South Florida Spine & Sports Specialists, LLC

Mark Fishman, DO   Francisco Romero, MD

Name/Nombre: ________________________________ Today's Date/Fecha: ______________
Last/Apellido   First/Nombre

DOB/Fecha de Nacimiento (MM/DD/YY):____/____/____ Social Security/Seguro Social: _____-_____-_____

Address/Dirección: ____

Email: ______________________ Marital Status: ______________________

Home Phone/Teléfono: ________________ Cell Phone/Teléfono Celular: ________________

Ethnicity: ______________________ Race: ______________________

Emergency Contact/Contacto Emergencia: ________________ Phone/Teléfono: ________________

Address/Dirección: ____

Preferred Pharmacy: ____

Primary Physician/Médico Primario: ________________ Phone/Teléfono: ________________

Referring Physician/Médico que Refiere: ____

Is your visit related to an accident?_____ If yes, circle type Auto / Work / Slip&Fall/ Other

Primary Insurance/Seguro Médico Primario: ____

Policy Number/Póliza: ________________ Claim/ Reclamación: ________________

Secondary Insurance/Seguro Médico Secundario: ____

Relationship to Policy Holder/Relación al Asegurado Principal: ______________________

Attorney's Name ______________________ Phone/Teléfono ________________

Date of Injury(MM/DD/YY) ______________________ Approved Body Part ________________

I understand and acknowledge that if I have any complaints of increased pain, fever, difficulty breathing, worsening weakness, bowel/bladder changes, or any other worrisome symptoms I am to present to the nearest emergency room for evaluation and contact my physician immediately.

I, The undersigned patient or person responsible for the patient, do hereby direct and authorize South Florida Spine & Sports Specialists, LLC to furnish my insurance company, attorney, personal physician, or any representative thereof, and all information which may be pertinent regarding my medical condition and medical treatment rendered to me. I authorize my doctor to act as my agent to make claims, assist in obtaining payment from my insurance company(ies) and authorize payment directly to my physician or to the party who accepts assignment. I understand that I am responsible for my billing, including co-payments and deductibles. I further understand and agree to pay all costs and reasonable agency fees if any charge for services rendered and placed with an attorney or collection agency in the event of non-coverage. I agree to assume responsibility for payment should my insurance decline payment. I hereby declare by my signature below that I have read and understand all of the provisions above.

Patient's Signature/Firma: ______________________ Date/Fecha: ________________

PATIENT HISTORY FORM

Date: ______/________/_______

NAME: ____ Birthdate: _____/______/_____
Last First M. I.

Age:__________ Sex: ❑ F ❑ M

How did you hear about us?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Drug Allergies: ❑No Allergies ❑Aspirin ❑Sulfa ❑Iodine ❑Other___________________________

Previous Surgeries:

Orthopedic Problems: Shoulder Y/N Elbow Y/N Wrist Y/N Hip Y/N Knee Y/N Ankle/Foot Y/N

Smoking: Y / N Alcohol: Y / N Illicit drugs: Y / N

CURRENT MEDICATIONS		**PAST MEDICAL HISTORY**
Include non-prescription medications & vitamins or supplements: **Name of drug**	**Dose**	❑ Diabetes Insulin Y / N
1.		❑ High blood pressure
2.		❑ High cholesterol
3.		❑ Asthma
4.		❑ Stroke
5.		❑ Epilepsy (seizures)
6.		❑ Stomach or peptic ulcer
7.		❑ Anemia
8.		❑ Colitis
9.		❑Kidney disease
10.		❑Other
11.		
12.		

Occupation: ❑Retired ❑Disabled ❑Sick leave

South Florida Spine & Sports Specialists, LLC

PATIENT PAYMENT AGREEMENT

I understand that I am responsible for the cost of professional medical services provided to me by South Florida Spine & Sports Specialists, LLC regardless of the availability of certain other sources of payment, including insurance benefits and pending claims I may have against third parties who may be responsible for my medical condition. I elect to pay for the professional services provided by South Florida Spine & Sports Specialists, LLC as follows:

Check one of these if this is a legal case:	Check one of these is this is NOT a legal case:
○ I have a Third Party Claim (defined below) and intend to seek compensation from a third party. I have engaged an attorney and will sign, with my attorney, a Letter of Protection in favor of South Florida Spine & Sports Specialists, LLC. If PIP Insurance is available, a claim may be submitted to the applicable PIP Insurance company. I will not use any health insurance or Medicare benefits. I understand my charges may exceed the benefits available from my PIP insurance, and I am responsible for payment of all charges to the fullest extent. ○ Self-pay. I will be personally responsible for all charges by South Florida Spine & Sports Specialists, LLC	○ I intend to use available health insurance benefits, as applicable, subject to coordination of benefits rules applicable to these policies and benefits programs. ○ I intend to use any available PIP benefits. Once exhausted, I will personally be responsible for all remaining balances. ○ Self-pay. I will be personally responsible for all charges by South Florida Spine & Sports Specialists, LLC.

Accordingly, in consideration for the medical services rendered by South Florida Spine & Sports Specialists, LLC and its physicians, I agree to the following terms and conditions;

1. Guarantee of payment: I guarantee prompt payment of any such services not otherwise paid by insurance or any third party. Payment for any services provided to me that is not contingent upon the receipt of any award of damages or payment upon any claims I may access a third party.
2. Health or PIP Insurance: If I am entitled to and intend to utilize health insurance, Medicare, or PIP Insurance coverage for the services rendered to me by South Florida Spine & Sports Specialists, LLC, I understand that coinsurance and deductible amounts are due and payable at the time that professional services are rendered. Upon the exhaustion of the above benefits, I understand that I am responsible for all charges in excess of such exhausted benefits, to the extent permitted by law, which charges, together with charges for services which are not covered shall be payable at the time that professional services are rendered. I acknowledge that South Florida Spine & Sports Specialists, LLC charges may exceed the benefits available from my PIP and health insurance policies and that I am responsible for the payment of such services, to the fullest extent permitted by law.
3. Authorization: I hereby authorize any and all assigned insurance companies to pay the amount due in any pending claims directly to South Florida Spine & Sports Specialists, LLC. I understand that, unless otherwise required by law, any amounts not covered or not paid by my insurance policy or any third party payer, including charges for services which are not covered benefits under my insurance policy, are my personal responsibility, if any action of law or in equity is brought to enforce this agreement, South Florida Spine & Sports Specialists, LLC and/or treating physicians shall be entitled to recover attorney's fees, court costs, and any other costs of collection incurred.
4. Third Party Claims: If I seek, or intend to seek, the recovery of monetary damages in connection with an accident or other sort claim from a third party ("Third Party Claim"), I must provide a Letter of Protection, subject to the approval of South Florida Spine & Sports Specialists, LLC, that is duly signed by me and my legal counsel ("LOP"). According to the LOP, South Florida Spine & Sports Specialists, LLC will accept payment of professional fees upon settlement or final judgement in my case. I understand that, if there is no settlement or if I otherwise receive no payment in consideration of my Third Party Claim, I am fully responsible for the professional fees charged by South Florida Spine & Sports Specialists, LL, which fees shall be due and payable immediately upon the earliest to occur of the following: (i) final judgement against me or dismissal of my Third Party Claim, or (ii) the abandonment of my Third Party Claims by me or my counsel.
5. No Insurance Benefits: If I have no insurance and there is no third party payer available to pay for South Florida Spine & Sports Specialists, LLC's professional services, I understand that payment is due at the time professional services are rendered.

I further direct my insurer to direct all payments for services rendered by the Provider SOUTH FLORIDA SPINE & SPORTS SPECIALISTS, LLC/DR. MARK FISHMAN/DR. FRANCISCO ROMERO. THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original. I CERTIFY THAT THE INFORMATION CONTAINED IN THIS DOCUMENT HAD BEEN READ BY OR EXPLAINED TO ME AND THAT I UNDERSTAND THIS INFORMATION. I WILL RECEIVE A COPY OF THIS DOCUMENT UPON REQUEST. I ACKNOWLEDGE THAT A COPY OF THIS DOCUMENT WILL BE AS EFFECTIVE AS THE ORIGINAL.

Patient Signature: ______________________________ Date: ______________

Print Patient Name: ______________________________

Signature of Patient's Authorized Representative: ______________________________

Relationship to Patient: ______________________________

Updated 02/14/2019

SOUTH FLORIDA SPINE & SPORTS SPECIALISTS, LLC
NARCOTIC PRESCRIPTION CONTRACT

I, ____, agree to the following conditions:

1. I understand that I have a pain problem that may require the prescription of opioid pain medication to increase my function. The risks, side effects, and benefits of the medication have been or will be discussed with me in detail.

2. **I understand that the use of opioids in Pain Management is an acceptable practice. However, there is a potential for habit formation and in some instances may result in addiction.**

3. I will obtain prescriptions for the opioids and other controlled medicines only from my physician.

4. I may be requested to have prescriptions filled at one specific pharmacy and will provide the South Florida Spine & Sports Specialists with the name, phone number and fax number of that pharmacy.

5. I will take the medication only as prescribed and will promptly notify my physician if I do not.

6. I understand the eventual goal of tapering the opioid medication.

7. I will meet regularly with my physician to assess my progress and may be required to have a follow-up visit prior to obtaining refills of medication.

8. Lost, misplaced, or stolen medications **will not be replaced**. Refills will not be given early for any reason.

9. If I deviate from the above guidelines or the medication loses its effectiveness in increasing the function, I understand that it will be promptly tapered.

10. I will call to renew my medication, and understand **48 hours notice** is required to complete this request. **No prescription will be filled or called in after business hours or on weekends.**

11. I agree to random urine and blood tests to assess my compliance.

12. I may not discard any prescribed medications. All medications must be returned to my physician.

13. I understand that the use of illicit drugs may represent grounds for dismissal from our clinic.

FAILURE TO COMPLY WITH THE ABOVE TERMS OF THIS AGREEMENT MAY RESULT IN A DISMISSAL FROM THE SOUTH FLORIDA SPINE & SPORTS SPECIALISTS.

Patient's Signature: ______________________________ Date: ________________

Pharmacy: _________ Phone: _________ Fax: _________

NO-SHOW FEES

The following no-show fees will be applicable to those patients that do not cancel with a minimum of 24-hour notice:

Office Visits -$50.00

EMG- $150.00

Physical Therapy Evaluations and Follow-up treatment: $50.00

By signing this document, I understand and acknowledge South Florida Spine & Sports Specialists,LLC's no-show policy.

Patient Signature: ____________________________________

Print Patient Name:____________________________________

Date:____

MEDICAL RECORDS RELEASE FORM

RE: ______________________________

DOB: ______________________________

I hereby authorize South Florida Spine & Sports Specialists, LLC, to request my patient information from:

Name: ____

Address: ____

Phone: ____

Information to be released:

____

____

____

This authorization is subject to my written cancellation at any time.

______________________________ ______________________________
Signature of Patient Date

______________________________ ______________________________
Signature of Witness Date

South Florida Spine & Sports Specialists
3000 SW 148th Ave. Ste 115
Miramar, FL 33027
Ph (954) 438-7000
F (954) 589-1742

HIPPA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
Obtain payment from designated third-party payers.
Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions.

I understand that I amy revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

______________________________ ____________________

Patient's Name DOB: (mm/dd/yy)

______________________________ ____________________

Signed (Patient or Legal Representative for Patient) Date:

____

Legal Representative's Relationship to Patient

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

______________________ ____________ ______________________________

Name of Patient **Date of Birth** **Signature of Patient/Parent/Guardian** **Date**

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Print Name:______________________________ **Last four digits of SSN or other identifier:**__________

Print Name:______________________________ **Last four digits of SSN or other identifier:**__________

Print Name:______________________________ **Last four digits of SSN or other identifier:**__________

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number:

____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

Written Communication Address:

____

____ OK to mail to address listed above

____ E-mail me at:____________________

Work Telephone Number:

____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

Fax Communication:

____

____ OK to Fax at the number listed above

____ E-mail me at:____________________

Other:____

IV. The following person(s) <u>are not authorized</u> to receive my Patient Health Information (PHI):

Print Name:__________________________ **Print Name:**__________________________

Print Name:__________________________ **Print Name:**__________________________

V. The HIPAA Privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services or its internal operations. Also, the Practice does not have to account for disclosures for which I have executed an Authorization permitting disclosures of my PHI.

Date of disclosure request	Disclosed to whom: address/fax	Description of disclosure	Purpose of disclosure	Dates of Service of disclosure	Person completing request	Date completed