Policy Holder: __________________ Date of Birth:_______ Policy Holder:_________________ Date of Birth:______
Relationship: ___________________________________ Relationship: __________________________
Employer: ______________________________________ Employer: ______________

Reminder: Please remember your insurance card at the time of your visit so that we may obtain a copy.

Rx

Pharmacy: ___________________________ Location (Street/City):____________________ Phone#:_________________

Authorization Signature

I authorize **Neurosurgical Associates of Tampa Bay** to release information to the above insurance carriers regarding my medical care, and I hereby assign to **Neurosurgical Associates of Tampa Bay** all payments for services rendered to me. I understand that I am responsible for any amount not covered by insurance and have read the notice of privacy.

Signed/Acknowledged: _____________________ Date: ________________________
Worker’s Compensation Information (IF APPLICABLE)

Name of Employer: _________________________________ Phone#: _________________________________
Employer Address: ___________________________________________________________________________
Name of Insurance Carrier: ____________________________________ Phone#: ___________________________
Address: ___________________________________________________________________________________
Date of Injury: _________________________________ Date First Treated: ______________________________
Date Patient Unable to Work in Current Occupation: _________________________________________________
Worker’s Compensation Claim Number: ___________________________________________________________
Adjuster Name: ______________________________________________ Phone#: ___________________________
How Did Accident Happen? _______________________________________________________________________

Auto Accident Information (Please complete attached Auto Assignment of Benefit forms) (IF APPLICABLE)

Date of Accident: _______________________________ Place: ______________________________ State:___________
Name of Auto Insurance Carrier: __________________________________________________________________
Address: ___________________________________________ Phone#:________________________________________
Claim#:___________________________________________ Adjuster Name ____________________________________
How Did Accident Happen? _______________________________________________________________________

Attorney Information* (IF APPLICABLE)
*This is for information purposes only. Please note that we do not accept Letters of Protection (LOP) nor do we wait until a case is settled before expecting payment. Please refer to our Financial Policy for further information.

Attorney Name: ______________________________________________________________________________
Address: _____________________________________________________________________________________
Phone#:____________________________________________ Fax#:______________________________________
Please take a moment to complete this form. Completion of this form helps to provide your physician with a detailed medical history.

Height: _________  Weight: _________  □ Right Handed  □ Left handed

Occupation (if retired, previous occupation): __________________________________________

Who referred you to the clinic today? _______________________________________________

What is the problem you would like us to help you with today? Describe your symptoms.
______________________________________________________________________________
______________________________________________________________________________

When did your symptoms first start? _______________________________________________

Was it  □ sudden or  □ gradual?

What activities were you engaged in when your symptoms first started?____________________
______________________________________________________________________________

If applicable, at what time of day are your symptoms the worst:
□ Morning  □Later in the day  □Evening  □Constant

Frequency of Symptoms: □ Constant □Intermittent □Daily □Once per week □ other: _____________

Character of Pain: □ Burning □Electric Shock □Sharp □Shooting □Stabbing □ Deep ache □ other _____________

Aggravating Factors: (things that make the symptoms worse)
______________________________________________________________________________

Alleviating Factors: (things that make the symptoms better)
______________________________________________________________________________

How was the problem treated in the past? _________________________________________

Please check those that apply regarding treatment of this problem:
□Physician (please specify _______________) □Chiropractor □Neuropath □Physical Therapy □ Acupuncture
□Massage □Occupational Therapy □Pain Management □Steroid Injections □Brace □Aquatic Therapy
Other______________________________

Have you ever had chemotherapy?  □Yes  □No
If yes, what hospital? ___________________________________________________________

Have you ever had radiation? □Yes  □No
If yes, what hospital: ___________________________________________________________
HEALTH ASSESSMENT FORM FOR THE **SPINE** or **PERIPHERAL NERVE** PATIENT

***ONLY FILL THIS OUT IF YOUR SYMPTOMS ARE RELATED TO THE **NECK, BACK, ARMS OR HANDS** ***

Please take a moment to complete this form. Completion of this form helps to provide your physician with a detailed medical history.

Height: __________  Weight: ________  ☐ Right Handed  ☐ Left handed

Occupation (if retired, previous occupation): __________________________________________

Who referred you to the clinic today? _______________________________________________

What is the problem you would like us to help you with today? Describe your symptoms.
______________________________________________________________________________
______________________________________________________________________________

When did your symptoms first start? _______________________________________________

Was it ☐ sudden or ☐ gradual?

What activities were you engaged in when your symptoms first started?____________________
______________________________________________________________________________

When are your symptoms worse: ☐ Morning ☐ Later in the day ☐ Evening ☐ Constant all day

Frequency of Symptoms: ☐ Constant ☐ Intermittent ☐ Daily ☐ Once per week ☐ Other: _______________

Character of Pain: ☐ Burning ☐ Electric Shock ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Deep ache

☐ Other (please describe) __________________

Aggravating Factors: (things that make the symptoms worse)
☐ Lifting ☐ Standing ☐ Climbing Stairs ☐ Movement of neck
☐ Coughing ☐ Walking ☐ Sitting in Car ☐ Straining of bowels
☐ Sneezing ☐ Sitting ☐ Arms overhead ☐ Other: ___________

Alleviating Factors: (things that make the symptoms better)
☐ Walking ☐ Sitting ☐ Laying Down ☐ Moist Heat
☐ Ice pack ☐ Leaning forward ☐ Other: __________________

Does bed rest relieve your pain? ☐ Yes  ☐ No

How long can you sit? ____________________________________________________________

How far can you walk? __________________________________________________________

Do you have any of the following symptoms?

<table>
<thead>
<tr>
<th>Do you have any of the following symptoms?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand</td>
</tr>
<tr>
<td>Arm</td>
</tr>
<tr>
<td>Shoulder</td>
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<tr>
<td>Hip</td>
</tr>
<tr>
<td>Leg</td>
</tr>
<tr>
<td>Foot</td>
</tr>
</tbody>
</table>
**HEALTH ASSESSMENT FORM FOR THE SPINE OR PERIPHERAL NERVE PATIENT**

*****ONLY FILL THIS OUT IF YOUR SYMPTOMS ARE RELATED TO THE NECK AND BACK.*****

Using the pictures below, indicate which parts of your body are affected by pain by marking them with the abbreviations closest to the type of sensation you are experiencing:

- Numbness = N
- Knifelike = K
- Tingling = T
- Burning = B
- Aching = A
- Stiffness = S

Right  Left  Left  Right

How was the problem treated in the past?  ____________________________________________
________________________________________________________________________________
________________________________________________________________________________

Please check those that apply regarding treatment of this problem:

- [ ] Physician (please specify ____________)  [ ] Chiropractor  [ ] Neuropath
- [ ] Physical Therapy  [ ] Acupuncture  [ ] Massage  [ ] Occupational Therapy
- [ ] Pain Management  [ ] Steroid Injections  [ ] Brace  [ ] Aquatic Therapy
- [ ] Other________________________________________
IMAGING

What kinds of studies have you had in the past?
- □ CT scan
- □ MRI
- □ Myelogram
- □ Angiogram
- □ X-ray
- □ EMG
- □ Bone scan

Body Part: __________________________________________
Facility Name: _______________________________________
Date: __________________

LIFESTYLE

1. Are you currently working?  ☐ Yes  ☐ No
   When was your last day of work? _______________________
   Are you on disability?  ☐ Yes  ☐ No
   If yes what type? ___________________________________

2. Is your problem associated with an injury?  ☐ Yes  ☐ No
   If yes when did it occur? _____________________________
   Describe the injury: _________________________________
   Was the injury work related?  ☐ Yes  ☐ No
   If yes, are you still involved in any legal action or lawsuit concerning the injury, disability, or medical treatment?  ☐ Yes  ☐ No
   If yes, Attorney’s name: ______________________________

3. What is your current level of activity?
   - ☐ Normal activity, no restrictions.
   - ☐ Restricted physical activity, able to walk and do light work.
   - ☐ Able to walk and get around 50% of the time, unable to work.
   - ☐ Confined to chair or bed 50% of the time; need help with daily care.
   - ☐ Completely disabled; unable to care for self; confined to chair or bed.

MEDICATION LIST:
(List all medications currently taking and over the counter/non-prescription) Please attach list if necessary

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
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</tbody>
</table>
PAST MEDICAL HISTORY:
Check if the patient has any of the following diseases currently or in the past.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Family</th>
<th>Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Heart Disease</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>Lung Disease</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>High Blood Pressure</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>Stroke/TIA</td>
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<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>Diabetes</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>Ulcers</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>Seizures</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>Arthritis</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>Hernia</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>Peripheral vascular disorder</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>Autoimmune disorder/Lupus</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Patient</th>
<th>Family</th>
<th>Disease</th>
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<tbody>
<tr>
<td></td>
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<td>Cancer (type?)</td>
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<td>[ ]</td>
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<td>Thyroid problem</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>Blood Disorder</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>Hepatitis</td>
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<td>Kidney/bladder disorder</td>
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<td>Gout</td>
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<td>[ ]</td>
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<td>Mental/Nervous disorders</td>
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<td>[ ]</td>
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<td>Liver disorder</td>
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<td>TB</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>HIV</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>Fibromyalgia</td>
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</tbody>
</table>

Other and/or comments: _____________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

ALLERGIES: (List all allergies and reactions including medications, latex, iodine, contrast dye)
_________________________________________  _______________________________________
_________________________________________  _______________________________________
_________________________________________  _______________________________________
_________________________________________  _______________________________________ 

PAST SURGICAL HISTORY: Please list any surgeries and the dates performed.

<table>
<thead>
<tr>
<th>Year</th>
<th>Surgery Performed</th>
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</table>
FAMILY HISTORY: ****PLEASE CHECK ALL THAT APPLY****

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<thead>
<tr>
<th>MEMBERS</th>
<th>STATUS</th>
<th>ALIVE, DECEASED, UNKNOWN</th>
<th>YEAR OF BIRTH</th>
<th>AGE</th>
<th>DIABETES</th>
<th>HYPER-TENSION</th>
<th>HEART DISEASE</th>
<th>STROKE</th>
<th>MENTAL</th>
<th>CANCER</th>
<th>UNKNOWN</th>
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<tbody>
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<td>DAUGHTER(S)</td>
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<td>PATERNAL UNCLE</td>
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<td>SPOUSE</td>
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✓ MUST CHOOSE

Other: ____________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________
SOCIAL HISTORY:

Do you drink coffee?

☐ No  ☐ Yes, How Often?_________________________________________ ______

Tobacco:

Are you a:
☐ current smoker  ☐ former smoker  ☐ never smoker

If 'current smoker': How often do you smoke cigarettes?
☐ every day  ☐ some days, but not every day

If 'current smoker': How many cigarettes a day do you smoke?
☐ 5 or less  ☐ 6-10  ☐ 11-20  ☐ 21-30  ☐ 31 or more

If 'current smoker': How soon after you wake up do you smoke your first cigarette?
☐ within 5 minutes  ☐ 6-30 minutes  ☐ 31-60 minutes  ☐ after 60 minutes

If 'current smoker': Are you interested in quitting?
☐ Ready to quit  ☐ Thinking about quitting  ☐ Not ready to quit

If 'former smoker': How long has it been since you last smoked?
☐ 1-3 months  ☐ < 1 month  ☐ 3-6 months  ☐ 6-12 months  ☐ 1-5 years  ☐ 5-10 years  ☐ > 10 yrs

Alcohol:

Did you have a drink containing alcohol in the past year?
☐ Yes  ☐ No

If 'Yes': How often did you have a drink containing alcohol in the past year?
☐ Never  ☐ Monthly or less  ☐ 2-4 times a month  ☐ 2-3 times a month  ☐ 4 or more times a week

If ‘Yes’: How many drinks did you have on a typical day when you were drinking in the past year?
☐ 1 or 2  ☐ 3 or 4  ☐ 5 or 6  ☐ 7 to 9  ☐ 10 or more

If ‘Yes’: How often did you have six or more drinks on one occasion in the past year?
☐ Never  ☐ Less than monthly  ☐ Monthly  ☐ Weekly  ☐ Daily or almost daily

Recreational Drugs:  ☐ No  ☐ Yes, What?______________ How Often?___________

Comments: _____________________________________________________________________________________
<table>
<thead>
<tr>
<th>SYSTEMS REVIEW</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Please indicate if you are currently or regularly experiencing any of the following. <strong>CHECK YES OR NO.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>CONSTITUTIONAL SYSTEMS:</strong></td>
<td></td>
</tr>
<tr>
<td>Good general health lately</td>
<td>NO YES</td>
</tr>
<tr>
<td>Recent weight loss</td>
<td>NO YES</td>
</tr>
<tr>
<td>Fever</td>
<td>NO YES</td>
</tr>
<tr>
<td>Fatigue</td>
<td>NO YES</td>
</tr>
<tr>
<td>Headaches</td>
<td>NO YES</td>
</tr>
<tr>
<td><strong>EYES:</strong></td>
<td></td>
</tr>
<tr>
<td>Eye disease or injury</td>
<td>NO YES</td>
</tr>
<tr>
<td>Wear glasses/ contact lens</td>
<td>NO YES</td>
</tr>
<tr>
<td>Blurred vision</td>
<td>NO YES</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>NO YES</td>
</tr>
<tr>
<td><strong>EAR/NOSE/ MOUTH/THROAT:</strong></td>
<td></td>
</tr>
<tr>
<td>Hearing loss</td>
<td>NO YES</td>
</tr>
<tr>
<td>Earache or drainage</td>
<td>NO YES</td>
</tr>
<tr>
<td>Chronic sinus/rhinitis</td>
<td>NO YES</td>
</tr>
<tr>
<td>Nose bleeds</td>
<td>NO YES</td>
</tr>
<tr>
<td>Mouth sores</td>
<td>NO YES</td>
</tr>
<tr>
<td>Bleeding gums</td>
<td>NO YES</td>
</tr>
<tr>
<td>Bad breath or bad taste</td>
<td>NO YES</td>
</tr>
<tr>
<td>Sore throat or voice change</td>
<td>NO YES</td>
</tr>
<tr>
<td>Swollen glands on neck</td>
<td>NO YES</td>
</tr>
<tr>
<td><strong>CARDIOVASCULAR</strong></td>
<td></td>
</tr>
<tr>
<td>Heart trouble</td>
<td>NO YES</td>
</tr>
<tr>
<td>Chest pain/ angina pectoria</td>
<td>NO YES</td>
</tr>
<tr>
<td>Palpitations</td>
<td>NO YES</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>NO YES</td>
</tr>
<tr>
<td>Asthma or wheezing</td>
<td>NO YES</td>
</tr>
<tr>
<td><strong>RESPIRATORY:</strong></td>
<td></td>
</tr>
<tr>
<td>Chronic/ frequent cough</td>
<td>NO YES</td>
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<tr>
<td>Spitting up blood</td>
<td>NO YES</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>NO YES</td>
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<tr>
<td>Swelling foot/ ankle/ hands</td>
<td>NO YES</td>
</tr>
<tr>
<td><strong>GASTROINTESTINAL:</strong></td>
<td></td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>NO YES</td>
</tr>
<tr>
<td>Change in bowel movements</td>
<td>NO YES</td>
</tr>
<tr>
<td>Nausea or vomiting</td>
<td>NO YES</td>
</tr>
<tr>
<td>Frequent diarrhea</td>
<td>NO YES</td>
</tr>
<tr>
<td>Painful bowel movements</td>
<td>NO YES</td>
</tr>
<tr>
<td>Constipation</td>
<td>NO YES</td>
</tr>
<tr>
<td>Rectal bleeding</td>
<td>NO YES</td>
</tr>
<tr>
<td>Blood in stool</td>
<td>NO YES</td>
</tr>
<tr>
<td>Abdominal pain/ heartburn</td>
<td>NO YES</td>
</tr>
<tr>
<td>Ulcer stomach/duodenal</td>
<td>NO YES</td>
</tr>
<tr>
<td><strong>GENITOURINARY:</strong></td>
<td></td>
</tr>
<tr>
<td>Frequent urination</td>
<td>NO YES</td>
</tr>
<tr>
<td>Burning/ painful urination</td>
<td>NO YES</td>
</tr>
<tr>
<td>Change in force of strain</td>
<td>NO YES</td>
</tr>
<tr>
<td>Kidney stones</td>
<td>NO YES</td>
</tr>
<tr>
<td>Sexual difficulty</td>
<td>NO YES</td>
</tr>
<tr>
<td>Female- Pain w/ periods</td>
<td>NO YES</td>
</tr>
<tr>
<td>Incontinent of urine</td>
<td>NO YES</td>
</tr>
<tr>
<td>Dribbling</td>
<td>NO YES</td>
</tr>
<tr>
<td><strong>GENITOURINARY CONTINUED</strong></td>
<td></td>
</tr>
<tr>
<td>Male- Testicle pain</td>
<td>NO YES</td>
</tr>
<tr>
<td>Female- Irregular periods</td>
<td>NO YES</td>
</tr>
<tr>
<td>Blood in urine</td>
<td>NO YES</td>
</tr>
<tr>
<td>Vaginal discharge</td>
<td>NO YES</td>
</tr>
<tr>
<td># of pregnancies</td>
<td>NO YES</td>
</tr>
<tr>
<td>Date of last Pap Smear</td>
<td></td>
</tr>
<tr>
<td><strong>MUSCULOSKELETAL:</strong></td>
<td></td>
</tr>
<tr>
<td>Joint pain</td>
<td>NO YES</td>
</tr>
<tr>
<td>Joint stiffness</td>
<td>NO YES</td>
</tr>
<tr>
<td>Weakness</td>
<td>NO YES</td>
</tr>
<tr>
<td>Back Pain</td>
<td>NO YES</td>
</tr>
<tr>
<td>Cold extremities</td>
<td>NO YES</td>
</tr>
<tr>
<td>Difficulty walking</td>
<td>NO YES</td>
</tr>
<tr>
<td><strong>INTEGUMENTARY:</strong></td>
<td></td>
</tr>
<tr>
<td>Rash or itching</td>
<td>NO YES</td>
</tr>
<tr>
<td>Change in skin color</td>
<td>NO YES</td>
</tr>
<tr>
<td>Change in hair/ nails</td>
<td>NO YES</td>
</tr>
<tr>
<td>Varicose veins</td>
<td>NO YES</td>
</tr>
<tr>
<td>Breast pains</td>
<td>NO YES</td>
</tr>
<tr>
<td>Breast lumps</td>
<td>NO YES</td>
</tr>
<tr>
<td>Breast discharge</td>
<td>NO YES</td>
</tr>
<tr>
<td><strong>NEUROLOGICAL:</strong></td>
<td></td>
</tr>
<tr>
<td>Headaches, frequent</td>
<td>NO YES</td>
</tr>
<tr>
<td>Light headed or dizzy</td>
<td>NO YES</td>
</tr>
<tr>
<td>Convulsions/ seizures</td>
<td>NO YES</td>
</tr>
<tr>
<td>Numbness/ tingling</td>
<td>NO YES</td>
</tr>
<tr>
<td>Tremors</td>
<td>NO YES</td>
</tr>
<tr>
<td>Paralysis</td>
<td>NO YES</td>
</tr>
<tr>
<td>Stroke</td>
<td>NO YES</td>
</tr>
<tr>
<td>Head injury</td>
<td>NO YES</td>
</tr>
<tr>
<td><strong>PSYCHIATRIC:</strong></td>
<td></td>
</tr>
<tr>
<td>Memory loss/confusion</td>
<td>NO YES</td>
</tr>
<tr>
<td>Nervousness</td>
<td>NO YES</td>
</tr>
<tr>
<td>Depression</td>
<td>NO YES</td>
</tr>
<tr>
<td>Insomnia</td>
<td>NO YES</td>
</tr>
<tr>
<td><strong>ENDOCRINE:</strong></td>
<td></td>
</tr>
<tr>
<td>Glandular problems</td>
<td>NO YES</td>
</tr>
<tr>
<td>Hormone problems</td>
<td>NO YES</td>
</tr>
<tr>
<td>Thyroid disease</td>
<td>NO YES</td>
</tr>
<tr>
<td>Excessive urination</td>
<td>NO YES</td>
</tr>
<tr>
<td>Hot/cold intolerance</td>
<td>NO YES</td>
</tr>
<tr>
<td>Skin dryness</td>
<td>NO YES</td>
</tr>
<tr>
<td>Change hat/ glove size</td>
<td>NO YES</td>
</tr>
<tr>
<td><strong>HEMATOLOGIC/ LYMPHATIC:</strong></td>
<td></td>
</tr>
<tr>
<td>Cuts slow to heal</td>
<td>NO YES</td>
</tr>
<tr>
<td>Tendency to bleed/ bruise</td>
<td>NO YES</td>
</tr>
<tr>
<td>Anemia</td>
<td>NO YES</td>
</tr>
<tr>
<td>Phlebitis</td>
<td>NO YES</td>
</tr>
<tr>
<td>Past transfusions</td>
<td>NO YES</td>
</tr>
</tbody>
</table>
HIPAA PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your physician, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies, please do not hesitate to ask our privacy officer, Nadine Williams, who can be reached at 727-828-8406.

Information We Collect About You:
We collect personal information about you and your family as part of our registration process, during the course of your care and from other health care entities you utilize, such as hospitals, laboratories, other physicians, imaging facilities and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, and health history and insurance policy/coverage information. During the course of your treatment we will collect health information regarding diagnosis, treatment plans, progress and any test results or films/images.

How Your Information is Used:
The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency/attorney to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian. Our office does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

Safeguarding Your Personal and Health Information:
We are required by law to (1) make sure that medical information that identifies you is kept private, (2) provide you with our privacy policy and (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal health information to only those employees who require the information to complete their job duties and provide quality service to you. Our office maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with our office.

Changes to Our Privacy Policy:
All new patients will receive a copy of our privacy policy. Our office occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be posted and copies will be available upon request at the front office.

Your Right to Restrict Use of Information:
You have the right to request restrictions to our uses or disclosures of your personal or health information in writing, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Signed/Acknowledged: _____________________    Date: ________________________
Dear Patient,

We are honored that you have chosen us as your healthcare provider. Today we have exciting news regarding your health management!

As we continue in our efforts to provide our patients with the highest quality of care, we are constantly looking for methods of working together with you to ensure that you are not only aware of, but also involved in the management and improvement of your health.

We are proud to inform you that our practice now offers the opportunity to use the power of the web to track the most important aspects of your healthcare through our office. The Patient Portal enables our patients to communicate with our doctors, nurses, and staff members easily, safely, and securely via the Internet.

Participating patients are given secure User IDs and passwords, enabling them to access the Portal to view their personal and private documents, educational information, billing statements, and other health information.

Through the Patient Portal, you are able to:

- ask questions of doctors and staff members
- request prescription refills
- request or cancel appointments
- view upcoming or prior appointments

... all from the comfort of your home, whenever it is convenient for you!

You can also send a message to the office through the Portal and expect a prompt reply.

To learn more or to sign up, contact our office today at 727-828-8400 ext 201. Or, go to our website, https://mycw5.eclinicalweb.com/natb/jsp/login.jsp, and follow the simple directions to register.

Begin today to take an active role in managing your healthcare!

___ Yes, I would like to be web enabled.
My email address: _____________________________
MEDICATION REQUEST

Medications may be prescribed around the time of surgery or we will arrange for these to be written after your surgery.

Discomfort or pain due to surgery usually resolves within a few weeks. Your surgeon will continue to provide pain medication, if needed, for up to 6 weeks following surgery. Our physicians will not provide any pain medications refills greater than 6 weeks after your surgery.

Beyond that, any medication prescriptions should once again be obtained from your primary care or pain management physician.

All requests for prescriptions or refills of medications must be completed during office hours. For the patient’s safety, the chart must be available for review before a medication can be prescribed or refilled. Please note pain medications should only be prescribed from one medical doctor only.

Our physicians are in surgery during the week, plan on a 3-5 day turnaround time.
If you need a medication refill, you can log on to the patient portal on our website at www.nsatb.com and request your refill by secure email. You can also contact your pharmacy who can initiate the request electronically or leave a message on our prescription refill line: 727-828-8400 option 5.

The purpose of this information is to prevent misunderstandings and to help both you and your physician to comply with the state and federal law regarding controlled pharmaceuticals.

I UNDERSTAND AND HAVE REVIEWED THE ABOVE.

_______________________________________ __________________
Signature         Date
MEDICAL RECORDS/HIPPA AUTHORIZATION

Date: ____________

Disclaimer: This document is provided solely for reference purposes. Covered entities under HIPAA are advised to refer to their institution’s Privacy Policy for specific requirements for the HIPAA authorization.

I, ______________________________, give my permission to Neurosurgical Associates of Tampa Bay to:

___ Use the following protected health information and/or
___ Disclose the following protected health information to:

_____________________________________________________________________________________

_____________________________________________________________________________________ 

_____________________________________________________________________________________ 

Please indicate whether or not we may leave a message on your:

___Home Phone   ___Cell Phone: ___Work Phone: ___Email

Information to be disclosed (check all that apply):

___Medical Records   ___Treatment Records   ___Diagnostic Records   ___Billing Records

___Other: _____________________________________________________________________________

This protected health information may be released to the following party/parties without hesitation:
Please list any family member(s) and other you wish to share your records with.

Name: _________________________________  Relationship: __________________________________

Name: _________________________________  Relationship: __________________________________

___ This authorization expires on: _____________________ or  ___ does not expire. (check one)

You may inspect or copy the protected health information to be used or disclosed under this authorization. You may also revoke this authorization in writing at any time by sending written notification to our office (as addressed above). Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

Signed/Acknowledged: _____________________    Date: ________________________
FINANCIAL AGREEMENT

INSURANCE COVERAGE:
It is your responsibility to be aware of your coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is obtained by contacting your insurance carrier. We attempt to verify that your coverage is valid at the time of service. This includes verifying the amount of your co-payment and whether or not your deductible and/or out of pocket expenses have been met. If your coverage is not in effect at the time of service, the entire fee for the visit is your responsibility. You must notify us of any changes to your insurance as even the slightest discrepancy on a claim form can cause a denial. Any amount due that is deemed “patient responsibility” is due at the time services are rendered.

REFERRALS AND/OR AUTHORIZATIONS:
Many insurance carriers require pre-authorizations and/or a referral for each visit with us. You are responsible for obtaining these referrals or authorizations. This is typically done through your primary care physician. It is strongly suggested that you contact your primary care physician immediately upon receiving an appointment date/time for our office to allow them ample time to obtain the referral/authorization. If you are unsure as to whether or not the services to be rendered require a referral or authorization, please contact your insurance carrier directly. You may also contact our Insurance Specialist if you need further assistance.

SURGERY:
Our office will complete any pre-certification or authorization requirements prior to your surgery date. Our surgical coordinator will review any deductibles and/or out of pocket expenses with you as outlined by your insurance plan. If there is any patient responsibility, we require that to be paid prior to the procedure being performed. This will be considered a “pre-surgical deposit” and will be posted to your account. However, please keep in mind that the calculated amount is an estimated cost and is subject to change once the insurance carrier receives and processes the claim. Therefore, there is a possibility that, after processing, there may still be a balance due or even a refund due back to you.

DISABILITY FORMS:
Our surgical coordinator completes all FMLA, short and long term disability forms. We require a $25 pre-payment for each form completed. Allow 7-10 days for the forms to be completed.

CANCELLATIONS:
I understand cancellations must be made with at least 48 hour notice before my appointed time or a $25 fee must be paid prior to scheduling another appointment.

DURABLE MEDICAL EQUIPMENT/SUPPLIES:
Your physician may determine that you need certain medical equipment and/or supplies that may or may not be covered by your insurance plan. Please be aware that we will bill your insurance carrier for these supplies, but in the event they deny the claim as “not reasonable or necessary, or simply not covered by your plan, the fee will become your responsibility. You should also be aware that some supplies may be available for purchase at most major drug stores.

INSURANCE PAYMENTS SENT TO YOU:
If insurance payments are sent to you erroneously, you are responsible for forwarding them to our office.

HOW MAY I PAY:
We accept Cash, Check and the following Credit/Debit cards: Visa, MasterCard, Discover or AMEX

I have read, understand and agree to the above Financial Policy. I acknowledge my personal financial responsibility and I consent to continue with treatment.

Signed/Acknowledged: _____________________    Date: ________________________
Living Will

Declaration made this ______ day of ______, 20____, I, ____________________________, will fully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and (choose one or more below)

1) ______ I have a terminal condition  2) ______ I have an end-stage condition 3) ______ I am in a persistent vegetative state and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition:

- I do ☐ or do not ☐: want CPR (cardiac resuscitation).
- I do ☐ or do not ☐: want a ventilator or other form of mechanical respiration.
- I do ☐ or do not ☐: want tube feeding or any other artificial or invasive form of nutrition (food).
- I do ☐ or do not ☐: want fluids administered by tube.
- I do ☐ or do not ☐: want blood or blood products.
- I do ☐ or do not ☐: want surgery.
- I do ☐ or do not ☐: want a kidney machine (dialysis).
- I do ☐ or do not ☐: want antibiotics.
- I do ☐ or do not ☐: direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.
- I do ☐ or do not ☐: want to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

Additional instructions (optional):

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name ________________________________ Phone ________________________________
Address ______________________________ City __________________________ State ______

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration. It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences for such refusal.

Patient Signature ________________________________

Witness Name ________________________________
Address ______________________________ City __________________________ State ______
Phone ______________________________
Signature ______________________________ Date ________________

At least one witness must not be a spouse or a blood relative of the principal.
Designation of Health Care Surrogate

Patient Name ________________________________

In the even that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name______________________________ Relationship_________________________ Phone________
Address_________________________ City________________ State_________ Alt. Phone________

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name______________________________ Relationship_________________________ Phone________
Address_________________________ City________________ State_________ Alt. Phone________

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility. Additional instructions (optional):

____________________________________________________________________________
____________________________________________________________________________

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. My health care surrogate's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I initial either or both of the following spaces:

By initialing here______, I do □ or do not □ authorize my health care surrogate to receive my health information immediately.

By initialing here______, I do □ or do not □ authorize my health care surrogate to make health care decisions for me immediately. I understand that any health care decisions I make or instructions I give, whether orally or in writing, regarding my care will have priority over any health care decisions or instructions of my health care surrogate, unless I am determined, as provided by Florida law, to lack the capacity to make decisions on my own behalf.

Patient Signature_________________________ Print Name________________ Date________
Address______________________________ City________________ State________

Signature of Witnesses: (At least one witness must not be a spouse or blood relative.)

Print Name_________________________ Print Name________________
Address______________________________ City________________ State________
Signature_________________________ Date________

Print Name_________________________ Print Name________________
Address______________________________ City________________ State________
Signature_________________________ Date________