SEA SPINE
ORTHOPEDIC INSTITUTE
"Patients first... that's the difference."

Toll Free: (866) 816-7846
Phone: (954) 458-4488
Fax: (954) 458-2928
www.seaspineortho.com

NEW PATIENT PAPERWORK

Date of Service: _____ **Acct #:** _____ *(Acct # to be filled by staff)*

Patient Information

Name (last, first, initial):_____

Address:_____

City/State/Zip:_____

Phone: Home:_____ **Cell:**_____

Work:_____ **email:**_____

DOB:_____ **Age:**_____ **SSN:**_____

Driver License:_____

Marital status (circle one): Married Separated Divorced Single Widowed Other

Race (circle one): White African American Asian Hispanic Declined Other

Current Employer:_____

Current Occupation:_____

Employer Phone:_____

Emergency contact information

Name: _____ **Relationship:**_____

Phone:_____

Pharmacy Name:_____ Phone #:_____

Primary Care Doctor Information:

Name:_____ **Type:**_____

Phone:_____ **Treating** (circle one): **Yes** **No**

Primary Health Insurance Information:

Health Ins. Carrier _____ **Group#:**_____

Policy holder name:_____ **Policy#:**_____

Policy holder DOB:_____ **SSN:**_____

Relationship to patient:_____

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Automobile Insurance (PIP) Information:

Auto Ins. Carrier:_____ **Claim#:**_____

Policy holder name:_____ **Policy#:**_____

Policy holder DOB:_____ **SSN:**_____

Relationship to patient (circle one): Self Spouse Child/Dependent Other

Are you being seen as a result of an Injury or Accident? _____Yes _____No

What Type: _____Auto _____W/C _____Slip & Fall _____Other

Date of Injury: _____

.....

I HEREBY AUTHORIZE AND RELEASE any and all information to my insurance companies and/or attorneys and permit, and hereby permit a copy of this authorization to be used in place of the original for this purpose.

I HEREBY AUTHORIZE Sea Spine Orthopedic Institute, LLC, my doctor and/or his employees to act as my agent assisting to obtain payment from my insurance company/companies, and I further authorize payment from my insurance company directly to Sea Sine Orthopedic Institute, LLC for services rendered, or in the alternative, to the party who accepts the assignment.

I FURTHER UNDERSTAND that I am ultimately individually responsible for my balance, including co-payments, co-insurance and/or deductibles that must be met based on the policy limits outlined by my insurance company, who, by my instruction, shall be billed for any/all consented treatment rendered by Sea Spine Orthopedic Institute, LLC. I further agree to individually assume the responsibility for any unpaid balance. I understand and agree to pay any/all associated costs and reasonable attorney's fees, or agency fees charged for collection of the unpaid balance for the authorized services rendered that are not paid for and/or found to not be covered, which may be placed with an attorney or collection agency for collection. My signature below hereby attests that I have reviewed the information above, and I hereby certify that the information provided on this document is, to the best of my knowledge, complete and correct.

Signature:**X**_____ **Date:**_____

(parent/legal guardian signature, where the patient is a minor)

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FINANCIAL AGREEMENT WITH HEALTH CARE PROVIDER

I, _____, a patient of Sea Spine Orthopedic Institute, LLC, hereby authorize _____ pay out of any proceeds they may receive by way of settlement/judgment from my case involving an accident/incident which occurred on _____, to Sea Spine Orthopedic Institute, LLC, the full amount of my medical bills for any medical service, treatment, medication and/or consultation rendered to me that is due to Sea Spine Orthopedic Institute, LLC, and/or to become due as a result of said accident/incident. This lien is irrevocable, having been given in consideration for my care and treatment rendered by Sea Spine Orthopedic Institute, LLC. No further documentation or signature shall be required by me to effect and ensure full payment directly to this provider. A copy of this agreement shall be considered valid and binding as the original.

Further, I hereby grant and give to Sea Spine Orthopedic Institute, LLC an irrevocable lien for the full amount of any medical bills which are due and/or may become due as the result of professional services and treatment rendered to me as a result of said accident /incident. I fully understand that I am individually directly and fully responsible to Sea Spine Orthopedic Institute, LLC for all medical bills for care and service rendered to me. This agreement is made solely for the additional protection and in consideration of Sea Spine Orthopedic Institute, LLC awaiting payment. I further understand that such payment is not contingent on any settlement, judgement, or verdict which I may eventually be awarded. I also understand that Sea Spine Orthopedic Institute, LLC is not waiving or relinquishing any rights or remedies, whether legal or equitable, to collect the full amount of any and all medical bills which are due and/or may become due and owing, with all rights of Sea Spine Orthopedic Institute, LLC are expressly reserved, including but not limited to Sea Spine Orthopedic Institute, LLC's right to all available remedies to collect the full amount of any and all medical bills which are due and/or may become due as a result of professional services and treatment rendered to me by Sea Spine Orthopedic Institute, LLC.

I further acknowledge that Sea Spine Orthopedic Institute requires that I provide 24-hour's notice when cancelling and/or re-scheduling my appointment. I further understand that with a cancellation of my appointment with less than 24-hour's notice given, that I shall be subject to a Cancellation/No-show fee. Patients who do not show for their appointment and do not call to cancel or reschedule will be considered and documented as a no-show appointment and the cancellation/no-show fee shall be incurred. **The appointment cancellation and/or no show fee are the responsibility of the patient and should be paid in full prior to the patient's next scheduled appointment.** I further acknowledge receipt of the Sea Spine Orthopedic Institute's telephone number for the billing department (1-800-816-7846 ext. 105) for any questions I may have concerning this policy.

Standard Cancellation / No Show Fees are as follows:

Patient Appointment	$50
In Office Procedure Appointment	$175
Surgery at Facility or Hospital	$2,700

Not canceled within 72 hours of Date of procedure / surgery

_____ _____

Patient Signature **Date**

x_____ _____ _____

Witness **Print Name** **Date**

Sea Spine Orthopedic Institute, LLC _____

Provider **Date**

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ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to **SEA SPINE ORTHOPEDIC INSTITUTE, LLC** (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my individual responsibility.

I further authorize the Provider to negotiate, collect, and settle any claim with any insurance carrier or other third party payer with regard to these services, which authorization shall include but is not limited to authority to: 1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, any Independent Medical Examination Reports, policies, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me, and 2) to endorse in my name on any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF THE RIGHTS AND BENEFITS UNDER THE POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each of the above provisions:

_____
Print Patient Name

X_____ **Date:** _____
Patient's Signature

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AUTHORIZATION AND CONSENT FOR TREATMENT

Please sign where indicated, applicable to your health conditions (see the receptionist if you need assistance):

I hereby authorize the participating doctor(s) at Sea Spine Orthopedic Institute, LLC and his/her staff and billing agent to release and/or obtain x-rays, medical records, payment records and any information to/from any physician, medical center, insurance company, employer, adjustor or attorney, prior and in the future, related to my care related to this claim.

I hereby authorize Sea Spine Orthopedic Institute, LLC and whomever the doctor(s) may designate and his/her assistant(s) to perform medical examinations, and perform noninvasive diagnostic procedures. If any unforeseen condition arises in the course of the procedure which calls for their judgment and/or procedures in addition to or different from those not contemplated, I further request and authorize Sea Spine Orthopedic Institute, LLC and their physicians and/or staff to perform whatever my treating doctor deems advisable. The nature and the purpose of these procedures have risks involved, and the possibility of complications has been fully explained to me. I acknowledge that no guarantee has been made to me as to the results that may be obtained.

I expressly authorize and give limited power of attorney to Sea Spine Orthopedic Institute, LLC and its billing agent, for the signing and completing of any form in the completion of my claim(s) and endorsing any check made payable to me, in support of processing or making payment of any claim for any charges incurred by me at your office. Further, Sea Spine Orthopedic Institute, LLC acknowledges that it is only entitled to receive payment for those charges which were incurred through this office and any overpayment will be refunded appropriately and timely. I expressly authorize and appoint the billing entity selected by Sea Spine Orthopedic Institute, LLC to act as my limited attorney-in-fact to pursue benefits due me, and to come forward and act on my behalf for payment of any treatment deemed necessary and provided by my healthcare provider.

I fully understand that I am individually, directly and fully responsible to Sea Spine Orthopedic Institute, LLC for all medical bills submitted by them for services rendered to me, and that this agreement is made solely for Sea Spine Orthopedic Institute, LLC's additional protection and in consideration for it awaiting payment; and I further understand that such payment is not contingent on any settlement, judgment, or verdict where I may eventually recover a fee and/or award.

_____ _____

PRINT PATIENT NAME **Date**

X _____ _____

PATIENT SIGNATURE **Date**

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Patient Authorization for Use and Disclosures of Protected Health Information to Third Parties

Section Must be completed for all authorizations

I hereby authorize the use and/or disclosure of my individually protected health information. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name:

Persons/Organizations Receiving Information:
List persons that you authorize our office to release your protected health information

Name	**Relationship**
1. _____	My Physician
2. _____	My Attorney
3._____	
4._____	

The patient or the patient's representative must read the following statements:

I understand that I may revoke this authorization at any time by notifying Sea Spine Orthopedic Institute, LLC in writing, and if I do, it will not have any effect on any actions they took before they received the revocation.

X _____ _____
Signature of patient or representative **Date**
(Form MUST be completed before signing)

Printed name of patient's representative: _____

Relationship to patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

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RECORDS RELEASE AUTHORIZATION

Please initial appropriate classification of information when applicable:

_____Drug & Alcohol Treatment Information and/or records

_____Mental health Information and/or records

_____HIV/AIDS Information and/or records

I understand that, under Florida Law, the classification of records checked above relating to treatment rendered to me are privileged and confidential, and cannot be released to me or to those designated by me or my legal guardian without my expressed and informed consent. In addition, I understand that those records will not be released to persons and agencies other than those designated by me, or my personal representative, or otherwise provided in Florida law.

Patient's Name:_____

Address:_____

Phone Number:_____

Date of Birth:_____ Social Security Number:_____

I, _____, authorize_____to

release my Health information indicated below to the following party:

Send Reply Here:

SEA SPINE ORTHOPEDIC INSTITUTE
Phone: 866-816-7846 OR 954-458-4488
Fax: 954-458-2928

_____All X-ray reports

_____Medical records

_____Diagnostic test reports

_____PIP LOG

The complete history and records in your possession, concerning my illness and/or treatment during the period _____ _____to _____.

I understand that if the person(s) or entity (ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release SEA SPINE ORTHOPEDIC INSTITUTE, LLC and its employees from any and all liability arising from this disclosure of my health information.

I understand that I may inspect or request copies of any information disclosed by this authorization. I understand that I may revoke this authorization by notifying in writing the Sea Spine Orthopedic Institute, LLC Medical Records Department, knowing that previously disclosed information would not be subject to the revocation request.

I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

Patient's Signature: X_____ Date: _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning Sea Spine Orthopedic Institute, LLC's Notice of Privacy Practices.

Date:_____

X_____
Patient or Patient's Representative

_____
Print Patient's Name

If signed by Representative, state name of Representative:_____

Relationship to Patient:_____

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NEW PATIENT QUESTIONNAIRE

Acct #: _____ *(Acct # to be filled by staff)*

Date of Service: _____ **DOB:** _____ **Date of Injury:** _____

Patient Name: _____

What is the **primary condition/body part** for which you are seeking medical care?

_____

What is the **date of onset** for the primary condition noted above? _____

Is the condition presented today the result of an accident or traumatic injury? (*circle one*) **YES NO**

What body parts are you here to have evaluated? *(choose & circle all that apply)*

_____NECK:	LT	RT	_____BACK:	UPPER	MIDDLE	LOWER
_____SHOULDER:	LT	RT	_____HIP:	RT	LT	
_____ELBOW:	LT	RT	_____KNEE:	RT	LT	
_____WRIST/HAND:	LT	RT	_____ANKLE/FOOT:	RT	LT	
_____CHEST:	LT	RT	_____ABDOMEN:	RT	LT	
_____HEAD/FACE:	LT	RT	_____OTHER:			

Have you received any physical therapy and/or chiropractic treatment? **YES NO**

If yes, **list physician name**?_____

What type of physical therapy and/or chiropractic care_____

Have you had any **prior injuries**? **YES NO**

If yes, please identify and describe: _____

Have you had any diagnostic testing related to the condition that you are seeking orthopedic treatment? (*circle one*)

MRI, CT Scan, CT/Myelogram, X-ray(s), Nerve Test, Discogram

With regard to your present condition, have you had same/similar pain in the past? (*circle one*) **YES / NO**

If yes, have you had any prior treatment? (*circle one*) **YES / NO**

What type of treatment (*ie.Medication, physical therapy, chiropractic, braces, heat, cold*)? _____

Have you received treatment through a Pain Management Clinic? (*circle one*) **YES / NO**

If yes, what clinic? _____

What type of Pain Management treatment?_____

Last office visit? _____

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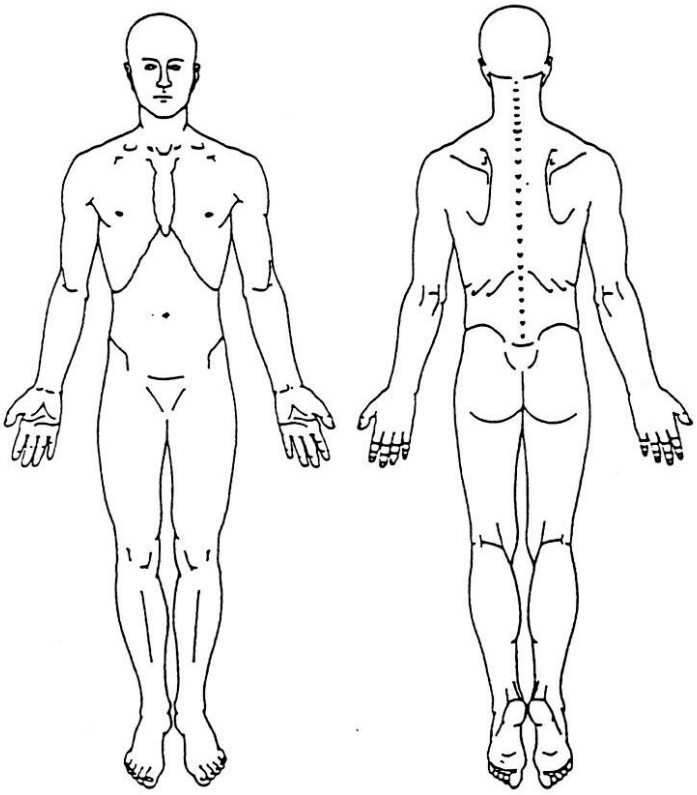
Body Diagram

Instructions:
Please indicate on the diagram below where your pain is located at the present time. Please DO NOT indicate areas of pain that are not related to your present injury or accident condition presented today. Place and "X" in the area(s) you have pain and a "0" in the area which you are experiencing numbness and/or tingling. Thank you for taking the time to complete this questionnaire, as it will allow us to provide optimum care/treatment of your orthopedic needs.



0 1 2 3 4 5 6 7 8 9 10
No pain Worst Possible Pain

If you have indicated arm pain, which arm bothers you more?	**RIGHT**	**LEFT**
If you have indicated leg pain, which leg bothers you more?	**RIGHT**	**LEFT**
If you have indicated neck pain, does the pain radiate?	**YES**	**NO**
Have you experienced and numbness in tingling?	**YES**	**NO**

If yes, in what body part(s) do you experience the numbness/tingling?_____

Have you experienced any changes in urination and/or bowel habits? **YES** **NO**

If yes, please explain: _____

Do you have difficulty walking? **YES** **NO**

If yes, how far can you walk before it hurts too much to go any further?

Less than a block One to three blocks

More than four I have difficulty getting to the mailbox

Patient initials_____

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HISTORY OF PRESCRIPTION MEDICATIONS:

What medications are you presently taking, including vitamins, supplements, herbal and any over the counter medications? Please list. _____

_____

Are you allergic to any Medications? _____

Do you have any allergies to contrast dye, shellfish, or latex? _____

Past Medical History

Do you have any history of the following conditions?

_____High Blood Pressure _____Osteoarthritis _____Thyroid Disease

_____Diabetes _____Kidney Disorder _____Stroke

_____Rheumatoid Arthritis _____High Cholesterol _____Asthma

_____Coronary Artery Disease Cancer (please indicate what type)_____

SURGICAL HISTORY:

Prior surgeries/hospitalizations? (please list any/all prior surgeries) _____

FAMILY HISTORY:

Please check any/all chronic illnesses that have affected immediate family members *(parents, grandparents, siblings, aunts/uncles, children, etc).*

_____SUGAR DIABETES
_____ASTHMA/BRONCHITIS
_____ANXIETY/DEPRESSION
_____SEIZURES
_____RHEUMATOID
_____BOWEL PROBLEMS
_____HIGH CHOLESTEROL
_____OSTEOARTHRITIS
_____STROKE
_____HIGH BLOOD PRESSURE
_____HEAD ACHES
_____HISTORY OF CANCER/ TUMORS
_____SLEEP PROBLEMS
_____ARTHIRITIS
_____URINATION PROBLEMS
_____KIDNEY DISORDER
_____THYROID DISEASE
_____CORONARY ARTERY DISEASE

OTHER: _____

Patient initials_____

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SOCIAL HISTORY:

Do you smoke cigarettes? (circle one) **YES / NO** If yes, how many packs per day? _____ How many years? ____

If you were a prior smoker, how long ago did you quit smoking? _____

Do you drink alcohol? (circle one) **YES / NO** If yes, how often? _____

Do you exercise? (circle one) **YES / NO** If yes, how often? _____

Are you currently working? (circle one) **YES / NO** If yes, what is your occupation? _____

If you are not working, please choose one of the following:

RETIRED, LEAVE OF ABSENCE, STUDENT, SEEKING EMPLOYMENT, HOMEMAKER, DISABLED / CURRENTLY ON DISABILITY, OTHER _____

Do you have children? **YES** **NO**

If yes, how many? _____, & what are their ages?_____

Which hand is your dominant hand? (*circle one*) RIGHT LEFT

What types of hobbies/activities do you like to participate in, but have not been able to do so because of your current level of pain associated to this injury/accident?

_____

_____