Comprehensive NeuroSpine
Carlos Casas-Reyes, MD - Neurosurgeon
Christine Whelan, RN – Business Practice Manager
Phone: 954-800-8877 – Fax: 954-800-5588
Email: info@ComprehensiveNeuroSpine.com

WELCOME TO OUR PRACTICE

At Comprehensive NeuroSpine, we believe in a healthy, pain-free quality of life for everyone. The company was created to assist anyone suffering from neck or back pain to have access to a comprehensive approach to total patient care and well-being, under the direction and supervision of a highly skilled and renowned Neurosurgeon.

Dr. Carlos Casas and his staff will help to find a solution to your spinal pain whether it's surgical or not. If you need pain management, we can refer you to experts in Dade, Broward and Palm beach counties.

Dr. Casas is a Board - Certified Neurosurgeon. He completed his Internship in General Surgery at Jackson Memorial Hospital & VA Healthcare System, University of Miami, Miami FL. He completed Residency training in Neurosurgery at Henry Ford Hospital in Detroit Michigan, and his Fellowship in Comprehensive Spine Surgery and Radiosurgery (Cyperknife) at Stanford University School of Medicine in Sanford, California. In the past, (2013-2018) Dr. Carlos Casas worked as a Neurosurgeon employed by Holy Cross Hospital in Fort Lauderdale, FL. Now in private practice since 2018, he continues to serve south Florida's tri-county areas and will be expanding service lines to offer a comprehensive care pla to his patients.

Dr. Carlos Casas is trained in the latest minimally invasive spine surgeries and offers treatment of degenerative spine, spinal deformity, trauma, tumor, infection, as well as cervical disc replacement.

Dr. Casas is dedicated to excellence in patient care and Comprehensive NeuroSpine is dedicated to helping you.

Our NEW Office location as of January 2022 is:

IN FORT LAUDERDALE
5353 N Federal Highway
Suite #300
Fort Lauderdale, FL 33308

Comprehensive NeuroSpine

Patient's Bill of Rights and Responsibilities

A PATIENT HAS THE RIGHT TO:

- Be treated with courtesy and respect, with appreciation of his or her dignity, and with protection of privacy.
- Receive care in a safe setting.
- Be free from all forms of abuse or harassment and from any act of discrimination or reprisal.
- Receive a prompt and reasonable response to questions and requests.
- Know who is providing the medical services and is responsible for his or her care.
- Change providers if another qualified provider is available.
- Know what patient support services are available, including if an interpreter is available if the patient does not speak English.
- Know what rules and regulations apply to his or her conduct.
- Be given by health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- If a patient is adjudged incompetent under applicable State law by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on patient's behalf.
- If the State court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.
- Be given gull information and necessary counseling on the availability of known financial resources of care.
- Know whether the healthcare provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare.
- Receive prior to treatment, a reasonable estimate of charges for medical care.
- Receive a cop of an understandable itemized bill and, if requested, to have the charges explained.
- To be notified of the office policy on Advanced Directives, as required by state or federal law and regulations.
- To approve or refuse the release of patient disclosures and records, except when release is required by law.
- Patient disclosures and records are treated confidentially.
- Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such research.
- Express complaints regarding any violation of his or her rights and any grievances regarding treatment or care that is (or fails to be) furnished.

A PATIENT IS RESPONSIBLE FOR:

- Providing the health care provider complete and accurate information to the best of his/her ability about present complaints, past illnesses, hospitalizations, medications, including over-the-counter products and dietary supplements, and all allergies or sensitivities and any other information about his or her health.
- Reporting unexpected changes in his or her condition to the healthcare provider.
- Reporting to the healthcare provider whether he or she understands a planned course of action and what is expected of him/her.
- Following the treatment plan recommended by the health care provider and participate in his/her care.
- Keeping appointments and, when unable to do so, notifying the health care provider or facility.
- His or her reactions if treatment is refused or if the patient does not follow the health care provider's instructions.
- Making sure financial responsibilities are carried out.
- Following health care facility conduct rules and regulations.
- Behaving respectfully towards all the health care professionals and staff, as well as other patients.
- Providing a responsible adult to transport him/her from the facility and remain with him/her for 24 hours, if required by his/her provider.

If you have any suggestions, complaints or grievances, you may contact the following organizations:

AGENCY FOR HEALTHCARE ADMIN. CONSUMER ASSIST UNIT
2727 MAHAN DRIVE BLDG 1, TALLAHASSEE FL 32308
1-888-419-3456

OFFICE OF THE MEDICARE BENEFICIARY OMBUDSMAN
WWW.CMS.GOV/CENTER/OMBUDSMAN.ASP

Comprehensive NeuroSpine - Carlos Casas, MD
Phone: 954-800-8877 / Fax: 954-800-5588

PATIENT INFORMATION

PATIENT'S NAME: DATE:			MARITAL STATUS: S M D W PARTNERED
SS#:	DATE OF BIRTH:	AGE:	SEX: M F
HOME ADDRESS CITY/STATE/ZIP CODE			
CELL PHONE #:	HOME PHONE #:	RACE: ETHNICITY:	
EMERGENCY CONTACT:		CONTACT PHONE #:	RELATIONSHIP:
EMAIL ADDRESS:		HOW DO YOU PREFFERR TO BE CONTACTED? ☐TEXT(CELL) ☐HOME(MAIL) ☐EMAIL ☐HOME(PHONE CALL)	
RELIGION:	PRIMARY LANGUAGE: ☐ENGLISH ☐SPANISH ☐OTHER:	EMPLOYER:	

REFERRING PHYSICIAN INFORMATION	PRIMARY CARE DOCTOR INFORMATION
PROVIDER NAME AND SPECIALTY:	PROVIDER NAME:
PHONE NUMBER:	PHONE NUMBER:

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE NAME:	POLICY ID#:	POLICY GROUP #:	INSURANCE PHONE #:
	SUBSCRIBERS NAME: (IF DIFFERENT FROM PATIENT)	SUBSCRIBER D.O.B:	RELATIONSHIP TO PATIENT:

SECONDARY INSURANCE:

INSURANCE NAME:	POLICY ID#:	POLICY GROUP #:	INSURANCE PHONE #:
	SUBSCRIBERS NAME: (IF DIFFERENT FROM PATIENT)	SUBSCRIBER D.O.B:	RELATIONSHIP TO PATIENT:

ACCIDENT INFORMATION

AUTO ACCIDENT ☐YES ☐NO		WORKERS COMP INJURY ☐YES ☐NO
AUTO INSURANCE COMPANY NAME:		WORK. COMPENSATION COMPANY NAME:
ADJUSTER NAME & PHONE #:		CLAIM #:
POLICY HOLDER'S NAME:		EMPLOYER NAME:
POLICY ID#:	CLAIM #:	ADJUSTER NAME & PHONE:

ATTORNEY INFORMATION: (ONLY IF SEEING DR. CASAS IS DUE TO A LEGAL MATTER)

ATTORNEY'S NAME:	ATTORNEY'S PHONE#
CASE MANAGER'S NAME:	CASE #:

ASSIGMENT OF BENEFITS

I hereby assign all Medical and / or Surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, Private Insurance, and any other health plan to Comprehensive NeuroSpine, LLC. The assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether paid by my current insurance or not. I hereby authorize said assignee to release all information necessary to secure the payment. I certify that I have read and fully understand the provider's billing policy and agree to make payment in full as outlined in the CNS agreement of financial responsibility. (CNS.000100.02)

_____ _____

PATIENT SIGNATURE DATE

Comprehensive NeuroSpine
Carlos E. Casas-Reyes, MD - Neurosurgeon/Christine Whelan, RN – Business Practice Manager
Office: 5353 N. Federal Highway, #300, Ft. Lauderdale, FL 33308-3236
Phone: 954-800-8877 – Fax: 954-800-5588 – Email: info@ComprehensiveNeuroSpine.com

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for COMPREHENSIVE NEUROSPINE LLC (the Practice) to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked “Personal and Confidential.”

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

Patient Signature: _____ Date: _____

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Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also, over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Patient Signature:_____ Date: _____

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CONSENT TO RELEASE AND/OR OBTAIN MEDICAL RECORDS

CNS MRN: _____

Patient Name:_____ D.O.B: _____

Instructions: Please read, then initial each item in the allotted space and sign the bottom of the form. Our office staff will witness your signature at time of your appointment.

_____ I authorize **Comprehensive NeuroSpine** to request and obtain **ALL** medical information from my referring physician, my primary (family) physician, all treating physicians, Hospital and Diagnostic Centers where I may have been treated in the past, and to have these records faxed to 954-800-5588 or sent to **Comprehensive NeuroSpine** address: 5353 N. Federal Highway, #300, Fort. Lauderdale FL 33308-3236, ATTN: DR. CARLOS CASAS.

_____ I authorize **Comprehensive NeuroSpine** to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release information to **Comprehensive NeuroSpine**.

_____ I hereby authorize **Comprehensive NeuroSpine** to release copies of my medical records to:_____
_____ Fax #: _____.

_____ I understand that my request for **Comprehensive NeuroSpine** to send medical records to another provider may take up to 5 business days to complete. I agree to check the patient portals at all my provider's offices to help expedite this request for sharing my clinical records between my doctors.

_____ I agree to keep these authorizations in effect until I provide written cancellation to **Comprehensive NeuroSpine**.

_____ **Comprehensive NeuroSpine**, and staff is released from any legal responsibility of liability, for the release of my medical records to the extent indicated and authorized herein.

_____ _____
Patient Signature Date

_____ _____
Witness Date

Comprehensive NeuroSpine
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NOTICE TO ALL PATIENTS OF CARLOS E. CASAS-REYES, MD

"Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.

This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who ail to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

-Florida Regulation: 458.320

YOUR SIGNATURE BELOW ACKNOWLEDGES THAT YOU HAVE BEEN PROVIDED A CURRENT MALPRACTICE STATUS FOR THIS PHYSICIAN.

_____ _____

Patients signature Printed Name

_____

Date

Comprehensive NeuroSpine
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HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided.
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- That this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Patient signature: _____ Date: _____

Comprehensive NeuroSpine

AGREEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing Comprehensive NeuroSpine & Dr. Carlos Casas as your health care provider. We are committed to providing exceptional care and service to all our patients. The following is a statement of our financial policy, which require that you read and agree to, prior to any treatment.

- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your photo ID and insurance card for our records. They will be scanned into your Electronic Medical Record. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits, and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- Please understand that payment of your bills is considered part of your treatment. Fees are payable when services are rendered. We accept cash, credit cards, and pre-approved insurance payments for those we are a contracted provider.
- If we have a contract with your insurance company, we will bill your insurance company first; Less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 30-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered; this may be collected when you sign in or at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Please understand that some insurance coverages have Out-Of-Network benefits that have co-insurance charges, higher co-payments, and limited annual benefits. If you receive services as part of an Out-Of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies outlined above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for any part of services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Responsible Party Date

_____ _____

Name of patient/Responsible party [PRINT] Relationship to patient

_____

Witness signature

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