Comprehensive NeuroSpine
Carlos Casas, MD / Christine Whelan, RN
Business Office: 1007 N. Federal Highway, # 2010, Fort Lauderdale, FL 33304-1422
Phone: 954-800-8877 Fax : 954-800-5588 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 the team at Comprehensive NeuroSpine 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 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 Stanford California. For the past 5 years, (2013-2018) Dr. Carlos Casas worked as a Neurosurgeon for Holy Cross Hospital in Fort Lauderdale, FL . Now in private practice, He continues to serve south Florida's tri-county areas and will be expanding to serve the International markets as well. Dr. Casas speaks several languages.

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.

The number to call for an appointment is 954-800-8877

Email: info@comprehensiveneurospine.com

For more information, please visit our website: www.comprehensiveneurospine.com

Follow us on www.Facebook.com & www.LinkedIn.com too !

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 medical services and is responsible for his or her care.
- Change providers if other qualified providers are 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 the 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 laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.
- If a 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 full information and necessary counseling on the availability of known financial resources for care.
- Know whether the health care 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 copy of an understandable itemized bill and, if requested, to have the charges explained.
- To be notified of the office policy on Advance 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 any allergies or sensitivities and any other information about his or her health.
- Reporting unexpected changes in his or her condition to the health care provider.
- Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or 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 actions 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 home 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 HEALTH CARE ADMINISTRATION
CONSUMER ASSISTANCE UNIT
2727 MAHAN DRIVE / BLDG 1 TALLAHASSEE, FL 32308
1-888-419-3456

OFFICE OF THE MEDICARE BENEFICIARY OMBUDSMAN
www.cms.hhs.gov/center/ombudsman.asp

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

Comprehensive
NeuroSpine

"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 fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

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

SIGNATURE / PRINTED NAME DATE

Comprehensive NeuroSpine
Phone: 954-800-8877 – Fax: 954-800-5588

PATIENT INFORMATION

PATIENT'S NAME		DATE		MARITAL STATUS S M W D PARTNER
SS#	DOB	AGE	SEX M F	ETHNICITY: RACE:
HOME ADDRESS	CITY, STATE, ZIP CODE			HOME PHONE #
EMPLOYER NAME	WORK PHONE #		CELL PHONE #	
EMERGENCY CONTACT (NOT LIVING WITH YOU)		PHONE #		RELATIONSHIP
SPOUSE OR PARTNER'S NAME		SPOUSE OR PARTNER'S PHONE # (NOT SAME AS HOME #)		
RELIGION:	PRIMARY LANGUAGE: ENGLISH / OTHER		SECONDARY LANGUAGE:	
EMAIL ADDRESS:	WHERE DO YOU PREFER TO BE CONTACTED: (Circle) Home number Work number Cell number Text to Cellphone Email Mail to Home address ALL			INTERESTED IN RESEARCH STUDIES: YES NO MAYBE

REFERRING PHYSICIAN INFORMATION

PRIMARY CARE DOCTOR:	PHONE #	REFERRING DOCTOR:	PHONE #

INSURANCE INFORMATION

PRIMARY INSURANCE NAME		SECONDARY INSURANCE NAME	
CLAIM ADDRESS		CLAIM ADDRESS	
INSURANCE PHONE #		INSURANCE PHONE #	
POLICY #	GROUP #	POLICY #	GROUP #
SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT	SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT
SUBSCRIBER'S SS#	SUBSCRIBER'S DOB	SUBSCRIBER'S SS	SUBSCRIBER'S DOB
EMPLOYER'S NAME	EMPLOYER'S PHONE #	EMPLOYER'S NAME	EMPLOYER'S PHONE #

ACCIDENT INFORMATION

AUTO ACCIDENT YES NO	DATE OF ACCIDENT	WORKMAN'S COMP ACCIDENT YES NO	DATE OF ACCIDENT
AUTO INSURANCE COMPANY NAME		WORKMAN'S COMPENSATION COMPANY NAME	
ADJUSTER NAME & PHONE #		ADJUSTER NAME & PHONE #	
POLICY HOLDER'S NAME/PHONE #/RELATIONSHIP		EMPLOYER'S NAME AT TIME OF ACCIDENT	
POLICY # (ID CARD)	CLAIM # (ISSUED FOR CASE)	CLAIM #	

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

NAME	PHONE #	CASE #

ASSIGNMENT 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 assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by my current insurance. 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

Agreement of Financial Responsibility

MRN:________

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 of our patients. The following is a statement of our financial policy, which we 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 bill 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 (please print) Relationship to Patient

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Name : ______________________ **CNS MRN:** ______________

Date of Birth : ______________________ **Instructions: Please read, then initial the boxes and sign the bottom of the form. Our office staff will witness your signature at time of your appointment.**

CONSENT TO RELEASE +/or OBTAIN MEDICAL RECORDS

☐ 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 954-800-5577or sent to **Comprehensive NeuroSpine** mailing address: 1007 North Federal Highway, #2010, Fort Lauderdale Fl 33304-1422 , 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 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.

Signature: ______________________ Date: ______________

Witness : ______________________ Date: ______________

Background Information

Name: ______________________ Date of Birth: ______________

1) Weight: __________ Height: __________

2) Marital status: ☐Married ☐Divorced ☐Separated ☐Single ☐Widowed

How long: ____________ Number of children: _____

3) Current living arrangement: ☐Live alone ☐I live with: ______

4) Level of education: ______________________

5) Current employment status: ☐Full time ☐Part time ☐Unemployed ☐Retired

☐Homemaker ☐Student ☐Unemployed ☐Unemployed due to pain

6) What is/was your most recent occupation: ______________________

7) When was your last day of work? Month: ____________ Year: ________

Reason: ______________________

8) Would you return to work if you did not have a pain problem? ☐Yes ☐No

9) Have you tried to return to work? ☐Yes ☐No

10) Is your previous or present job still available to you? ☐Yes ☐No

11) Has your employer been understanding about your pain problem? ☐Yes ☐No ☐N/A

Characteristics of Your Pain

12) What is the main problem for which you are seeking treatment? ______________________

____

13) How long have you had your current pain problem? ______ Years ______ Months

14) How did your current pain start, was there a precipitating event? ______________________

____

15) How often do you have your pain? ☐Constantly (100% of the time) ☐Nearly constantly (60% - 95% of the time)

☐Intermittently (30% - 60% of the time) ☐Occasionally (less than 30% of the time)

16) During the past month when has your pain been the worst? ☐Morning ☐Afternoon ☐Evening

☐Night ☐No typical pattern

17) Please mark the location(s) of your pain on the diagram below:

Going to work	1	2	3	4	5
Performing household chores	1	2	3	4	5
Doing yard work	1	2	3	4	5
Socializing with friends	1	2	3	4	5
Participating in recreation	1	2	3	4	5
Having sexual relations	1	2	3	4	5
Physically exercising	1	2	3	4	5
Sleeping	1	2	3	4	5
Eating	1	2	3	4	5

20) How often do you lie down because of the pain?

☐Never ☐Seldom ☐Sometimes ☐Often ☐Constantly

21) Which of the following best describes your usual level of pain?

☐Mild ☐Uncomfortable ☐Distressing ☐Very severe ☐Unbearable

22) Please rate your pain intensity on a scale from 0 (no pain) to 10 (worst pain possible)

0	1	2	3	4	5	6	7	8	9	10
No pain	Mild		Discomforting		Distressing		Horrible		Excruciating	

My pain at its worse is: ________

My pain at its least is: ________

My pain on the average is: ________

23) When in pain, how often is your family supportive of you?

☐Never ☐Seldom ☐Sometimes ☐Frequently ☐Always

24) During the past month, how often have you been depressed, anxious or irritable?

☐Never ☐Seldom ☐Sometimes ☐Frequently ☐Always

25) Have any of your family members ever had a chronic pain problem? ☐Yes ☐No

If yes, who and what kind of pain? ____________________

26) Do you smoke cigarettes? ☐Yes ☐No ☐Never Smoked ☐Quit; How long ago? ______

If yes, how many packs per day? _____ For how many years? ________

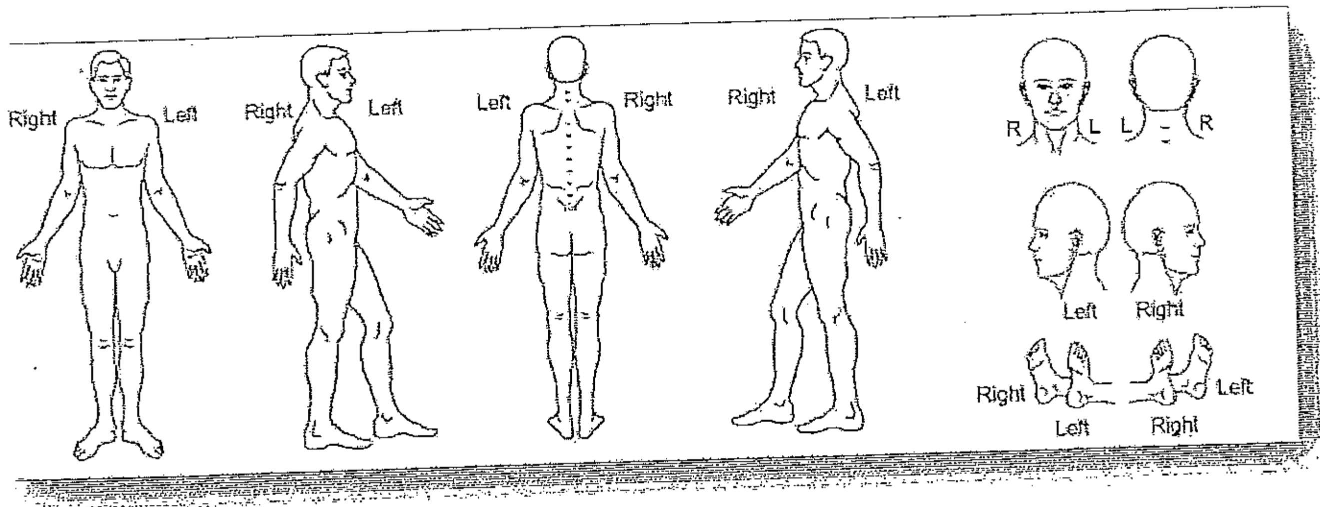
27) Do you drink alcoholic beverage? ☐Yes ☐No ☐Never Drank

If yes, what, how much and how often? ____________________

28) Aside from your pain problem, how is your general health?

☐Excellent ☐Minor health problems ☐Major health problems

29) Have you had any of the following health problems?



18) How do the following activities affect your pain? Mark with an "X".

ACTIVITY	INCREASES	DECREASES	NO CHANGE
Bending Backward			
Bending forward			
Changes in Weather			
Climbing Stairs			
Coughing/Sneezing			
Driving			
Lifting Objects			
Looking upward			
Looking downward			
Rising from seated position			
Sitting			
Standing			
Walking			
Bowel Movements			

What other factors worsen or affect your pain which is not mentioned above? ______________________

What other factors make your pain better which is not mentioned above? ______________________

19) During the last month, how much did your pain interfere with the following activities?

1 = Not at all	2 = Minimally	3 = Somewhat	4 = Moderately	5 = Extremely

☐High Blood Pressure ☐Bleeding Problem ☐TIA or stroke
☐Angina or Chest Pain ☐Arthritis ☐Seizure or Epilepsy
☐Heart Attack ☐Diabetes ☐Cancer
☐Asthma/Wheezing ☐Kidney Disease ☐Other, Specify: ________
☐Chronic Cough ☐Liver Disease

30) Please specify any past surgeries or procedures:

Date	Hospital	Type of Surgery	Type of Anasthesia

Patient Signature: ______________________________

Comprehensive NeuroSpine

Carlos E. Casas-Reyes, MD

☐ 2500 E. Hallandale Bch Blvd, Ste. 211
Hallandale, FL 33009

9970 N Central Park Blvd. Suite 207
Boca Raton , FL 33428

☐ 21000 NE 28th Avenue, Ste. 201
Aventura , FL 33180

(954) 800-8877 (954) 800-8877

Patient Name:______________________________ Date of Birth ______________

Advance Beneficiary Notice of Non-coverage (ABN)

The purpose of this notice is to inform you in advance that Comprehensive NeuroSpine (CNS) have reason to expect that Medicare may not pay for the INITIAL CONSULTATION / FOLLOW UP OFFICE VISIT/ OR PROCEDURE listed below.

Medicare does not pay for everything, even patient care that you or your health care providers have good and valid reason[s] to think you require.

NOTE: By way of this notice, you are informed that if Medicare or your insurance does not pay you may have to pay.

Procedure	Reason Medicare May Not Pay:	Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so that you can make an informed decision about your care.
- Ask us any questions that you may have after you have finished reading your options.
- Choose an option below that informs us how you wish to proceed regarding this matter.
  Note: If you choose Option 1 or 2; we may help you to use any other insurance that you may have, but Medicare cannot require us to do this.

DIRECTIONS: PLEASE CHOOSE AND CHECK ONE BOX. THE STAFF CANNOT CHOOSE FOR YOU.

☐ **OPTION 1**

I want the______________________________ as listed above.

- I may be asked for payment to CNS now; but I want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN).
- I understand that if Medicare does not pay, I am responsible for agreed-upon payment to CNS.
- I understand that **I can appeal to Medicare** by following the directions on the MSN.
- If Medicare does make payment to CNS; I understand that I will be refunded any and all payments I have for the above exclusively to CNS, less co-pays or deductibles.

☐ **OPTION 2**

I want the ______________________________ as listed above,

- I do not want Comprehensive NeuroSpine (CNS) to bill Medicare.
- I may be asked for payment to CNS now, as I am responsible for full amount agreed-upon payment to CNS.
- I understand I cannot appeal a decision if Medicare is not billed.

☐ **OPTION 3**

I **do not** want the______________________________ as listed above.

- I understand with this choice I am **not** responsible for payment.
- I understand with this choice I cannot make an appeal to verify if Medicare would pay.

This notice gives our opinion, and is not an official Medicare decision. If you have other questions on this notice or on Medicare billing, please call **1-800-MEDICARE** 1-800-633-4227/**TTY:** 1-877-486-2048).

Your signature below means that you have received and understand the contents of this notice.

Signature:	Date: