



Patient Registration

Name: _____ Sex: M F DOB: ___/___/___ SSN: _____
 Address: _____ City: _____ State/Zip: _____
 Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____
 Email: _____ Contact Preference: ___ Home ___ Cell ___ Work

Race: African American/Black Alaskan Native/American Indian Asian Pacific Islander/Native Hawaiian White
 Ethnicity: ___ Hispanic ___ Other ___ Decline Language: _____ Marital Status: M S D W

How did you hear about us? _____

Primary Care Physician: _____

Other Routine Physicians: _____

Assignment of Benefits/Release of Billing Information

I authorize Central Florida Spine Institute and/or their staff to leave medical information pertaining to my care by phone, voicemail, and to contact me via email for appointment reminders and other important office information.

INSURANCE CARRIERS:

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

I request that payment of services from Medicare benefits be made to Central Florida Spine Institute, PLLC. I authorize any holder of medical information about me be released to all providers involved in my care and to my insurance company for the purpose of processing and reimbursement for services rendered. I acknowledge that I am responsible for payment of any balance not covered by my insurance company. **Central Florida Spine Institute makes great effort to respectfully ask patients if your spine condition is due to an automobile accident, or worker's compensation incident and if you have retained an attorney for your spine condition. Failure to notify Central Florida Spine Institute at your initial visit (or any subsequent visit) that your injury is due to an automobile accident, worker's compensation incident, or if you have retained an attorney may result in your appointment being canceled. Your openness is greatly appreciated.**

Guardian (if patient under 18): Last Name: _____ First Name: _____

Emergency Contact Name: _____ Relationship: _____

Home Phone: () _____ Cell Phone: () _____

Consent for Treatment – I hereby authorize Central Florida Spine Institute to provide evaluation and medical treatment necessary, including diagnostic, surgical, and/or therapy interventions, by authorized member(s) of the practice or their designee.

* Central Florida Spine Institute complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex

X



Financial Policy and Privacy Statement

General Policy – As a participating provider, we will accept the carrier's allowable amount. Patients are responsible for co-payments, co-insurance amounts and/or deductibles and payment for services not covered by the carrier. Copays will be collected at each visit. If you are insured under a plan that we do not participate with and you choose to receive your care with us, we can make arrangements to bill the carrier; however, the patient is responsible for the bill in its entirety.

Please remember that your insurance plan is a contract between you and your insurance carrier. This contract usually requires a shared responsibility between the insurance and the patient for services rendered. While we will act on your behalf to obtain payment for our services, once we have exhausted all efforts, the patient is responsible for the balance due. Our office also accepts Visa, MasterCard and Discover in addition to cash and personal checks as method of payment. The billing department can also develop a payment plan to suit your needs to ensure that your account remains in good standing, should this become necessary. There will be a charge of \$25.00 for all returned checks for insufficient funds.

Referrals – If your insurance requires a referral from your PCP for your visit, their referral must be obtained and presented at the time of the visit. If a referral is not present at the time of visit, the visit can be rescheduled to allow time to contact your PCP to obtain.

No Show Appointments – Patients that do not show for their scheduled appointment and do not call the office at least 24 hours in advance, a 25.00 no show fee will apply.

Secondary Insurance – We will submit your bill to your secondary; however, failure to obtain payment within 60 days will result in the balance being billed to you, CFSI does not file to tertiary insurances, but will provide you the necessary documents to do so upon request.

Self-Pay Policy – Patients without insurance coverage who wish to receive care with us must pay in full with our billing department prior to receiving services.

Surgeries – When you choose to schedule a surgery with Central Florida Spine Institute, we will check with your insurance carrier with any outstanding deductible, co-pays or coinsurance amounts. If there is a deductible amount not yet satisfied for that benefit period, co-pay or coinsurance for the procedures, you will be asked to pay a portion of that amount.

Collection – Our office will make every effort to communicate with you about your account and will present reasonable options for payment. In the event that we involve a third party for collect of an account, you will not be permitted to return for a new episode of care until you have satisfied the old debt.

Disability Forms (Short – term and FMLA) - Our office will complete your disability insurance claim forms; however, it is the patient's responsibility to provide the office with the forms, job description and contact information. **The fee for each form is \$25 and must be paid in advance.**

Medical Records – Medical records are processed on a weekly basis. Upon written request, medical records will be processed and completed within 5-7 business days. Payment for medical records must be paid in full in order to complete the request.

Privacy Statement – I have received a copy of the protected health information. I give permission to Central Florida Spine Institute to use and disclose my health information in accordance with it.

Legal/Third Party Payer - Central Florida Spine Institute makes great effort to respectfully ask patients if your spine condition is due to an automobile accident, or worker's compensation incident and if you have retained an attorney for your spine condition. Failure to notify Central Florida Spine Institute at your initial visit (or any subsequent visit) that your injury is due to an automobile accident, worker's compensation incident, or if you have retained an attorney may result in your appointment being canceled. **Your openness is greatly appreciated.**

I have read the Financial Policy as outlined above.

X

Patient Name

Signature

Date

2FO (2023)

(Office use only: _____ Refused to sign _____ Refused Copy of Privacy Notice)



CENTRAL FLORIDA SPINE INSTITUTE

Minimally Invasive Spine Surgery

HIPAA Authorization Form

Central Florida Spine Institute has taken measures to protect all our patient's private medical information. We will not release any information to anyone unless you have provided the requested information below.

Please see receptionist with any questions prior to signing this Authorization Form.

I, _____ am authorizing the person/people listed below to obtain medical information about myself. I understand that Central Florida Spine Institute is not responsible for the information provided if it is given to a person that I have listed below.

1. Name: _____ Phone: _____ Date of Birth: _____ Relationship: _____

2. Name: _____ Phone: _____ Date of Birth: _____ Relationship: _____

3. Name: _____ Phone: _____ Date of Birth: _____ Relationship: _____

4. Name: _____ Phone: _____ Date of Birth: _____ Relationship: _____

I acknowledge and agree that Central Florida Spine Institute may:

____: Leave a message regarding upcoming appointments.

____: Leave a message regarding billing questions on home answering machine/cell voicemail.

I have read and understood the information in this consent. I may receive a copy of this consent if I so choose. I, the patient or the authorized legal guardian of the patient sign this document verifying consent to the above terms.

Patient Name (print): _____

Patient/ Legal Guardian Signature: _____ Date: _____



CENTRAL FLORIDA SPINE INSTITUTE

Minimally Invasive Spine Surgery

2025 FIRST VISIT QUESTIONNAIRE

Central Florida Spine Institute is a spine only specialist office, therefore due to insurance purposes we will focus on one part of the spine at each visit. If you have any questions, please ask for assistance.

Name: _____ DOB: _____ Date of Visit: _____

Sex: Male Female Is this a second opinion? YES NO

Referred By: _____

Primary Care Physician: _____

Pharmacy Preference (NAME AND PHONE): _____

Is the condition you are being seen for a result of a motor vehicle accident / slip and fall / or a work-related injury?

Please indicate.

A. **Yes, please list date of accident:** _____

B. No _____

Has an attorney or adjuster been retained? Please indicate.

A. Yes, Adjustors or attorneys name/phone number

B. No

IF pain is due to an accident, please describe circumstances regarding accident below.

C. Have you had any recent radiological diagnostic studies for the spine condition that we are seeing you for today?

Please circle any/all that apply.

Where and when performed?

CERVICAL: MRI
CT
XRAYS

LUMBAR: MRI
CT
XRAYS

THORACI: MRI
CT
XRAYS

MEDICAL RECORD

ALLERGIES

Do you have any known drug or other allergies (including iodine/contrast dye or shellfish)?

PLEASE CIRCLE ONE:

- A. NO known drug allergies
- B. YES, please list

Allergy

Reaction

CURRENT MEDICATIONS

Are you currently taking ANY medications (prescribed or over the counter)? If you have a prepared list, please mark see attached.

- A. None
- B. Yes

See Below

See Attached List

<u>Name</u>	<u>Dose</u>	<u>Reason for Taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

Has mother, father, brother, sister been diagnosed with the following condition(s)?

Arthritis	Heart Disease	Scoliosis
Cancer/Malignant neoplastic disease	Hypertension/High Blood Pressure	Stroke
Diabetes	Musculoskeletal Disease	Other: _____
Disorder of the Back	Osteoarthritis	_____
Disorder of the Neck	Osteoporosis	_____
Heart Attack – Cardiovascular Incident	Rheumatoid Arthritis	

MR # _____

SOCIAL HISTORY

Do you currently smoke/vape? NO YES: Packs Per day _____ Number of Years: _____
Tobacco Use? NO YES: Amount per day _____
Did you ever smoke regularly before? NO YES: Packs Per day _____ Number of Years: _____
How many years did you smoke? _____ When did you quit smoking? _____

Education: ___ Did not complete high school ___ High School ___ College ___ Graduate school

Occupation: _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Live: ___ Alone ___ With others

Home: ___ Single level ___ Multi-level

Alcohol Consumption (per week): NONE < 6 drinks 6-12 drinks 12-24 drinks 24-48 drinks 48 drinks or over

Illicit Drugs: NO YES: Specify: _____

Exercise Level: ___ None ___ 2 x a week ___ 5 x a week ___ Everyday

Sporting Activities: Please list.

Are you currently Employed? NO YES, Employer: _____

What is your current work status? (Please circle and specify if needed)

Full time with / without restrictions

Part time with / without restrictions

Retired by choice

Unemployed/Student

Disabled

SURGICAL HISTORY

Have you had **Spine Surgery** in the past? Neck or back, please specify.

- A. NO
- B. YES, please list below

<u>Date</u>	<u>Procedure & Levels</u>	<u>Surgeon Name</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any other surgical procedures (other than the spine)?

- A. NO
- B. YES, please list below

<u>Date</u>	<u>Procedure</u>	<u>Surgeon Name</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Covid 19 Vaccination Status: N/A or Dose 1: _____ Dose 2: _____
 Dose 3: _____ Dose 4: _____

**PAST MEDICAL HISTORY
 (Circle all that apply)**

- | | | |
|--------------------------|------------------------|-----------------------------|
| Alzheimer's/ Dementia | Heart Disease | Pacemaker |
| Anemia | Heart problems | Parkinson's Disease |
| Arthritis | Hepatitis: Type _____ | Pulmonary disease |
| Asthma | High blood pressure | Peripheral vascular disease |
| Bleeding disorder | High cholesterol | Rheumatoid arthritis |
| Blood clots | Immune disorder | Seizures/Epilepsy |
| Cancer: Type _____ | Kidney disease | Stroke: When _____ |
| Circulation problems | Leg or foot ulcers | Tuberculosis |
| Coronary artery disease | Liver disease | Thyroid condition |
| Depression | Mental Disorder: _____ | Ulcers |
| Diabetes: Type _____ | Migraines | UTI |
| HIV/AIDS | Osteopenia/ | Other: _____ |
| Heart attack: When _____ | Osteoporosis | |

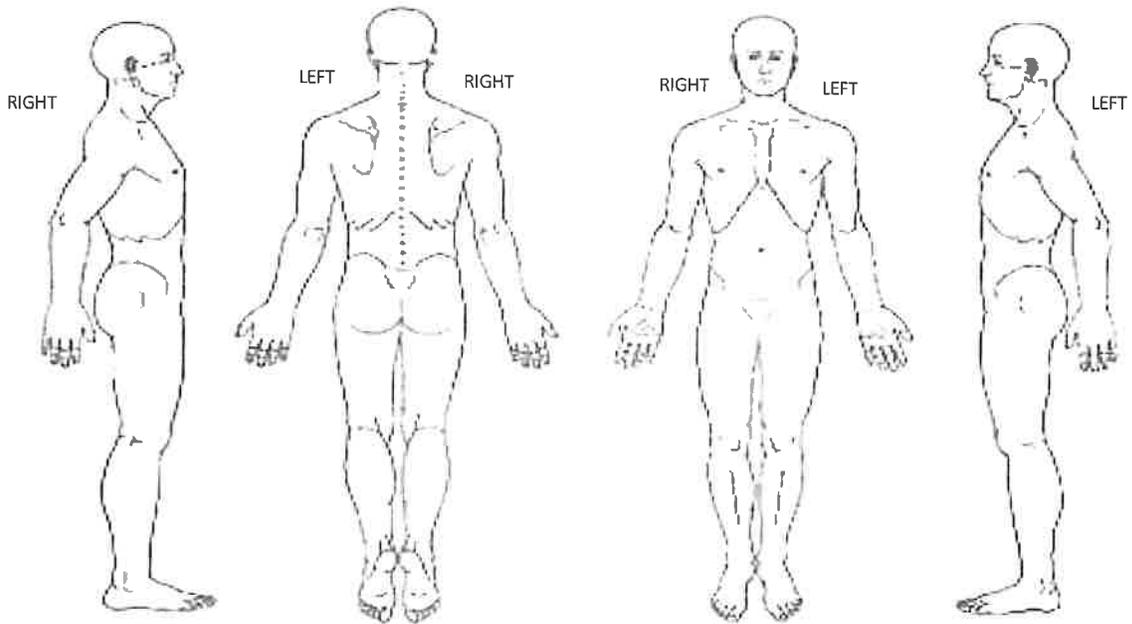
REVIEW OF SYSTEMS**(Circle all that apply)**Have you recently experienced any of the following?

Constitutional:	Fever	Night sweats	Weight Gain	Weight Loss
Eyes:	Dry Eyes	Irritation	Vision Changes	
ENMT:				
Ears:	Difficulty Hearing			
Nose:	Frequent nose bleeds Nose or sinus problems			
Mouth/Throat:	Sore throat	Bleeding gums	Snoring	Dry Mouth Oral Abnormalities
	Mouth Ulcers	Teeth Abnormalities	Mouth Breathing	
Cardiovascular:	Chest Pain on Exertion	Arm Pain on Exertion	Shortness of Breath when walking	
	Shortness of Breath when lying down	Palpitation	Known Heart Murmur	
	Lightheaded on standing			
Respiratory:	Cough	Wheezing	Shortness of Breath	Coughing up Blood Sleep Apnea
Gastrointestinal:	Abdominal Pain	Vomiting	Change in Appetite	Black tarry stools
	Frequent diarrhea	Vomiting Blood		
Genitourinary:	Urinary loss of control	Difficulty urinating	Increased urinary frequency	
	Hematuria	Incomplete Emptying		
Musculoskeletal:	Muscle aches	Muscle weakness	Back Pain	Arthralgia/joint pain
	Swelling in extremities			
Integumentary:	Abnormal mole	Jaundice	Rash	Itching Dry Skin Growth/lesions
Neurologic:	Loss of consciousness	Weakness	Numbness	Dizziness Seizures
	Frequent headaches/migraines		Restless legs	

PAIN DIAGRAM

Please indicate where your pain is on your body.

X=PAIN O=NUMBNESS/TINGLING



On a scale of 1 to 10, please indicate what you would consider your daily pain level to be _____

On a scale of 1 to 10, please indicate what you would consider your highest pain level has reached _____

Signature: X _____

Medical Assistant: _____