

T·B·O·S

Tampa Bay Orthopaedic & Spine

Orthopaedic & Spine Surgery

1700 Mc Mullen Booth Rd. Ste A2-1
Clearwater, FL. 33759
P: 727-669-0900 F: 727-669-0090

12021 West Linebaugh Ave
Tampa, FL. 33626
P: 813-855-8450 F: 813-855-7540

Patient: _____ Age: _____ DOB: _____
Height: _____ Weight: _____ Work Comp _____ MVA _____ Slip & Fall _____
Date of Injury: _____ Today's Date: _____

What is the main reason you are here.

If this was as a result of an accident please explain exactly how you were injured.

Following the injury, did you go to the hospital ____ Yes ____ No Name of Hospital _____

Please indicate any of the procedures performed at the hospital

____ X rays of _____
____ Prescription for _____, _____, _____
____ Stitches _____

Please indicate all doctors you have seen since the accident and the type of care they have provided. If none, please skip

Doctor _____ Date seen _____
Treatments _____

Doctor _____ Date seen _____
Treatments _____

Doctor _____ Date seen _____
Treatments _____

Doctor _____ Date seen _____
Treatments _____

Doctor _____ Date seen _____
Treatments _____

Please check any of the following medical treatments you have had FOR YOUR INJURIES

____ Surgery for _____ Name of doctor _____
____ Injections Areas injected _____ Name of doctor _____

Did Treatment help? ____ Yes ____ No Explain _____

(For below, please check as appropriate if this pertains to your pain)

Please describe each painful area you have at this time

_____ **Low Back Pain**

___ Ache ___ Burning ___ Sharp ___ Other _____

Does pain travels to another area of your body from this area ___ Yes ___ No

If yes, describe _____

Please check any of the following you have in your legs ___ Numbness ___ Pins and needles

___ Weakness in my ___ Left / Right / Both

Does anything lessen your pain? ___ Yes ___ No Describe _____

Does anything worsen your pain? ___ Yes ___ No Describe _____

___ Previous injuries, if any to Low Back ___ Complete recovery ___ Still being treated by

_____ **Neck Pain**

___ Ache ___ Burning ___ Sharp ___ Other _____

Does pain travels to another area of your body from original area ___ Yes ___ No

If yes, describe _____

Please check any of the following you have in your arms ___ Numbness ___ Pins and needles

___ Weakness in my ___ Left / Right / Both

Does anything lessen your pain? ___ Yes ___ No Describe _____

Does anything worsen your pain? ___ Yes ___ No Describe _____

___ Previous injuries, if any to Neck ___ Complete recovery ___ Still being treated by

_____ **Headaches** that are in ___ Front of head ___ Back of head ___ All of head
with ___ dizziness ___ change in vision ___ passing out ___ nausea and vomiting

Additional comments _____

Additional Painful Area (where?) _____

___ Ache ___ Burning ___ Sharp ___ Other _____

Does pain travels to another area of your body from original area ___ Yes ___ No

If yes, describe _____

Does anything lessen your pain? ___ Yes ___ No Describe _____

Does anything worsen your pain? ___ Yes ___ No Describe _____

Additional comments _____

Additional Painful Area (where?) _____

___ Ache ___ Burning ___ Sharp ___ Other _____

Does pain travels to another area of your body from original area ___ Yes ___ No

If yes, describe _____

Does anything lessen your pain? ___ Yes ___ No Describe _____

Does anything worsen your pain? ___ Yes ___ No Describe _____

Additional comments _____

Please list all **previous** injuries , if any, and current treatment for these , if any.

Injury

Treatment now receiving

Past Medical History

Check all that apply

- Diabetes
- Asthma
- Hypo/Hyper Thyroid
- Kidney disease
- Other: _____
- High Blood Pressure
- Bronchitis or Emphysema
- Rheumatoid Arthritis
- Hepatitis
- HIV +
- Heart Disease
- Seizure history
- History of Cancer
- type: _____
- Heart Attack
- Ulcers
- Blood Clots

Past Surgical History

Please list any surgeries you have had _____, _____
_____, _____, _____

CURRENT MEDICATIONS (List all medications you are taking NOW -use back of this sheet if you need more room)

MEDICATION	DOSAGE	# Per Day /Frequency	Reason for Taking (if known)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ARE YOU ALLERGIC TO ANY MEDICATIONS: YES NO If so what happens when you take these

Family Medical History

Has anyone in your family had an adverse reaction to anesthesia: Yes No
Has anyone in your family had an adverse reaction to Latex: Yes No

Social History

Who do you live with now: SPOUSE BY YOURSELF OTHER FAMILY FRIENDS OTHER

Do you smoke tobacco? YES NO How much? _____ packs per day How long? _____ years
Do you drink alcohol? YES NO How much? _____ drinks per day How long? _____ years
Do you use any street drugs? YES NO (These may interact with medication we prescribe so we must know)
Occupation _____ Time lost from work _____
Have you returned to your workplace ____ Yes ____ No

DO YOU NOW HAVE ANY PROBLEMS RELATED TO THE FOLLOWING?

Constitutional Symptoms	Eyes	Allergic	Ear/Nose/Throat	Genitourinary
Fever Y N	Blurred Vision Y N	Hay Fever Y N	Ear infection Y N	Unrine Retention Y N
Chills Y N	Double Vision Y N		Sore Throat Y N	Painful Unination Y N
			Sinus Problems Y N	Loss of bladder control Y N
Neurological	Endocrine	Gastrointestlona	Respiratory	Hemotologic/Lymphatic
Tremors Y N	Excessive Thirst Y N	Abdominal Pain Y N	Frequent Cough Y N	Swollen Glands Y N
Dizzy Spells Y N	Too hot/cold Y N	Nausea/Vomiting Y N	Short of Breath Y N	Blood Clots Y N
	Tired/Sluggish Y N	Rectal Bleeding Y N	Wheezing Y N	" Easy Bleeder" Y N
		Ulcers Y N		
Cardiovascular	Integumentary	Musculoskeletal	Psychologic	
Chest Pain Y N	Skin Ras Y N	Joint Pain Y N	History of depression Y N	
Varicose Veins Y N	Boils Y N	Muscle Adches Y N	History of bipolar disorder Y N	
High B.P. Y N	Persistent Itch Y N	Fiibromyalgia Y N	History of schizophrenia Y N	
Other _____	Other _____	Other _____		

Other Medical Conditions that you have we should be aware of:

PATIENT / PHYSICIAN AGREEMENT

FAILURE TO FOLLOW PHYSICIAN ORDERS

"Physician Orders" are meant to improve and/or resolve the patient's medical condition and / or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician care and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can include but is not limited to missing, postponing, or refusal of additional tests to rule out, confirm, or discover illness. Also, missing, postponing or refusal of making scheduled appointments can be considered failing to follow physician's orders. I have read, understand and agree with the above.

Patient / Guardian Signature: _____ Date: _____

PRESCRIPTION REFILLS

Please don't wait until you run out of medicine to call for a refill. In fact, call at least two days ahead. In order to protect you, your doctor must review your medical file before renewing a prescription. Therefore please do not call for medications after hours or on weekends when records are unavailable. **It could take up to 48 hours after you call before your doctor can review your file and call in any prescription.** The files are reviewed and prescriptions are called to pharmacies at the end of office hours after all patients have been seen. By law, doctors cannot order refills for certain narcotics over the phone. A written prescription is required in those cases. I have read, understand and agree with the above.

Patient / Guardian Signature: _____ Date: _____

MEDICAL RECORDS

Your records are kept in strict confidence as part of our permanent file. We will release copies only if we have your written permission. We prefer to mail copies of records, but we will give them to you in person to hand-carry if time is critical. **Please give us at least 48 hours notice prior to coming in and picking up records as it does take some time to get things together for you.** I have read, understand and agree with the above.

Patient / Guardian Signature: _____ Date: _____

STATEMENT OF FINANCIAL RESPONSIBILITY

I the undersigned realize that all medical and surgical charges incurred by me or my dependent/s are my financial responsibility. All court fees, attorney fees, and other fees necessary to collect this amount are payable by me. I grant consent to Tampa Bay Orthopaedic & Spine to use and disclose my protected health information for the purposes of diagnosing or providing treatment and conducting surgical operations. My protected health information includes demographic information which is collected from me, created or received by my physician or another health care provider, and my employer. This protected information relates to my past, present and future physical and mental health condition/s. I can receive from Tampa Bay Orthopaedic & Spine a copy of the Notice of Privacy Practices prior to signing this document and understand it is subject to change. I understand that diagnosis and treatment of me Tampa Bay Orthopaedic & Spine may be conditioned upon my consent as evidenced by my signature on this document. I have read, understand and agree with the above.

Patient / Guardian Signature: _____ Date: _____

CONFIDENTIALITY

In an effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints, symptoms, test results and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and / or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method that can assist with the care of the patient. I have read, understand and agree with the above.

Patient / Guardian Signature: _____ Date: _____

INDIVIDUAL PATIENT AUTHORIZATION

Name the people and/or organization and their relationship to you that are authorized to use and/or disclose your personal health information.

IRREVOCABLE MEDICAL LIEN

I hereby do authorize any and all parties, including any insurance company and my attorney (if applicable), to pay directly to Tampa Bay Orthopaedic & Spine sums as may be due and owing for medical services rendered to me and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Tampa Bay Orthopaedic & Spine. If applicable, I also authorize my attorney to **release any and all information** without limitation regarding any legal proceedings, judgments, or settlements that will aid in the recovery of Tampa Bay Orthopaedic & Spine's unpaid sum.

I hereby further give an irrevocable lien to Tampa Bay Orthopaedic & Spine against any proceeds of any settlement, judgment or verdict which may be paid to you, my attorney or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Tampa Bay Orthopaedic & Spine for all medical bills incurred by me for services rendered in consideration of waiting for payment. I further understand that such payment is **not** contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have read, understand and agree with the above.

Patient / Guardian Signature: _____ Date: _____

PATIENT'S SIGNATURE

I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IN THE PATIENT INTAKE FORMS ARE ACCURATE.

Patient / Guardian Signature: _____ Date: _____

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AUTO ACCIDENT PATIENT QUESTIONNAIRE

Patient Name: _____

Date of Accident: _____ Location of Accident: _____

Were you wearing a Seat Belt? _____

Were you the driver or a passenger? _____

If a passenger, were you in the front or back seat? _____

Describe the accident in your own words:

Were you struck in the front, rear, driver side, or passenger side of the vehicle?

Were you knocked unconscious? _____ If yes, How long? _____

Did you feel immediate pain? Yes No Where? _____

Did you go to the hospital? Yes No Hospital: _____

Were there X Rays taken? _____ Medication Given? _____

What was your diagnosis? _____

Have you ever been treated by another physician since the accident? Yes No

Name of Physician: _____ Treatment: _____

Did you have symptoms prior to the accident? _____

Are the symptoms improving, getting worse or the same? _____

Have you ever been in an auto accident before? Yes No

Date and Injury(s):

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Assignment of Benefits

Patient : _____ Date of Loss: _____
Insurance Company Name: _____ Claim Number: _____
Policy Owner's Name: _____ Policy Number: _____

Patient: I the undersigned patient, understand and agree that the above-referred Provider requires payment at the time services are rendered, in consideration of Provider not requiring payment at the time services are rendered, hereby assign the rights and benefits of insurance of the applicable personal injury protection, medical payments, and/or other insurance which may be available to pay Provider on my behalf to the said Provider. This assignment is for services and/or supplies rendered for treatment of personal injuries sustained in the automobile accident or incident on the above-referenced date to myself; the undersigned patient, who is covered by Personal Injury Protection (P.I.P.) coverage or other insurance coverage under the above-named Policy Owner's name, in accordance with Florida Statute (627.736(5)). The undersigned is responsible for any applicable deductible or co-payment not covered by the said P.I.P. or other insurance. P.I.P. or other insurance policy rights, which I am assigning hereby, are to be covered through a policy of insurance with the company commonly known as the above referred insurance company, under the above referred policy or claim number. In the event an error has been made in naming the appropriate insurance benefits and/or policy rights from any applicable PIP, medical payments, and/or other insurance for which benefits may be paid to said Provider on my behalf as a result of injuries sustained by me in the above-referred incident/accident.

This assignment of Benefits is intended to transfer all of the patient's rights to collect benefits from the said insurance company, including but not limited to, all rights to collect benefits directly from the insurance for services that I have received and all rights to proceed against the insurance company which is obligated to provide benefits in any action including legal suit if for any reason the insurance company fails to make payments of benefits to which I am due. This assignment further includes the right to collect payment for the reasonable costs connected with copying and mailing records to the insurer at the insurer's request and in accordance with Florida Statutes 627.736(6), this assignment also includes any right to recover attorney's fees and cost for such action brought by the Provider as patients' assignee. I agree that the said Provider may select any attorney it wishes and understand and agree that the attorney selected by them may be different than the attorney handling my personal injury/bodily injury claim or case. In the event of litigation or arbitration, I agree to cooperate with the said Provider and in any reasonably required. I understand that this cooperation may include giving sworn testimony at deposition trial of the case, or any other proceeding that may be reasonably required, and I also agree to execute any releases, settlement papers and settlement checks. I further agree not to compromise or extinguish the value of this assignment by taking a position inconsistent with the said Provider's pursuit of payment.

This assignment of Rights and Benefits is intended to become effective immediately and binding upon the said insurance carrier upon my execution, I hereby instruct the said insurance carrier that in the event the subject medical benefits are disputed for any reason. Including medical reasonableness and/or necessity that the amount of benefits claimed by the said Provider is to be set aside and not dispersed until the dispute is resolved. As part of this assignment of Rights and Benefits, I further instruct the insurance carrier to notify the Provider immediately of any dispute as to payment so that it may exercise its legal rights. I have read and understood the information herein, and it is true to the best of my knowledge and belief:

Patient/Guardian's Name

Patient/Guardian's Signature

Date

Provider: The undersigned on behalf of the above-referred Provider, hereby accepts assignment of the insurance rights and benefits for the services rendered to the above-referred patient, and to be paid directly to the above-referred Provider under the above-referred patient's Personal injury Protection (P.I.P.) or other insurance coverage with the above-referred insurance carried in accordance with Florida Statute 627.736 et Seq.

Authorized Agent/Representative

Date

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DIRECT PAYMENT AUTHORIZATION WITHOUT ASSIGNMENT OF BENEFITS

The undersigned insured/patient hereby authorizes, requests and directs the applicable personal injury protection, medical payment, bodily injury, uninsured motorist, and/or third party liability payment insurance carrier(s) to make payment directly to **Tampa Bay Orthopaedic & Spine, Provider**, for services and/or supplies necessitated by an accident which occurred on or about _____.

The undersigned insured/patient also authorizes Tampa Bay Orthopaedic & Spine to sign insured/patient's name to any check written in both Tampa Bay Orthopaedic & Spine and insured/patient's name where such check is in payment for its services. This authorization is limited to submission of claim forms and acceptance of benefit checks for services rendered and I will countersign all invoices/encounter forms.

The undersigned insured/patient specifically has not granted an assignment of benefits to provider, as the patient expressly desires to retain all rights to enforce the applicable insurance contract, and has not transferred any right, title or interest in said contract provider. The insured/patient intends to merely authorize the applicable insurance company to pay provider directly as a convenience to the insured/patient regarding the payment of bills. The undersigned insured/patient has not transferred and expressly reserves the right to demand payment from any and all insurance companies obligated to pay medical bills and related to treatment rendered by provider.

Provider has not accepted, nor agreed to accept and assignment of benefits from the undersigned insured/patient and has not consented or agreed to arbitrate or do anything else that would in any way prevent the undersigned insured/patient from enforcing any provision of the insurance contract with the applicable insurance company.

It is the intention of the undersigned insured/patient and provider that if medical bills are not paid that the insured/patient will have the right and duty to pursue said medical benefits with any and all applicable insurance companies and that the insured/patient shall remain personally responsible for the appropriate outstanding balances due.

This authorization for direct payment does not constitute an assignment of benefits, nor is it intended, by either the undersigned insured/patient or provider, to constitute an assignment of benefits. The sole consideration for this authorization is the mutual convenience of the patient and provider.

TAMPA ORTHOPAEDIC & SPINE LETTER OF PROTECTION

A patient receiving care in our office is ultimately responsible for payment of all services rendered, regardless of whether a recovery is made against a third-party insurance carrier. I agree to be responsible for any medical bills submitted by the office of **Tampa Bay Orthopaedic & Spine**, any litigation costs and all attorney fees necessary to enforce the payment of any outstanding balance and/or bills due.

I, _____, authorize and direct you, my attorney, to disburse directly to Tampa Bay Orthopaedic & Spine all proceeds of settlement, judgment or verdict which may be paid to you, my attorney, or myself of which is necessary to satisfy my signed Medical Lien by paying any outstanding balance due for care and treatment rendered to me, as a result of the injuries for which I have been treated or injuries in connection therewith.

By signing below, I hereby acknowledge that my automobile carrier's Personal Injury Protection forbearance in the receipt of payment for medical services rendered, even though some or all of said medical services may be reimbursed by personal injury protection benefits or third party insurance coverage, is good, valuable, and sufficient consideration for the promises contained herein from myself and my attorney.

This Letter of Protection may be delivered to my attorney for their signature and acknowledgment. I hereby give them authorization and direct my attorney to sign this Letter of Protection acknowledging they will abide by the terms of this LOP on my behalf. This letter is binding on any attorney who may represent me for the above stated injuries.

By signature below, I acknowledge read, receipt, understand and agree with the above Letter of Protection and Direct Payment Authorization and direct my attorney to sign this Letter of Protection acknowledging they will abide by the terms of this LOP on my behalf. This letter is binding on any attorney who may represent me for the above stated injuries.

Patient Name (Print)

Patient Signature

Date

Witness for Tampa Bay Orthopaedic & Spine

Date

Attorney Signature (if applicable)

Date

T•B•O•S

Tampa Bay Orthopaedic & Spine

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PAIN MANAGEMENT AGREEMENT

The purpose of this agreement is to prevent misunderstanding about certain medicines you will be taking to the control of your pain. This is also to help you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that if I break this agreement which is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

I understand that if I break this agreement, my doctor will stop prescribing these pain control medicines. In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment program may be recommended.

I have communicated, and will continue to communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve the pain.

I will not use illegal controlled substances, including marijuana, cocaine, etc. at any time.

I will inform Dr. _____ of all the medications I am presently taking, including all remaining refills. I will not attempt to obtain any controlled medicines which include opiod pain medicines and refills, controlled stimulants, or anti-anxiety medicines from **ANY OTHER DOCTOR**.

I will not share, sell, or trade my medication with anyone.

I will safeguard my pain medicine/s from loss or theft. Lost or stolen medicines **WILL NOT** be replaced.

I understand that Dr. _____ reserves the right to terminate my care and treatment if such is the case at anytime.

Please don't wait until you run out of medicine to call for a refill. In fact, call at least two days ahead. In order to protect you, your doctor must review your medical file before renewing a prescription. Therefore please do not call for medications after hours or on weekends when records are unavailable. It could take up to 48 hours after you call before your doctor can review your file and call in any prescription. The files are reviewed and prescriptions are called to pharmacies at the end of office hours after all patients have been seen. By law, doctors cannot order refills for certain narcotics over the phone. A written prescription is required in those cases.

I have read, understand and agree with ALL of the above mentioned. I agree to use _____ for my Pharmacy, located at _____ with telephone number _____ for filling prescriptions for all my pain medicine/s.

Patient Name (Print)

Patient Signature

Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Tampa Bay Orthopaedic & Spine, LLC, we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act requires us to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice at any time upon request.

If we change any details of this notice we will notify you in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer: Barbara Knapp at (727) 446-5681. This notice went into effect on October 01, 2007.

Acknowledgement: I have read, understand, and agree with the above Notice of Privacy Practice.

Patient/Guardian (Please Print Name)

Patient/Guardian (Signature)

Date