NEW PATIENT PACKET

Thank you for choosing South Florida Interventional Orthopedics and Spine for your medical needs. To prepare for your first visit, we have provided a new patient checklist.

□ Completed New Patient Packet, enclosed.
□ Photo Identification
□ Current insurance card(s)
□ Co-pays and any out of pocket expenses are collected at the time of service.
□ Medical records and medical record diagnostics: X-rays, MRI, CT, EMG scans on CD.
□ Primary Care Physician, referring doctor, name, address, phone and fax number. This allows us to coordinate care, if appropriate.
□ Pharmacy and Imaging facility preference name, address, and phone number.

We thank you in advance for having these items prepared prior to your arrival. We look forward to having you as our patient.

SOUTH FLORIDA
INTERVENTIONAL ORTHOPEDICS
AND SPINE

PATIENT REGISTRATION FORM

DATE:_____

Patient's Name First: _____ M: _____ Last: _____

Date of Birth_____/____/_____ Age ____ Sex ____ Race ____ Language _____

SS# _____ /____ /_____ Marital Status □ Married □ Single □ Divorced

Parent/Guardian First: _____ M: ____ Last: _____

Local Address _____ City _____ State ____ Zip_____

Permanent Address _____ City _____ State ____ Zip_____

Contact Info: Home#: (___) _____ Mobil #: (___) _____ Email: _____

Employer Name: _____ Phone: (___) _____ Address: _____

Primary Care Physician Name: _____ Phone: (___) _____ Address: _____

Referred by Name: _____ Phone: (___) _____ Address: _____

Type of Injury/Illness _____ Date of onset of Symptoms ___ /___ /___

If Accident, Date: ____/____/____ where did it occur: □ Auto □ Work □ School □ Home □ Other:

_____

INSURANCE INFORMATION

Primary Carrier	Secondary
Policy #	Policy #
Group #	Group #
Policy Holder	Policy Holder
Policy Holder Date of Birth	Policy Holder Date of Birth
Policy Holder SS#	Policy Holder SS#

GUARANTOR/ PERSON RESPONSIBLE FOR MEDICAL EXPENSES

Name First _____ M ____ Last _____ DOB_____ Relationship _____
Address _____ City _____ State ____ Zip_____ Phone (___) _____
Employer _____ City _____ State ____ Zip_____ Phone (___) _____

EMERGENCY CONTACT:

Name First _____ M ____ Last _____ Phone (___) _____ Relationship _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name: _____

Address: _____ Telephone: _____

SECTION B: To the Patient - Please read the following statements carefully

Purpose of Consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide to sign the Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain. You may obtain a copy of our Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Melissa Mercado**

Address: **130 Ridge Center Suite 206 Davenport, FL 33837**

Telephone: **786-512-9463**

Fax: **786-706-1070**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature: _____

I, _____ have had full opportunity to read and consider the contents of this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

Signature: _____ **Date:** _____

ELECTRONIC COMMUNICATION CONSENT FORM

Texting Consent:
As part of our practice's communications with you, we can send you SMS (text) Messages directly to your phone.

☐ I **consent** and accept to receiving **text messages**. I understand I can withdraw my consent at any time. Please provide your cellular number: _____

☐ I do not consent to receiving any text messages.

Email Consent:
The use of email is limited to setting up or canceling appointments and for sending appointment reminders. Due to security, details of one's case cannot be discussed via email. Email may also not be used as a means of providing services. You also agree not to use the clinic email address when trying to contact the clinic or your service provider in the event of an emergency, as our clinic cannot guarantee a rapid response via email.

By signing, you are also aware that email is not a guaranteed or secure way of sending and receiving information and that you may not hold our clinic or your service provider responsible for any breach of confidentiality that results from the use of the email addresses listed below.

☐ I **consent** and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.
Email: _____

☐ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Print name of Patient: _____ Date: _____

Patient Signature

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AUTHORIZATION/CONSENT FORM

A. AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF MEDICARE BENEFITS:

I authorize and holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim(s). I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Furthermore, I request that payment under the medical insurance benefits either to myself or to the party that accepts assignment below. I request that the medical insurance program be made to me or to **South Florida Interventional Orthopedics and Spine**. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the holder of medical information about me to release it to Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim(s). I understand that this is a lifetime signature authorization. Please initial here _____ *

B. ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION:

I authorize **South Florida Interventional Orthopedics and Spine** to release to your company or its representatives any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care. I also authorize and request your company to pay directly to the above-named doctor the amount due to me in my pending claim for Medical or Surgical treatment or service by reason of such treatment or service.

Please initial here _____ *

C. FINANCIAL RESPONSIBILITY:

I understand that I am financially responsible for charges not covered by this authorization and for the guarantees stated above. Also, I understand that it is my responsibility as the insured to pay all copayment and co-insurance at the time of the visit. Please initial here _____ *

D. REFERRALS AND AUTHORIZATIONS:

I understand that it is my responsibility to obtain all authorizations or referrals necessary for treatment. If an authorization or referral is not obtained by the time of the visit, the visit may be rescheduled once proper authorization has been obtained. Please initial here _____ *

E. CONSENT TO TREAT:

I authorize **South Florida Interventional Orthopedics and Spine** to take x-rays, or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I authorize the doctor(s) to perform all recommended treatment mutually agreed upon. I also agree to the use of appropriate mediation and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. I understand that all responsibility for payment for medical services provided in this office for myself are mine. I understand that payment is due and payable at the time services are rendered unless other arrangements have been made.

I understand that it is my responsibility to advise your office of any changes in the information contained in this form. Please initial here _____ *

F. MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to **South Florida Interventional Orthopedics and Spine**, or any issuer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page. _____ *

G. LIABILITY/ WAIVER AND RELEASE:

I know and agree that **South Florida Interventional Orthopedics and Spine** is not responsible for any loss or damage to personal valuables. I hereby release, discharge, and acquit **South Florida Interventional Orthopedics and Spine**, its agents, representatives, affiliates, employees, or of and from any and all liability claim, demand, damage, use of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and /or medical services, including but not limited to ambulance, EMT, or Physician service. Please initial here _____*

H. INSURANCE:

As a service to you, we will file insurance claims for each of your policies. You will need to provide the clinic with all necessary insurance information. Please bring your insurance cards to every visit. Please note, your insurance policy is an agreement between you and your insurance company to pay certain amounts for your medical care. Your physician's bill is an agreement between you and **South Florida Interventional Orthopedics and Spine**. You are responsible for full payment of your account, regardless of the status of your insurance claim. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. Please initial here _____ *

For patients without health insurance, payment is REQUIRED at the time of you visit. Please initial here if applicable_____*

I. NOTICE OF PRIVACY:

I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES. Please initial here _____ *

I, THE PATIENT/GUARANTOR/LEGAL GUARDIAN, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND INSURANCE TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I AUTHORIZE PHYSICIAN AND INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OR IT'S REPRESENTATIVE.

*PATIENT/ GUARANTOR SIGNATURE x. _____ DATE: _____

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DR. SETH KAUFMAN, D.O, F.A.A.P.M.R

Health History Questionnaire

Patient Name:_____ **S.S. #**_____ **D.O.B.**_____ AGE _____

Where is your pain? _____

Symptoms: _____

_____

How long have you had these symptoms? _____

_____

How long do your symptoms last? _____

_____

What makes your symptoms worse? _____

_____

What makes your symptoms better? _____

_____

Previous treatments: _____

_____

What is your Level of Pain (0-10)? _____

Who referred you? _____

Allergies: • YES • NO

List of allergies: _____

Medications: _____

_____

PHARMACY: _____

IMAGING FACILITY PREFERRED: _____

Medical History (Please check all that apply):

- ☐ Anemia
- ☐ Anxiety / Depression
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blood Clots
- ☐ Cancer _____
- ☐ COPD
- ☐ HIV
- ☐ Diabetes
- ☐ GERD
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Psych History
- ☐ Liver Disease
- ☐ Migraines
- ☐ Seizure Disorders
- ☐ Sleep Disorder
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Hepatitis
- ☐ **Other Conditions:** _____

Surgical History: _____

_____

Family Health History:

Father ☐ **Heart Attack (age_____)** ☐ **Stroke** ☐ **Hypertension** ☐ **Diabetes** ☐ **Cancer**
☐ other _____

Mother ☐ **Heart Attack (age_____)** ☐ **Stroke** ☐ **Hypertension** ☐ **Diabetes** ☐ **Cancer**
☐ other _____

Grandmother ☐ **Heart Attack (age_____)** ☐ **Stroke** ☐ **Hypertension** ☐ **Diabetes** ☐ **Cancer**
☐ **other** _____

Grandfather ☐ **Heart Attack (age_____)** ☐ **Stroke** ☐ **Hypertension** ☐ **Diabetes** ☐ **Cancer**
☐ **other** _____

Brother ☐ **Heart Attack (age_____)** ☐ **Stroke** ☐ **Hypertension** ☐ **Diabetes** ☐ **Cancer**
☐ other _____

Sister ☐ **Heart Attack (age_____)** ☐ **Stroke** ☐ **Hypertension** ☐ **Diabetes** ☐ **Cancer**
☐ other _____

Other_____☐ **Heart Attack (age_____)** ☐ **Stroke** ☐ **Hypertension** ☐ **Diabetes** ☐ **Cancer**
☐ other _____

Personal Habits:

Tobacco use: ☐ **Yes** ☐ **No** **If yes, how much per day?**_____ **How many years?** _____

Alcohol use: ☐ **No** ☐ **Occasional** ☐ **Regularly** **How much?**_____ **Type of Liquor:**_____

_____**Use of Drugs:** ☐ **Yes** ☐ **No** **If yes, name of drug?** _____

Occupation:_____

Do you currently take any medication that contains Aspirin? _____

_____

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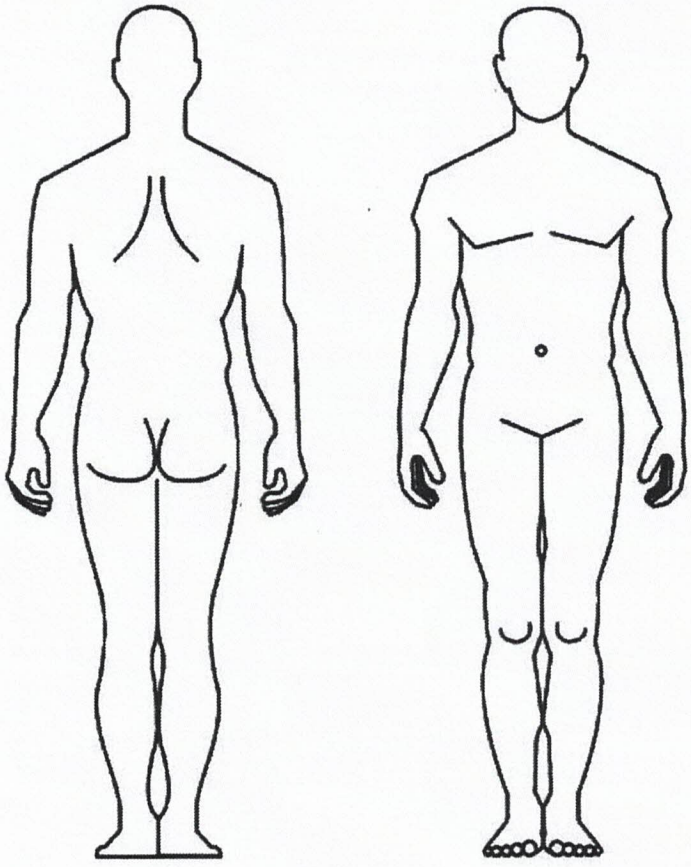
PLEASE MARK THE AREA(S) ON THE BODY DIAGRAM THAT CORRESPONDS TO YOUR SYMPTOMS.

X=PAIN
O=NUMBNESS/TINGLIN
GZ=OTHER



CIRCLE THE WORDS WHICH BEST DESCRIBE YOUR SYMPTOMS:

DULL/ACHE	SORE	GOSWING	SHARP/STABBING
SHOOTING	HEAVINESS	BURNING	TIGHTENING/CONSTRICTING
AWARENESS	THROBBING	WEAKNESS	OTHER: _____

HOW LONG HAVE YOU HAD YOUR CURRENT PROBLEM? _____