HEALTH HISTORY

Patient Name: _____

Was this related to a motor vehicle injury? YES/NO

Is this visit related to an on-the-job injury? YES/NO

Date of Injury (if applicable): _____

Briefly describe your injury/accident/problem: _____

_____

_____

Past Medical History (please check all that apply):

- ☐ *NONE*
- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding Disorders or Clotting
- ☐ Bipolar Disorder
- ☐ Breast Cancer
- ☐ Hyperlipidemia
- ☐ Ischemic Heart Disease
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non Insulin
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity, Morbid
- ☐ Obesity
- ☐ PBPH
- ☐ Prostate Cancer
- ☐ Pulmonary Embolism
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke
- ☐ Other_____

Past Surgical History (please check all that apply):

- ☐ *NONE*
- ☐ Appendix (Appendectomy)
- ☐ Breast: Mastectomy ○Right ○Left ○Both
- ☐ Breast: Lumpectomy ○Right ○Left ○Both
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removal
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA (Stents)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Removed: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Tonsilectomy
- ☐ Hysterectomy
- ☐ Hysterectomy: Caesarean
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ Other_____

Past Orthopedic History (please check all that apply):

- ❑ *NONE*
- ☐ Ankylosing Spondylitis
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ Cubital Tunnel Syndrome
- ☐ DISH
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Handedness -
  - ○Right ○Left
  - ○Ambidextrous
- ☐ Hand Fracture
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Myasthenia Gravis
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Polio
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shoulder impingement
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ Other_____

Past Orthopedic Surgery (please check all that apply):

- ❑ *NONE*
- ☐ Carpal Tunnel Decompression
  - ○Right ○Left ○Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ CMC Arthroplasty
- ☐ ○Right ○Left ○Both
- ☐ Distal Radius ORIF
  - ○Right ○Left ○Both
- ☐ Ganglion Cyst Excision
- ☐ ○Right ○Left ○Both
- ☐ Joint Fusion
- ☐ Joint Replacement: Hand
- ☐ ○Right ○Left ○Both
- ☐ Joint Replacement: Hip
  - ○Right ○Left ○Both
- ☐ Joint Replacement: Knee
  - ○Right ○Left ○Both
- ☐ Joint Replacement: Shoulder
  - ○Right ○Left ○Both
- ☐ Knee Arthroscopy
  - ○Right ○Left ○Both
- ☐ Meniscus Repair
  - ○Right ○Left ○Both
- ☐ Reverse Total Shoulder Replacement
  - ○Right ○Left ○Both
- ☐ Revision of Total Knee Arthroplasty
  - ○Right ○Left ○Both
- ☐ Revision of Total Shoulder Arthroplasty
- ☐ ○Right ○Left ○Both
- ☐ Rotator Cuff Repair
  - ○Right ○Left ○Both
- ☐ Shoulder Arthroscopy
- ☐ ○Right ○Left ○Both
- ☐ Trigger Finger Release
  - Location: _____
- ☐ Other_____

Social History (please check all that apply)

Cigarette Smoking **(MUST ANSWER)**
- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker

Alcohol Use
- ☐ Do not drink alcohol
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Exercise Frequency
- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never

Vaccination Status

Pneumonia Vaccine - Have you received a pneumonia vaccination? ○Yes ○No

Flu Vaccine – Have you had the Flu Vaccine within the last year? ○Yes ○No

Any recent falls during past 3 months? ○Yes ○No

Family History (please inform us of your family members' medical history by marking the appropriate box):

☐ **No Family History** (checking this box indicates no past family medical history)

	Mother	**Father**	**Sister**	**Brother**	**Daughter**	**Son**	**Other:**
Cancer							
Hypertension							
Osteoarthritis							
Osteoporosis							
Scoliosis							
Diabetes, Type 2							
Ischemic Heart Disease							

LIST OF CURRENT MEDICINES

Medication (Brand or generic Name)	Dose	How and how often you take the medicine	Reason for taking	Date started	Date stopped	Doctor Name
Example: Lisinopril	10mg	Oral - Once a day	High blood pressure	01/10/15		Dr. Smith

List all tablets, patches, inhalers, drops, liquids, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, nitroglycerin).

Allergies (please list all known allergies or check option which applies):

☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

Alerts* (check yes or no for the following)

Alert	Yes	No
Allergy to Latex		
Under Pain Management Contract		
Pacemaker		
Deaf / Hard of hearing		
Blind		
Spinal Cord Stimulator		

Please inform the physician, medical assistant or front desk staff of any other medical conditions or concern.

Please list the name and phone number of physicians you are currently under the care of:	
Medical Doctor/Internist	
Cardiologist	
Pain Management Specialist	
Rheumatologist	
Pulmonologist	

PATIENT INFORMATION

Today's date:	Patient's last name:	First name:	Nickname:
Mailing Address:	City:	State:	Zip:
Home phone:	Work phone:	Cell Phone:	
Sex:	Birth Date:	Employer Name and Address:	
Email Address:	Patient's Social Security Number:		
Referring Physician:	Primary Care Physician :		
Marital status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ separated	Race:	Ethnicity:	Language:
Secondary Address (from:_____ to _____):	City, State, Zip	Secondary Address Phone:	

EMERGENCY CONTACT PERSON

Last Name:	First Name:	DOB:
Home phone:	Relationship:	Cell phone:

RESPONSIBLE PARTY (GUARANTOR) *(if different from patient)*

Guarantor's last name:	First name:	Middle name:	
Address:	City:	State:	Zip:
Guarantor's phone number:	Guarantor's Sex:	Guarantor's DOB:	Guarantor's Social Security Number:

PHARMACY INFORMATION

Pharmacy name:	Pharmacy location (address or intersection is okay):	Pharmacy phone number :

NEUROSCIENCE & SPINE ASSOCIATES, P.L.

PATIENT FINANCIAL POLICY

As health care providers we are committed to providing our patients with the best medical care possible. As a business, we are committed to providing a streamlined fiscal process that allows our patients to clearly understand their financial responsibility. Our Business Office is committed to providing outstanding customer service for all financial questions, and our professional staff members are experts working with commercial insurance companies, Medicare, and Workers' Compensation.

Identification

- Proper identification must be presented prior to service being rendered.
- Current insurance cards must be presented prior to service being rendered.

Commercial Health Insurance

- Co-Payments
  - Insurance companies require that co-payments are collected prior to service.
- Co-Insurance/Deductibles
  - New co-insurance or deductible amounts will be billed after the date of service.
  - These amounts can only be calculated after your appointment.
- Non-Participating Insurance
  - NASA does not contract with every insurance company.
  - Patients are responsible for asking if NASA is a participating provider with their insurance company.
  - NASA will bill non-participating insurances. However, outstanding balances are the responsibility of the patient.
- Secondary Insurance – as a courtesy NASA will file to your secondary insurance carrier one time.

Medicare

- NASA will submit claims to Medicare, however you may need to sign an ABN form for non-covered services.
- NASA will submit to Medicare as your secondary insurance carrier one time.

Workers' Compensation

- Patients are financially responsible for medical services related to Worker's Comp.
- Patients will supply WC contact information prior to services being rendered.

Motor Vehicle/Third Party Liability

- Patients are financially responsible for medical services related to motor vehicle accidents.
- Patients shall supply auto insurance, third party, and/or attorney information as requested by NASA.

Self-Pay

- Self-pay account exist if patient has no insurance coverage.
- Full payment is due at the time of service for all self-pay patients

Statements/Payments

- Statements
  - Statements are sent to patients on a monthly basis and will show outstanding balances.
  - After insurance pays, patients are responsible for all outstanding balances.
- Payment Methods
  - We accept all major credit cards, checks, money orders, and cash.
  - Low interest payment plans are available. Patients need to discuss options with the Customer Service Representative.
- Returned Check Fees – a fee of $25.00 will be charged for all returned checks.
- **Durable Medical Products (DME) purchased in our office are non-refundable.**

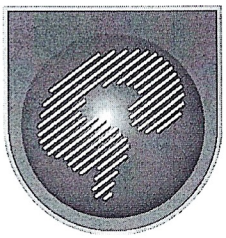
I hereby assign, to Neuroscience & Spine Associates, payment of medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine my benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand I am financially responsible for all charges whether or not they are covered by my insurance policy, as well as any co-payments or co-insurance.

Printed Name:

Signature: _____

Date: _____

NASA
NEUROSCIENCE
&
SPINE ASSOCIATES



Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my health care, Neuroscience & Spine Associates originates and maintains paper and electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I understand I have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent;
- The right to object to the use of my health information for directory purposes;
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Neuroscience & Spine Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164 506 of the Code of Federal Regulations.

I further understand that Neuroscience & Spine Associates reserves the right to change their notice and practices, in accordance with Section 164.520 of the Code of Federal Regulations. Should Neuroscience & Spine Associates change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use of disclosure of my health information:_____

_____

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and ( )accept / ( )decline (check one) the terms of this consent.

Patient / Responsible Party Signature:_____ **Date:**_____

Patient's Name (Printed): _____

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003
Revised March/26/2013

Neuroscience and Spine Associates, P.L.

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Kelley Sharon	239-631-7166	ksharon@nasamri.com
HIPAA COMPLIANCE OFFICER	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

NASA
NEUROSCIENCE
&
SPINE ASSOCIATES

MEDICAL RECORDS RELEASE / REQUEST

NAME_____

Phone:_____ Fax: _____

herein give permission to ***Neuroscience & Spine Associates***

1660 Medical Blvd, Ste 200, Naples, FL 34110 P 239.449.7937 / F 877.793.1399 **to Release my Records to:**

Name:_____

Address:_____

Phone: _____ Fax:_____

OR Request my Records From:

Name:_____

Address: _____

Phone: _____Fax:_____

A copy of the (***) COMPLETE MEDICAL*** **RECORD OR choose of the following:**

Dates of Service: *From*_____ to _____

( ) Progress Notes / Consultation Reports ( )Lab Report(s) ( ) X-Ray / MRI Report(s)

( ) MRI Discs or X-Ray Discs ( ) EEG/EMG Reports ( ) Medication List / Medication Allergies

( ) Surgical Procedures / Biopsy Report(s) ( ) Other: _____

For the purpose of: Personal Use _____ Insurance _____ Continuing Care _____ Legal _____ Other: _____

Please initial to allow the designated facility to disclose information protected under federal law relative to:

_____ Drug and/or alcohol treatment

_____ Psychiatric care

_____ Diagnosis or information specific to HIV, AIDS

_____ Sickle Cell Anemia

I wish to allow the following person(s) access to my medical records:

Name: _____Relationship: _____

Name:_____Relationship: _____

This authorization will expire 2 (two) years following the last date of service. After this date, Neuroscience and Spine Associates can no longer use or disclose patient records without a new authorization form. I have read this authorization and understand what information will be used or disclosed, by Neuroscience and Spine Associates PL.I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth. The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Neuroscience and Spine Associates, P.L. must receive the revocation in writing and must include:

** The patient's name, address, and patient number, if applicable. * The effective date of this authorization, and the recipients of the protected health information according to this authorization, * The patient's desire to revoke this authorization, the date of the revocation, and the patient's signature.* All revocations must be sent to:

Neuroscience and Spine Associates, P.L. Attn: Medical Records 1660 Medical Blvd. Ste. 200 Naples, FL. 34110

Revocations are not effective until received by Medical Records. I fully understand and accept the terms of this authorization.

Patient or Authorized Personal Representative: _____ Date:_____

Personal Representative Description:_____