ORLANDO NEUROSURGERY

Patient Demographics

Date: _____

Last Name	**First Name**		Middle
Birth Date	Age	Sex: M F	Email:
Street Address	City	State	Zip
Social Security #	Home Phone	Cell Phone	
Employer	Work Phone		
Emergency Contact	Emergency Contact #		
Relationship of Emergency Contact			
Primary Care Physician	**Phone #**		
Referring Physician	**Phone #**		

Primary Insurance Company		**Phone #**
Insured Person Name	Insured Person Birth Date	
Relationship to Insured Person	Group #	Policy / ID #
Secondary Insurance Company		**Phone #**
Insured Person Name	Insured Person Birth Date	
Relationship to Insured Person	Group #	Policy / ID #

Race: ☐ American Indian/ Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Pharmacy Name:	**Phone #**
Address:	

Do you have an Advance Directive? ☐ **Yes** ☐ **No**

** Please complete sections below **ONLY** if your visit is related to injury sustained by automobile accident or worker's compensation**

Auto Injury	***Date of Injury:***	
Adjuster Name:	*Phone #*	*Fax #*
Attorney Name:	*Phone #*	*Fax #*
Worker's Compensation Injury	***Date of Injury:***	
Adjuster Name:	*Phone #*	*Fax #*

ORLANDO NEUROSURGERY

Date: _____

Patient Name: _____ **Date of Birth:** _____

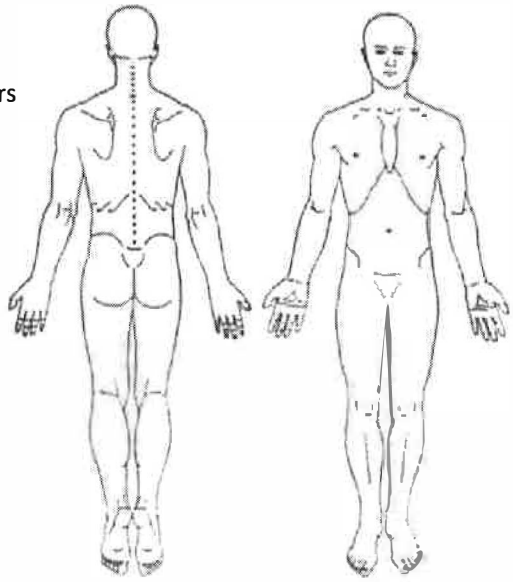
MEDICAL INTAKE FORM

What is the reason for today's visit? _____

_____

_____

If appropriate, please draw where your symptoms are located on the human diagram →



How long have you had your symptoms? _____ weeks / months / years

Are you RIGHT or LEFT handed? *(circle)*

Past treatments for symptoms: *please check ALL that apply*

- ☐ Over the counter medications: _____
- ☐ Prescribed medications: _____
- ☐ Physical Therapy: _____ (Date)
- ☐ Spinal Injections: _____ (Physician & Date)
  - ☐ Epidural
  - ☐ Facet Blocks
  - ☐ Facet Rhizotomies
  - ☐ Trigger Point Injections
  - ☐ SI Joint
  - ☐ Other Injection(s): _____
- ☐ Other Treatments: _____

Have you seen any other specialists or had additional testing for the above symptoms? *please describe*

☐ CT ☐ MRI ☐ DEXA / Bone Density ☐ EMG/Nerve Conduction

_____

_____

Medical History: *check ALL that you have been diagnosed or treated for*

- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blood Clots
- ☐ Brain Aneurysm / AVM
- ☐ Brain Mass
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Crohns Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Gastric Reflux
- ☐ Gout
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hyperlipidemia
- ☐ IBS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Murmurs
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Peripheral Neuropathy
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other: _____

Surgical History: *list ALL major surgeries & dates*

_____

_____

_____

☐ I have not had any surgeries

Family History: *list all pertinent family history*

_____

_____

Date: _____

Patient Name: _____ Date of Birth: _____

Medication List: *please list ALL medications / supplements below OR provide copy of list*

Medication Name	Dosage and Frequency	What is it for?

☐ I do NOT take any medications

Allergies: *list ALL drug and food allergies* _____

☐ NO allergies

Social History:

Occupation: _____ ☐ Student ☐ Retired ☐ Disabled

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Are you a smoker? ☐ NO ☐ YES: _____ pack per day for _____years ☐ Former Smoker; Quit _____ (year)

Do you drink alcohol? ☐ NO ☐ YES: On Occasion _____ *or* Moderately _____

Review of Systems: *check ALL that currently apply*

Constitutional:
- ☐ Fatigue
- ☐ Body Aches
- ☐ Fever
- ☐ Weight Loss
- ☐ Chills

Eyes
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Visual Loss/Change in Vision

Ears, Nose, Throat
- ☐ Thyroid Mass
- ☐ Vertigo
- ☐ Sinus Pain
- ☐ Sore Throat

Cardiovascular
- ☐ Chest Pain
- ☐ Syncope
- ☐ Lightheadedness
- ☐ Irregular Heart Beats
- ☐ Lower Extremity Edema
- ☐ Rapid Heart Rate

Respiratory
- ☐ Shortness of Breath
- ☐ Hoarseness
- ☐ Wheezing
- ☐ Cough

Gastrointestinal
- ☐ Nausea
- ☐ Constipation
- ☐ Heartburn
- ☐ Vomiting
- ☐ Loss of Appetite
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Abdominal Pain

Genitourinary
- ☐ Urgency
- ☐ Retention
- ☐ Frequency
- ☐ Difficulty Voiding
- ☐ Incontinence
- ☐ Possible Pregnancy
- ☐ Skipped Menstrual Cycle

Neurologic
- ☐ Muscular Weakness
- ☐ Speech Difficulties
- ☐ Seizures
- ☐ Loss of Balance / Falls
- ☐ Memory Difficulties
- ☐ Tremors
- ☐ Head Injuries
- ☐ Tingling or Numbness

Musculoskeletal
- ☐ Joint Pain / Swelling
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Muscle Pain
- ☐ Arm Pain
- ☐ Leg Pain

Endocrine
- ☐ Loss of Hair
- ☐ Heat / Cold Intolerance
- ☐ Decreased Libido

Psychiatric
- ☐ Anxiety
- ☐ Feeling Confused
- ☐ Difficulty Sleeping

ORLANDO NEUROSURGERY

HIPAA NOTICE OF PRIVACY PRACTICES: CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information) and patient medical record information by Orlando Neurosurgery (the "Practice" in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for more complete description of the potential uses and disclosures of such information, and the patient has the right to review such Notice prior to signing this consent form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Practices, Patient may obtain a copy of the revised notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice as it pertains to the patient only.

Patient acknowledges and agrees that the Practice may disclose Patient's protected health information and patient medical record information to the following individuals who are either the Patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient: (list names below)

_____

_____

The patient agrees that the Practice may disclose the following types of information contained in the Patient's medical record below, unless otherwise indicated (please initial only IF YOU DO NOT WISH to disclose):

_____ HIV / AIDS Information
_____ Mental Health Information
_____ Substance Abuse Information
_____ Sexually Transmitted Disease Information
_____ Pregnancy Information (If patient under age of 18)

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action in reliance on the Consent.

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____ _____
Signature of Patient (or Authorized Representative*) Date

_____
Please Print Name

_____
*Authorized Representative's relationship to Patient

Office Policies

Medical Consent: I consent to all care, treatment, diagnostic imaging, laboratory testing and other medical procedures performed or prescribed by a physician of Orlando Neurosurgery and his/her designees.

Right of Refusal of Treatment: I understand that I have the right to make informed decisions regarding all aspects of my care. I should ask my health care provider to further clarify and explain anything I do not understand. I have the right to refuse treatment.

Acknowledgement of Receipt of Patient Rights & Notice of Privacy Practices: I have acknowledged that I have received both notices, Notice of Patient Rights/Responsibilities and HIPPA Notice of Privacy Practices.

Release of Medical Information: I authorize Orlando Neurosurgery to release any information necessary to facilitate healthcare processing of claims, or audit of payments in relation to my care and treatment. I also consent to the release of any information needed to other facilities, agencies or healthcare providers as per Orlando Neurosurgery's discretion. This order will remain in effect until revoked by me in writing.

Financial Policy: I certify that the insurance information I have provided to Orlando Neurosurgery is accurate, complete and current. I certify that no other coverage of insurance exists. It is my responsibility to understand the terms and benefits of my insurance plan. I understand I am financially responsible for charges not paid by my insurance. I may be required to pay co-payments, co-insurance or deductibles at the time of service unless other arrangements have been made in advance. Orlando Neurosurgery will make every attempt to notify me in advance if a service is not covered. If my insurance company has not paid my bill in full within 60 days, I will be expected to pay the remaining balance within 30 days. In the event of a large balance due from an operation, Orlando Neurosurgery may be able to arrange a payment plan suitable for all parties concerned.

Forms & Medical Records: If you require our office to complete any disability, FMLA, school/work, or personal forms; the first form is free; however, each additional form is a charge of $15 per form. Forms will be completed within 10-14 business days. If you require a copy of your medical records, you must sign a Medical Records Release form and a payment of $1.00/page for the first 25 pages, then $0.25/page after that will be due upon receipt of your request. Your request will be completed within 10-14 business days.

Appointment No Show / Cancellations: If it is necessary to cancel/reschedule your appointment, please do so 24 hours PRIOR to the time of your scheduled appointment. If you do not cancel an appointment or no show, you will be responsible for a $25.00 charge. The fee of $25.00 is to be paid by the patient and is not billable to any insurance.

Surgery Cancellations: If you must cancel a scheduled surgery, please notify our office by 12:00PM ten (10) business days (Monday – Friday) prior to your surgery to avoid a cancellation fee of $250.

Dispensing of Opioid (Narcotic) Pain Medications: In response to the "Opioid Crisis", The State Legislature of Florida passed the Controlled Substances Bill (CS/CS/HB 21) which regulates the prescribing of Schedule II and Schedule III pharmaceuticals. These regulations affect the prescriptions your providers are allowed to prescribe you after surgery. Schedule II narcotics are limited to a three (3) day supply for "acute pain exception". A seven (7) day supply can be provided under special circumstances. Our office will limit dispensing schedule II and III prescriptions to 14 days post-op. It is important to understand that Orlando Neurosurgery does not manage chronic pain. If you need chronic pain management, we are happy to provide a referral to a pain management specialist.

Return of Imaging CDs/Films: It is important for our providers to review your images for proper diagnosis and treatment; however, our office does not have the capacity to store these films. A copy of your images will be downloaded to our system at your appointment. Your images will be returned to you at the end of your appointment. If you leave your images for any reason past your appointment date, we will store them for 90 days as a courtesy. During this 90 days, you have the option to pick them up on the office at no charge, or we can ship them to you for a $10 service and handling fee. After 90 days, any remaining CDs/films will be disposed per HIPAA guidelines.

_____	_____	_____
Patient Signature	Printed Name	Date

Records Release

Authorization to Use and Disclose Confidential Information

Information may be disclosed *from*:	**Information may be disclosed *to*:**
_____ Person/Facility	_____ Person/Facility
_____ Address	_____ Address
_____ Phone	_____ Phone
_____ Fax	_____ Fax

The following information to be released:

☐ ANY/ALL MEDICAL RECORDS

☐ Office Notes
☐ History and Physical
☐ Progress Notes
☐ Problem list/Medication List
☐ Operative Reports
☐ Consultations
☐ Radiology Reports
☐ Lab/Pathology Reports

- I understand that the information may include the release of information about mental health, substance and/or alcohol use, HIV/AIDS, and STDs.
- This authorization will remain in effect for one (1) year or until I revoke it in writing.
- I have the right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The facility, it's employees, officers, and physicians are hereby released from any liability for the disclosure of the above information to the extent indicated and authorized therein.
- I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.
- I am aware that I may be charged a fee for this request as allowed by law, which may include up to $1.00 per page for Paper Records and fees associated with supplies and postage. Fees are waived when information is released to a health care provider for treatment purposes.

_____ _____
Patient Printed Name Date of Birth

_____ _____
Patient Signature Date

_____
Signature of Parent/Guardian or Legal Representative

**This page only needs a signature*