SPINE INSTITUTE OF CENTRAL FLORIDA
WORLD-CLASS SPINE CARE
EXCELLENCE IN MINIMALLY INVASIVE SPINE SURGERY
Comprehensive Center of Excellence in ALL Spine Care & Pain Management

SPINE INSTITUTE OF CENTRAL FLORIDA FIRST VISIT QUESTIONNAIRE

PATIENT NAME:_____ **TODAYS DATE:** _____ **DOB:**_____ **AGE:**_____ **HANDEDNESS:** RIGHT/LEFT/AMBIDEXTROUS

ALLERGIES:_____ **OCCUPATION:**_____ **PRIMARY CARE PHYSICIAN (NAME):** _____

Best Contact #: ( )_____

E-mail:_____

CHIEF COMPLAINT (What brings you here today?)

Describe your condition:_____

Please List all LOCATIONS of Your Pain: _____

TYPE OF PAIN (Circle all that apply):

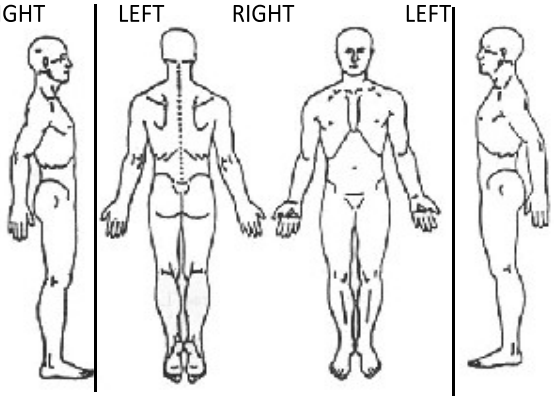
Weakness Burning Electricity Dull Ache
Numbness Stabbing Tingling Persisting Pins & Needles

Date of onset of symptoms: _____

How long symptoms have been present:_____

DRAW AN "X" TO MARK THE LOCATION OF YOUR PAIN/SYMPTOMS

RIGHT LEFT RIGHT LEFT LEFT



How bad is your Pain? (Circle the number)

0 1 2 3 4 5 6 7 8 9 10

Please CIRCLE if you now have or have had recently any of the following:

MUSCULOSKELETAL:
Painful joints
Cramps
Joint stiffness

HEMATOLOGIC:
Unusual bleeding
Easy bruising

RESPIRATORY:
Shortness of breath
Persistent Cough
Blood in sputum

CARDIAC:
Chest pain
Heart attack
Irregular heart beat

GENITOURINARY:
Difficulty Urinating
Incontinence
Recurrent bladder infections
Changes in bowel or bladder function

ENDOCRINE:
Excessive thirst
Excessive urination
Hot flashes

GASTROINTESTINAL:
Diarrhea
Stomach pain
Constipation
Vomiting
Blood in stools
Tarry stools

GENERAL:
Fever
Weight loss
Excessive tiredness

THROAT:
Swallowing difficulty
Jaw pain on chewing

NEUROLOGICAL:
Frequent headaches
Paralysis on one side
Numbness on one side
Slurred speech
Double vision
Loss of Consciousness
Incoordination

OTHER:
Hallucinations,
Loss of Energy
Panic attacks
Appetite changes
Depressed mood
Sleep disturbances
Difficulty concentrating
Agitation or sluggishness
Diminished interest in activities
Feeling of Guilt/Worthlessness

EYE:
Blindness
Cataract
Glaucoma
Sudden vision loss in 1 eye

EARS:
Hearing loss
Vertigo
Recurrent ear infections

ALLERGIC:
Red eyes
Hives
Nasal congestion

SKIN: Rashes

Suicidal Thoughts- Y / N
Homicidal Thoughts -Y / N

CIRCLE ALL PREVIOUS TREATMENTS

Nonsteroidal anti-inflammatory drugs (NSAIDS)
Ibuprofen
Aleve
Naproxen
Motrin
Celebrex
Mobic

Lyrica, Neurontin
Pain medications
Muscle Relaxers

Physical Therapy
Chiropractor
Brace
Home Exercises
Acupuncture

Cervical Spine Injections
Thoracic Spine Injection
Lumbar Spine Injection
Epidural Injection
Facet Injections
Nerve Ablation
Spine Surgery

List other treatments: _____

ORTHOPAEDIC INJURY

WAS AN AUTOMOBILE INVOLVED? Yes No
WAS INJURY WORK RELATED? Yes No
LITIGATION PENDING? Yes No

Describe the injury or condition and specify EXACTLY how it happened :

_____

_____

_____

_____

Since the pain began/condition began it (Circle all that apply):

Improved Comes & Goes Worsened Stayed the same

What AGGRAVATES the pain? (Circle all that apply):

Walking Sitting Stooping/Bending Nothing in Particular
Standing Lying Down Activity in General

Other/comments:_____

What makes the pain BETTER? (Circle all that apply):

Walking Standing Heat or Cold Compress
Sitting Lying Down Nothing in particular

Other/Comments: _____

Are you experiencing any of the following (Circle all that apply):

Hand clumsiness Changes in handwritting
Dropping things Difficulty opening jars
Dexterity changes Off balance when walking

Symptoms interfere with SLEEP? Never Occasionally Frequently

Have you had a previous NECK problem? Yes No

Have you had a previous BACK problem? Yes No

Difficulty WALKING relating to presenting symptoms? Yes No

Do you use any ASSISTIVE DEVICE(s) for ambulation? Yes No
(e.g. Wheelchair, walker, cane, crutches, scooter, etc.)

If yes, which assistive device do you use? _____

*****STAFF USE ONLY*****

S.I. / H.I Verified : YES ☐ NO ☐

PATIENT NAME:_____ TODAYS DATE: _____ DOB:_____ AGE:_____

CURRENT MEDICATIONS:

Medication	Dosage	# of times taken a day

Do you take Aspirin or Blood Thinners? Yes No

If YES, circle one: **Preventative** OR **Prescribed**

If Prescribed list provider: _____

(List medication on lines above)

SURGICAL HISTORY:

List all prior **SPINE** surgeries:

Procedure	Date	Surgeon	Place

List all other **NON SPINE** surgeries:

Procedure	Date

PAST MEDICAL HISTORY- DO YOU OR DID YOU HAVE:

Yes	No	High Blood Pressure	Yes	No	GERD
Yes	No	Diabetes	Yes	No	Stomach Ulcers
Yes	No	Heart Disease (Murmurs, Attacks)	Yes	No	Seizures (Epilepsy)
Yes	No	Stroke	Yes	No	HIV/AIDS
Yes	No	Migraine Headaches	Yes	No	Pneumonia
Yes	No	Irritable Bowel Syndrome	Yes	No	Rheumatic Fever
Yes	No	Chest Pain	Yes	No	Venereal Disease
Yes	No	Cancer (If yes, Type: _____)	Yes	No	Colon Polyps
Yes	No	Lung Disease (Emphysema, Asthma)	Yes	No	Hepatitis
Yes	No	Arthritis	Yes	No	Gall Bladder Disease
Yes	No	Thyroid Problems	Yes	No	Prostate Problems
Yes	No	Kidney Disease	Yes	No	Sexual/ Menstrual Dysfunction
Yes	No	Gout	Yes	No	Depression, Anxiety
Yes	No	High Cholesterol	Yes	No	Anemia/Bleeding Problems
			Yes	No	Liver Disease

List Any Other Medical Problems: _____

List Any Implants/Stents/Medical devices:_____

(Please provide a copy of the implant ID card to check-in staff)

Name Of Pharmacy:_____

Phone # :_____City: _____

Fax #:_____

FAMILY HISTORY: Do you have a family history of the following?

(Circle all that apply):

Rheumatoid Arthritis	Back Problems	Stroke
High Blood Pressure	Neck Problems	Cancer
Osteoarthritis	Heart Disease	Diabetes
	Scoliosis	Other: _____

SOCIAL HISTORY (Circle all that apply):

Smoke: Yes No ___ Packs Per Day For____ years No, Quit in _____ Never A Smoker

Alcohol: Yes No Drink: Socially Moderately Heavily Occasionally Rarely Amount Per Week: _____

Illicit/Recreational Drugs: None Marijuana Cocaine Heroin PCP Meth Others (list): _____

Do you take any pain medications NOT prescribed to you? Yes No If Yes, list all: _____

Marital Status: _____ **How Many Children:** _____

REFERRAL SOURCE (Circle all that apply):

Primary Care Doctor Another Patient Online/Internet

Insurance Company Self-Referral TV/Magazine

Hospital (Name):_____ Other Advertisement

Other Physician (Name): _____

Other (Please explain): _____

WORK STATUS (Circle one):

Employed Yes No Employer: _____

If no, out of work since what date: _____

Reason for unemployment: _____

_____

Please use back page for additional writing space.

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PATIENT INFORMATION

Date:_____ Cell Phone:_____ Home Phone:_____

Name:_____ Soc. Sec. No: _____
LAST NAME FIRST NAME M.I.

Address: _____

City:_____ State:_____ Zip:_____

Sex: □ M □ F DOB:_____ Age:_____ □ Single □ Married □ Widowed □ Divorced

Employer Name:_____ Work Phone:_____

Referring Physician:_____ Primary Care Physician:_____
LAST NAME FIRST NAME LAST NAME FIRST NAME

Emergency Contact:_____Relationship:_____ Phone:_____

PRIMARY INSURANCE

Insurance Company:_____ Phone Number:_____

Insured ID/Member Number: _____ Group Number: _____

Insurance Address: _____

Responsible Party:_____ Relation to Patient:_____

DOB:_____ Soc Sec No:_____ Phone Number:_____

Address:_____

City:_____ State:_____ Zip:_____

*You must present the insurance card to our office for any insurance listed above. Otherwise, we will be unable to submit your medical claims to the insurance company listed.

ADDITIONAL INSURANCE

Insurance Company:_____ Phone Number:_____

Insured ID/Member Number: _____ Group Number: _____

Insurance Address: _____

Responsible Party:_____ Relation to Patient:_____

DOB:_____ Soc Sec No:_____ Phone Number:_____

Address:_____

City:_____ State:_____ Zip:_____

*You must present the insurance card to our office for any insurance listed above. Otherwise, we will be unable to submit your medical claims to the insurance company listed.

ASSIGNMENT AND RELEASE

I, the undersigned, certify that (or my dependent) have active insurance coverage as listed above and assign all benefits to the Spine Institute of Central Florida, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Spine Institute of Central Florida to release all information, demographic and/or medical, necessary to secure the payments of benefits. I authorize the use of my signature on all insurance submission.

_____ _____ _____
RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE

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1218 Millennium Parkway | Brandon, Florida 33511
Phone: (863) 688-3030 | Fax: (863) 688-4430
www.SpineInstituteFL.com

HIPAA Patient Consent Form

Spine Institute of Central Florida is required by law to provide individuals with a notice of our legal duties and Privacy Practices with respect to Protected Health Information (PHI). Our Notice of Privacy Practices provides information about how we may use and disclose PHI about you.

The Notice has a Patient Rights section that describes your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to expressly limit the disclosure of your PHI that is not related to payment, treatment or health operations, and such disclosures will not be made without additional authorization from you.

By signing this form, you consent to our use and disclosure of PHI about you. You have the right to revoke this Consent, in writing signed by you, at any time. However, such revocation shall not affect any disclosures that we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You understand that:

- You have the right to expressly limit the disclosure of your PHI that is not related to payment, treatment or health operations, and such disclosures will not be made without additional authorization from you.
- You understand that health information will be used or disclosed to certain business associates who are part of the health care process. These business associates will also keep your health information confidential.
- You may revoke this Consent in writing at any time and all future disclosures that are unrelated to treatment, payment, or health care operations will cease.
- The Practice has a Notice of Privacy Practices and you can obtain a copy of this Notice upon request.
- The Practice is required to maintain the confidentiality of your medical record.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The Practice may condition receipt of treatment upon the execution of this Consent.

Please sign this form to acknowledge receipt of the Notice.

I hereby acknowledge that I have received the HIPAA Notice of Privacy Practices.

This Consent was signed by:

_____
Printed Name – Patient or Representative

_____ ____/____/____
Signature Date

_____
Relationship to Patient (if other than patient)

Witness:

_____
Name

_____ ____/____/____
Signature Date

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Patient Consent to Treatment

PURPOSE: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy. This disclosure is not intended to alarm or frighten you, but rather make you better informed so that you may give or withhold your consent to the proposed treatment.

CONSENT TO TREATMENT: I voluntarily request Dr. Okafor as my physician and such associates, assistants, nurses, and other health care providers as he may deem necessary or advisable to treat my condition. I understand that it is my responsibility to actively participate in my care in order to maximize improvement in my condition.

I understand that I may undergo extensive diagnostic tests and examinations during my treatment at the Spine Institute of Central Florida. If I am unable or unwilling to undergo such testing, my treatment plan may be revised and my outcome may be affected. During the course of treatment, I may be required to make frequent follow-up visits to review diagnostic and therapeutic test results. Accommodations for patients traveling significant distances will be made as much as possible, but patients will be required to personally attend office visits for appropriate care and treatment of their condition.

I agree to keep my physician and authorized associate(s) apprised of any changes in my medical condition. Certain diagnostic tests, treatments, and drug therapies can be dangerous under certain medical conditions or medication use. Pregnancy is one such medical consideration and females must be certain to acknowledge this condition prior to diagnostic imaging and initiation of any medication therapy. Female patients who become pregnant during the course of their treatment at the Spine Institute of Central Florida will need to notify their physician.

I understand that treatment of my condition will be directed initially toward conservative management in an effort to avoid surgical intervention, unless I have a condition that medically requires surgery without conservative management. Also, failing conservative care, I may then be considered a potential surgical candidate.

This Consent was signed by:

_____
Printed Name – Patient or Representative

_____ ___/___/___
Signature Date

_____
Relationship to Patient (if other than patient)

Witness:

_____
Name

_____ ___/___/___
Signature Date

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Spine Institute of Central Florida
Lifetime Authorization Statement Assignment of Benefits for Direct Payment

Patient Name:_____ Date:_____

Policyholder/Insured: _____

Spine Institute of Central Florida, which will hence forth be referred to as SICF, is pleased that you have selected this group to provide for your medical needs. Please review the following Lifetime Authorization Statement. Please do not hesitate to ask a staff member for clarification on any part of this document. Please sign where indicated and return it to the receptionist. If you disapprove, we certainly respect your right of refusal. Signing this form will not increase patient financial responsibility; however, without your signature your insurance may not pay SICF for the services provided. This will leave the full billed charges as patient financial responsibility. Therefore, we will have no alternative but to require that you be responsible for the cost of services rendered in full, prior to the service being rendered to you. Should you refuse this option, we have no other choice than to cancel your appointment. Thank you very much in advance for your cooperation.

Assignment of Insurance Benefits; Financial Responsibility

SICF will work for and with you in an effort to obtain proper reimbursement from your insurance plan. An assignment of benefits will assist SICF in working with your insurance plan.

I assign all applicable health insurance benefits to which I and/or my dependents are entitled, to SICF. I certify that the health insurance information I have provided is accurate as of the date set forth below and that I am responsible for keeping it updated. I will use my best efforts to assist with submitting insurance claims.

I authorize SICF to submit claims, on my and/or my dependent's behalf, for payment to Medicare, or any other payer for services provided to me or my dependent. I also instruct my benefit plan (or its administrator) to pay SICF directly for the services rendered to me or my dependent. To the extent that my current policy prohibits direct payment to SICF, I instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and SICF upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to SICF.

I assign the right to appeal payment denial or other adverse decisions made by my benefit plan (or its administrator), as well as the right to file a complaint or grievance, bring suit, or pursue arbitration, to SICF on my behalf.

I understand that I am financially responsible for the billed charges for the services provided to me by SICF, regardless of my insurance coverage, and in some cases may be responsible for an amount in addition to that which is paid by my insurance, such as co-pay, co-insurance, deductible, and any remaining balance. I agree to immediately remit to SICF any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to SICF.

Lifetime Authorization Statement/Assignment for Direct Payment

I hereby instruct and direct my current insurance carrier to pay by check made payable to:
Spine Institute of Central Florida 5050 South Florida Ave, Lakeland, FL 33813

For the medical, surgical, and diagnostic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to SICF. I have agreed to pay, in a current manner, any balance of said service charges over and above this insurance payment, including applicable co-payments, deductible, non-covered services and items, unauthorized services or any fees denied, except to the extent my liability for any such balance is
limited by agreement or law applicable to SICF. A photocopy of this assignment shall be considered as effective and as valid as the original.

I understand that SICF does accept assignment for Medicare and payments will be directed to SICF. Should my account be referred for collection procedures, I will also pay reasonable attorney's fees and collection expenses.

Consent for Treatment

I authorize Spine Institute of Central Florida to provide treatment as necessary for which I am, or my minor child, is being seen. This includes, but is not necessarily limited to evaluations, radiographic services, injection, fracture care, casework, rehabilitation, or any other treatment deemed proper care of my injury, condition, or illness.

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Authorization to Release Information

I hereby authorize Spine Institute of Central Florida to release any medical information in connection with these services to any person or corporation which is or may be liable for all or any portion of the charges, including insurance companies, health care service plans, workers' compensation carriers, adjusters or attorneys, to the extent necessary to obtain reimbursement; Also to my personal physician, referring physicians, or primary care physician. **I am aware that any/all information contained within my medical records/chart is the Property of Spine Institute of Central Florida.** SICF may need to obtain information from other sources in order to receive appropriate reimbursement from all available insurance sources.

Request for Insurance Disclosure

I authorize and direct any holder of medical information or documentation that may include city, county, and state accident reports about me or my dependent to release such information to SICF, its billing agents, CMS, its carriers and agents and/or any other payers or insurers as may be appropriate to determine any benefits payable for these or any other medical services provided to me or my dependent by SICF.

Pursuant to Florida Statutes Section 627.4137 relating to disclosure of insurance information, I am requesting the required statement under oath of a corporate officer, insurer's claims manager, or superintendent setting forth the following information regarding each known insurance policy, including umbrella or excess insurance: a) name of each insurer b) name of each insured c) limits of liability coverage d) limits of uninsured motorist coverage e) a statement of any policy or coverage defense f) a copy of each policy. Please respond by sending the requested information to 5050 South Florida Avenue Lakeland, FL 33813 or by fax at 863-688-4430 within 2 weeks.

ERISA Authorization (Only Applies to Employer Sponsored Plans):

I hereby assign and designate SICF to act as my agent and/or authorized representative, to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("EIRSA"). I grant SICF the right to act on my behalf, as my agent, for the purpose of obtaining payment and/or reimbursement for all medical treatment and/or services rendered to me by SICF and its affiliates; including but not limited to: (a) make claims against insurers or other third-party payors; (b) initiate, prosecute, and/or defend litigation, arbitration, and all other legal remedies; (c) enforce my rights to benefits; (d) sue on my behalf; (e) recover expenses, damages, legal fees, penalties or fines, and interest fees from my insurer; and (f) pursue and receive benefits and direct payment from my insurer and/or third-party payor(s).

I further assign SICF and its affiliates the right to pursue any available administrative appeals on my behalf, and to pursue any cause of action, with respect to any healthcare expense(s) incurred as a result of the service(s) I or my dependent received or will receive from SICF; including claims for violations of ERISA, to the extent permissible by law. These rights include all rights to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies.

To the extent that the applicable insurance policy and/or employee health care benefit plan lawfully prohibits any such assignments described above, I authorize SICF to take the above actions on my behalf. I assign to SICF the right to act as my agent and/or authorized representative, enforce my rights to benefits, and pursue and receive direct payment from my insurer.

Additionally, I have granted SICF limited power of attorney to act on my behalf, for the purpose of enforcing my rights to benefits, obtaining payment and/or reimbursement for all medical treatment and/or services rendered to me by SICF and its affiliates; as well as arbitrate, make claims, sue, and initiate or continue any and all other legal remedies on my behalf, recover expenses, damages, legal fees, penalties, interest, fines from my insurer, and pursue and receive benefits and direct payment from my insurer or third-party payer. I have granted SICF full authority to act in any reasonable and necessary manner for the purposes of exercising the above powers. I understand and fully agree to grant this power for purposes described.

The undersigned certifies that he/she has read and fully understands all the above, and as the patient, guarantor, or the patient's responsible party, fully agrees to and accepts all the terms above.

Signature of Patient/Responsible Party Signature of Witness Date

[ ] Witness reviewed patient identification, which clearly matched identify of Signator, and witnessed signature. ____

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Spine Institute of Central Florida Irrevocable Assignment for Insurance Benefits and Assignment of Lien for Medical Services Rendered

Patient Name:_____ Date:_____

Policyholder/Insured: _____

I hereby assign to Spine Institute of Central Florida any and all rights I may have to insurance benefits. This Assignment includes any and all Personal Injury Protection coverage (PIP), health, disability, liability coverage, self-insurance, workers' compensation, or other insurance coverage.

I authorize and direct my insurance carrier or any insurance carrier, including third-party carriers responsible for payment in whole or in part of my health care bill; to pay directly Spine Institute of Central Florida all the insurance benefits otherwise payable to me, the patient, but not to exceed Spine Institute of Central Florida's usual and customary charges.

This assignment includes my right to obtain automobile crash reports, to file insurance claims, and to take all remedies to enforce payment of the insurance proceeds. I understand Spine Institute of Central Florida is under no obligation to bring any action against any party on its behalf, or on my behalf.

If I receive or become entitled to receive any monies from any source whatsoever for my injuries, either through a lawsuit, settlement of a lawsuit or claim, awarded by a court or arbitrator(s), jury verdict or payment of insurance proceeds, I hereby assign and agree to pay said funds to Spine Institute of Central Florida (at the address listed above to the extent of any outstanding amounts then owed by me to Spine Institute of Central Florida for medical services before any other fees, costs or expenses are disbursed from any said funds. I further agree that the fee for the services to be performed by Spine Institute of Central Florida shall constitute a lien on any claim or lawsuit I may have as a result of my injuries and any settlement, award, jury verdict, or insurance proceeds that I receive or become entitled to receive as a result of my injuries.

This Assignment and Lien shall be placed in my chart and a copy thereof shall constitute actual notice to my attorney, or any other person, that my medical bills to Spine Institute of Central Florida shall be paid first from the proceeds of any such lawsuit, settlement, award, jury verdict or insurance. This authorization cannot be modified unless it is in writing and signed by both parties. I understand that I remain personally responsible for the payment of all fees owed by me to Spine Institute of Central Florida and that notwithstanding this Assignment and Lien, Spine Institute of Central Florida is not required to look to any other person or entity for payment.

I have given authorization to Spine Institute of Central Florida to forward a copy of this document to my attorney. This assignment and Lien shall be effective regardless of whether it is countersigned by any such attorney.

I fully understand that any and all care and services that is provided by SICF is being provided in reliance to this agreement.

The undersigned certifies that he/she has read and understands all the above, and as the patient, guarantor, or the patient's responsible party, agrees to and accepts the terms.

_____

Signature of Patient/Responsible Party | Signature of Witness | Date

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Patient Financial Policy Agreement

Thank you for choosing the Spine Institute of Central Florida as your health care provider. We are committed to providing you with the best possible care. Payment of your bill is considered a part of our professional relationship and a clear understanding of our financial policy is important.

Insurance is a means of payment but does not relieve you from financial responsibility. Typically, insurance carriers have designated patient contributions in the form of co-pays, deductibles, and co-insurance amounts. These amounts vary widely between insurance providers and amongst the large variety of contracts within an insurance company. Because your insurance contract is between you, your insurance company and/or your employer, we encourage you to take an active role in understanding your benefits and out of pocket expense. As the insurance subscriber, you have the ability to obtain the most accurate and detailed information regarding your insurance plan. As a third party, Spine Institute of Central Florida does not have access to the same information that is provided to the insurance subscriber. Therefore, it is your responsibility to identify what services are covered, what services are not covered, what facilities are covered, and what your financial responsibility will be if you proceed to receive any service on any given day. Ultimately, payment of the charges for services rendered to you is your responsibility.

We participate with most major payers, which means that covered charges will be paid directly to us based upon your benefit plan. As a courtesy to you, we will file a claim with your insurance carrier on your behalf. Any remaining balance will be billed to you directly and will be due no later than 30 days from the date of the billing statement. You are responsible for payment until the account is paid in full.

If there is a remaining balance after we receive payment from your insurance carrier, you will be billed for that amount. Additionally, if payment from your insurance carrier is delayed beyond a reasonable amount of time (in no event greater than 90 days from the date of service), then you will be expected to immediately make payment, after which you can then contact your insurance carrier for possible reimbursement.

If your insurance carrier fails to pay your claim, they should explain to you why it was rejected. If you are dissatisfied with their rejection, or the amount they pay, it is your responsibility to take the matter up directly with your insurance carrier. Out of courtesy, we will be happy to file an appeal on your behalf, but please do not blame Spine Institute of Central Florida, and do not seriously jeopardize your credit rating by not paying your bill promptly. You are responsible for cooperating with requests for additional information and assistance with appeals.

It is your responsibility to provide all information necessary to facilitate “Coordination of Benefits (COB)” with your insurance payer(s) as quickly as possible; including appropriately updating your COB information with your insurance company and promptly completing and returning any COB related forms sent to you from your insurance company. Failure to provide this information to your insurance payer(s) in a timely manner will result in claim denials and non-payment from your insurance payer(s). If your insurance payer denies payment of any claims for failure to provide and/or delay in providing information necessary to facilitate “Coordination of Benefits;” you will be responsible for payment of all charges associated with the care provided to you.

If you do not provide your complete insurance information (including: a copy of my insurance card, member ID number(s),group number(s), name of the beneficiary, and date of birth of the beneficiary) to our facility to allow submission of charges for your medical care to your insurance payer or do not authorize us to file claims to your health insurance; you will be responsible for payment of all charges associated with the care provided to you.

Every insurance payer has a timely filing requirement. Therefore, if you provide your correct and complete insurance information to our facility after service has already been rendered, or if you do not authorize us to make submissions; you will be responsible for payment of charges for services rendered. When care is being provided for personal injuries sustained where there is third-party liability insurance, if your PIP/MedPay benefits become exhausted; charges for your care will be submitted to your predetermined, preferred payment source. Customarily, most insurances require medical claims to be submitted to your PIP/MedPay prior to being submitted to your health insurance carrier. Therefore, when written notice of PIP/MedPay benefit exhaustion is received by SICF; the services rendered to you will then be submitted to your predetermined, preferred payment source. If, at that time, the timely filing requirement for your predetermined, preferred payment source has

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passed; you are still ultimately responsible for payment of all charges for services rendered to you. However, we will still submit the claims on your behalf to provide your insurance payer with a record of your care.

Additionally, if your insurance payer requires prior authorization and the service has already been rendered to you; your insurance payer may deny the claim for lack of prior authorization. By initialing below, I agree to this process of claim submission and do understand that this may result in waiving my rights as a third-party beneficiary under the contract between SICF and my health insurance company; if, for example, the timely filing requirement is not met due to the process described above.

If your insurance denies payment of any claims for the reasons stated above, you will be responsible for payment of all charges associated with the care provided to you.

It is your responsibility to determine whether our facility is in-network or out-of-network with your insurance carrier. If we do not participate in your insurance plan, you may still choose to be seen by the practice and your claim may be eligible for “out-of-network” benefits, which typically result in additional out of pocket expense. It is your responsibility to determine what out-of-networks benefits, if any, are available to you. You will be responsible for payment of all charges that are not covered by your insurance; and all charges related to your out-of-network status. Again, to emphasize, you are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a primary care physician (PCP) before receiving services at Spine Institute of Central Florida, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your insurance company provides incorrect or misleading information to Spine Institute of Central Florida during prior authorization, when such information is relied upon, but actually different from your plan benefits; (iv) your health plan determines that the services you received at Spine Institute of Central Florida are not medically necessary and/or not covered by your insurance plan; (v) your health plan coverage has lapsed or expired at the time you receive services at Spine Institute of Central Florida; or (vi) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your insurance company directly.

We require you to present proof of insurance at each medical visit. If we are unable to verify your insurance or you do not have your insurance card, you will be considered a self-pay patient and payment will be due at time of service. Insurance status presented at time of service will be considered the final status for that visit and retroactive changes are not processed.

Consistent with insurance regulations, co-pays, deductibles, and co-insurance amounts are due at the time of service. We accept cash, Visa, MasterCard, American Express, and Discover for your convenience. Additional fees, which are typically not covered by your insurance plan, will be charged for services such as copying medical records, completion of disability forms, and other such services.

Interest and Attorney’s Fees, and No-Show Fees: On all accounts with balances greater than 30 days past due an 18% per annum interest will be charged. There will be a $50.00 charge for any no-show to office visit, physical therapy, and MRI appointments. There will be a $300.00 charge for any no-show to a scheduled in-office procedure. If you cancel your appointment less than 24 hours prior to your appointment, a fee of $25.00 will be applied to your account. As much as we hope to avoid collection activity, we must inform you that delinquent accounts may be assigned to collections agency and all collection costs will be added to your outstanding balances. You shall be responsible for all costs and expenses incurred in efforts to collect past due amounts from you, including interest charges, court costs, and reasonable attorney's fees. If my account is sent to a Collections Agency, I understand and agree that a 30% collection fee will be applied to the sum of my outstanding balance and applicable interest charges. In other words, your amount due will be increased by 30% of the total amount of your outstanding balance and applicable interest charges. Additionally, patients with delinquent accounts may be dismissed from our practice.

Overpayments: If you make a payment that results in a surplus on your account, you authorize Spine Institute of Central Florida to apply the overpayment to any other account for which you are financially responsible; including your

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account, a member of your family's or dependent's account, or on any account for which you are a financially responsible party, which has an outstanding balance. Any remaining balance will be promptly returned to you, but only if there are no further outstanding balances, unresolved and/or pending insurance payments for services provided.

Ancillary Services: You may receive ancillary medical services while a patient of Spine Institute of Central Florida such as: anesthesia, interpretation of tests, neuropsychological testing, imaging services (e.g., x-rays, MRIs) and pathology specimen examination. By signing below, you understand that some physicians may not provide services in your presence but are actively involved in the course of diagnosis and treatment. You authorize payment directly for these services under the policy(s) or plan(s) issued to you by your insurance carrier. You may incur additional charges as a result of these ancillary services. You agree to pay all charges due with respect to such services after benefits paid on your behalf by any third-party are credited to your account.

If your insurance company sends you a questionnaire, please complete and return it promptly or you will be asked to pay the bill directly.

All care and services provided by Spine Institute of Central Florida are being performed in good faith that you and/or your insurance will fully pay for services rendered, and in reliance of the financial policy agreement. For all services rendered by Spine Institute of Central Florida, you guarantee payment of your account at the time services are provided for any and all balances that are not paid by an insurance carrier, government payer, or other third-party payer (together, referred to as "PAYER"), including if your PAYER denies a claim after first approving it. You understand that any out-of-network charges may be your responsibility as determined by your PAYER. You acknowledge that you will be responsible for paying Spine Institute of Central Florida for items and services provided to your dependents under these same policies, terms, and conditions whether or not you are listed as the "Responsible Party" on the Patient Account. The person listed as the "Responsible Party" on the Patient Account will also be responsible to Spine Institute of Central Florida for payment. All charges incurred are your responsibility.

Medical Bills from Other Entities That May Occur Based on Prescription/Orders Placed By Spine Institute of Central Florida Medical Providers. These Other Entities/Medical Providers Will Bill You Separately:

Please remember that as part of your medical care if a specimen is taken from you (for example a bone biopsy or bone marrow aspiration) this is sent to a Pathologist or to a Laboratory for analysis. You may also have labs ordered by one of our medical providers, where you may go to another facility to get blood draws, urine samples processed, or have laboratory tests performed at other facilities. You may also have imaging studies ordered which are performed at other facilities.

It is important to remember that your medical bills with Spine Institute of Central Florida covers services provided by Spine Institute of Central Florida medical providers. The bill does not include charges for medical providers not employed by Spine Institute of Central Florida such as pathologists, anesthesiologists, radiologists, laboratory physicians, rehabilitation medical providers, or other physician consultants or specialist. You will receive separate bills from these physicians if they provide you service, and you will be responsible for those bills as well separate from bills from Spine Institute of Central Florida.

Additionally, your bill from Spine Institute of Central Florida does not include charges for care or work-up performed at any other entity, company or facility (for example independent laboratory facilities, etc.) You will receive separate bills from these other entities if they provided you service, and you will be responsible for those bills as well separate from bills from Spine Institute of Central Florida.

You must make arrangements directly with the other facilities/entities or medical providers to pay any medical bills due, as these are unrelated to your Spine Institute of Central Florida medical bills.

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Patient Financial Agreement:

I certify that the information that I have reported with regards to my insurance coverage is correct. I further authorize the release of any information necessary to my insurance company to determine benefits for services rendered. I request that payment of authorized benefits be made payable directly to the Spine Institute of Central Florida on my behalf.

I understand and agree that it is my responsibility to determine from my insurance company whether prior authorization or referral is required for any service I receive, including my initial evaluation and procedures, and to ensure such authorization is obtained prior to my appointments. Otherwise, I understand it will be my responsibility to pay all charges for services rendered to me.

After any service is rendered, I understand I am ultimately responsible for payment of the care provided. If my insurance company delays in making payment for any reason, I am responsible for payment of all charges associated with the care provided. I understand such payment will be due immediately and must be paid within 30 days from the date of the billing statement. After I have made payment of the full balance on my account, I may choose to seek reimbursement from my insurance carrier as needed. Ultimately, it will be between me and my insurance company as to whether or not I receive any reimbursement for payments made to Spine Institute of Central Florida.

I understand that if I do not agree with this Financial Agreement, full payment for each service received is required prior to each service. I acknowledge that when any service(s) is rendered at SICF without me first FULLY pre-paying for charges relating to such service(s), such service is only performed in reliance of this agreement. By signing this Agreement, I am voluntarily agreeing to all its terms and stipulations. I understand and agree that, regardless of my insurance status or any insurance company decisions, I am responsible for payment of the balance on my account for any service rendered. I have read the above Financial Policy and agree to be bound by it. I have provided the Practice with the true, correct, and complete insurance information. Finally, I will notify the Practice promptly of any changes in my health care insurance coverage.

Signature of Patient/Responsibility Party Signature of Witness Date

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PATIENT CONSENT TO MEDICATION MANAGEMENT & PRESCRIBED CONTROLLED SUBSTANCES

All medications are associated with risks, harmful interactions, and benefits. I understand whenever any medication is taken, I am accepting all the risks associated with the medication. These risks are included in the medication packet inserts.

The long-term use of controlled substances such as opiates (narcotic analgesics), benzodiazepines, and other sedatives are controversial because there are no proven long-term benefits associated with their use. What is certain is the risk of an addictive disorder (psychological dependence/physical dependence) developing, as well as the risk of relapse occurring in a person with a prior addiction. The use of benzodiazepines and other sedatives in conjunction with opioids, may significantly increase my risk of overdose. Overdose of opiate medication may cause injury or death by causing a person to stop breathing. Therefore, I understand the importance of avoiding changes in dosage and uses of benzodiazepines and other sedatives, when used in conjunction with opioids; unless instructed to do so by my treating physician.

I understand and accept that there may be unknown risks associated with the long-term use of substances prescribed. This medication can cause physical dependence, neonatal abstinence syndrome (if opioid medication is taken during pregnancy, the baby can also become dependent on the opioid medication); use of opioids may limit pain control options.

I understand that if pregnant and on controlled substances or opioids, my pregnancy may be adversely affected, and medication discontinuation or changes may be needed. Hence, I am responsible for notifying my doctor if I become pregnant, or if there is any possibility of pregnancy.

I understand there are many effective non-opioid alternatives available to me including: Acetaminophen (Tylenol), Non-steroidal Anti-inflammatory Drugs (NSAIDs), Nerve Pain Medications, Medicated Creams, Foams, Gels, Lotions, Ointments, Patches, Interventional Pain Management Injection Procedures, Rehabilitation Therapies, Behavioral and Mental Health Therapies; to name a few. If I request opioid medication and it is medically necessary, I understand that I am not obligated to fill said prescription nor am I obligated to consume the prescribed medication. I understand I do NOT have to take a single opioid; rather, I can use effective non-opioid alternatives as recommended by my treating physician. If I ever have any unused opioids or controlled substances, I understand to properly dispose of such medication(s).

The risks and potential benefits of these therapies are explained elsewhere and I acknowledge that I have received such explanation(s).

I will read each of the policies listed below and initial and sign in the spaces provided for me.

Medication Prescription and Refill Policies

- No prescriptions will be refilled on Saturdays, Sundays or Holidays.
- We require **3 business days** minimum to process prescription(s) renewal and/or pick-up requests for non-controlled substances.
- The patient is responsible for knowing when medications (s) will need to be refilled (no early refills).
- Prescription phone-in/pick-up: Monday-Friday during business hours **ONLY** (9am-4pm).

By initialing here, I am indicating that I have READ and FULLY UNDERSTAND every single line on this page of the Medication Management Agreement. _____

- Prescriptions will not be filled for unauthorized "walk-in" patients.
- Non-controlled/non-narcotic medication refills require follow up appointment not further than every **3 months**.
- Controlled-substances/narcotic prescriptions require a follow up appointment not further than every **30 days**.
- New symptoms and/or events require a clinic appointment. Provider unable to diagnose via phone.
- Signed "Controlled-Substance/Narcotic Policy" required if using narcotic/controlled medications.
- No early refills if medications are overused/abused/misused. Must follow prescription directions.
- No medication/prescription will be replaced if lost, stolen, misplaced, overused, etc. ***Treat like money.***
- Medications are for the prescribed individual's use only. It is illegal to "share" your medicine.
- Patient must pick-up his/her prescription(s) in person, unless pre-authorized by staff.
- Patients receiving ongoing opioid or controlled-substance(s) CANNOT miss appointments; and if this occurs, cannot get refills of controlled-substance(s) or opioid medication(s) until the next re-scheduled "Chronic Pain" appointment date.
- If receiving ongoing opioid medication(s) or controlled substance(s), or under the Chronic Pain Service, you cannot receive refills or get changes in your controlled medications or opioid medications by coming to the Orthopaedic Urgent Care, for reasons including but not limited to missing appointment, medication not being effective, medication getting lost. You must wait for your upcoming "Chronic Pain" clinic visit appointment. If you miss your scheduled "Chronic Pain" clinic appointment, you may not be able to refill the medication on time, and may even go into withdrawal, which could be uncomfortable.
- Whenever there is a change in your controlled medication(s), for your safety, you are required to follow-up 2-weeks following the date of your controlled medication(s) was adjusted or changed.
- I will notify my treating and/or prescribing Spine Institute of Central Florida physician of any change in my medical condition, including pregnancy for females. I will hold harmless Spine Institute of Central Florida for any risks/complications that develop for my failure to immediately notify my treating and/or prescribing physician of my pregnancy and/or if I consume any prescribed medication after becoming pregnant without expressly and directly being instructed by my physician to take such medication(s) while pregnant.
- I will take any and all prescribed medications only as directed by my physician or authorized associate.
- I will not obtain pain medications, or any controlled medications from more than one physician, I will not be involved in "doctor-shopping", I will NEVER request early refills, and will NEVER request replacement of lost or stolen medications or prescriptions.
- I will NOT request refills after hours, on weekends, or on holidays. Controlled medications can NEVER be provided after hours.
- I will fully read the packet inserts of prescribed medications, in order to fully understand the risks and benefits of each prescribed medication. I will present any questions or concerns that may arise after reading the inserts to my physician.

By initialing here, I am indicating that I have READ and FULLY UNDERSTAND every single line on this page of the Medication Management Agreement. _____

- I will submit to random urine or blood prescription monitoring testing to ensure medications are utilized properly and as prescribed and that no illegal substances are present. I do acknowledge that if I do not present for the random urine or blood drug screen when requested I may no longer be able to receive any future controlled medication(s) or opioid medications from Spine Institute of Central Florida, and if receiving treatment under the Chronic Pain Service, I may be discharged from the Chronic Pain Service.

- If receiving treatments for Chronic Pain, or under the Chronic Pain Management Service, I acknowledge that Urine Drug Testing will be required for all Chronic Pain clinic visits. I understand and agree that I will submit to urine drug testing during each Chronic Pain clinic appointment, to ensure medications are utilized properly and as prescribed and that no illegal substances are present. Additionally, I understand and agree that I must present to each of my Chronic Pain Management appointments with my pill bottles for all controlled medications that have been prescribed to me.

- I realize that it is my responsibility to keep others and myself from harm, this includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve. This applies to all medications prescribed by Spine Institute of Central Florida.

- Opioid use significantly increases the risk of having a fall, especially in older adults, which hence directly increases the risk of morbidities resulting from falls, such as serious fractures and other more severe injuries. Opioid use can also lead to cognitive impairment.

- I will keep all medications prescribed to me by Spine Institute of Central Florida, out of the sight and reach of children. **Accidental or deliberate ingestion by a child may cause respiratory depression that can result in death. If a child is exposed to one of your prescriptions medications, you MUST seek immediate medical attention.**

- I do understand that Spine Institute of Central Florida medical providers will NOT negotiate with me on what medication(s) to prescribe. Spine Institute of Central Florida medical providers will provide me with treatment that they recommend, and will explain to me why the treatment is being recommended.

- If receiving treatment for Chronic Pain, I am required to concurrently receive treatment with the Clinical Psychologist at Spine Institute of Central Florida as per Center for Disease Control and Prevention (CDC) Guidelines. This will help maximize my response to treatments, and improve symptoms while also minimizing my dependence on opioid medication(s). Such Clinical Psychology appointments will also teach me pain coping skills.

- I do understand that while receiving treatment for Chronic Pain, I will NOT only focus on opioid medications for my treatment. I will follow advice of my treating providers, and will follow recommendations that involve also including other non-opioid related treatments with the aim of reducing my symptoms and discomfort and improving my functionality and quality of life; while minimizing the risks of treatment.

- I fully understand that Spine Institute of Central Florida and its providers are only responsible for providing medically necessary prescriptions to you. Spine Institute of Central Florida is NOT responsible for your successfully filling the prescribed medications. If your pharmacy does not carry the medication, or does not have enough in stock to fill your prescription, or if your pharmacy refuses to fill your prescription; it will be between you and the pharmacy. You may choose to find another pharmacy and change your pharmacy. That is fully up to you to make that decision. You must notify Spine Institute of Central Florida of your new pharmacy so as to update your records. You fully understand that Spine Institute of Central Florida will not be able to help you if you have a properly written prescription involving a medication that is not in national back order. Once you have a properly written prescription, it is your responsibility to find a Pharmacy that will be able to fill such medication for you.

By initialing here, I am indicating that I have READ and FULLY UNDERSTAND every single line on this page of the Medication Management Agreement. _____

- I understand it is extremely dangerous to self-administer non-prescribed benzodiazepines or other central nervous system (CNS) depressants (including alcohol) while taking your prescribed controlled substance(s).

- I will not use any illegal substances (cocaine, heroin, methamphetamine, LSD, marijuana, "crystal meth", ecstasy, ketamine, mushroom, speed, etc.) while being treated with controlled substances. Violation of this will results in the cessation of the prescribing of any controlled substances and termination of care at Spine Institute of Central Florida effective immediately. Due to risks of death, there will be zero tolerance for using controlled medication(s) and illegal substances. If you are found to be using illegal substances while on the Chronic Pain Service, you will be immediately discharged from Spine Institute of Central Florida Chronic Pain Service, and will no longer receive any further controlled substances at Spine Institute of Central Florida.

- I will not alter my medication in any way (for example crushing or chewing tablets) or use any other auto-delivery (for example injection or insufflations) other than as prescribed by Spine Institute of Central Florida.

- I do understand that if for any reason following assessment(s) or evaluation(s), I am placed at a high-risk pool for opioid related morbidities or misuse; I may have to be monitored closer, with more frequent evaluations, urine drug screens, psychological assessments for my own medical safety, so as to minimize risks to myself and others.

- I fully understand that disruptive and combative behavior will never be tolerated under any situation. As there are other patients at the facility receiving very serious medical treatments. And for the respect of all patients, medical staff and myself, I will NOT at any time be disrespectful of staff or medical providers, and will not be combative or argumentative because I did not get the medication or treatment that I was requesting. I do understand that there will be zero tolerance for combative and disruptive behavior. And if this occurs, I will be immediately discharged from Spine Institute of Central Florida.

- I do understand that from time to time blood work may be needed if on ongoing chronic medications, and will follow any recommended blood work to ensure there are no adjustments needed in my medications for my own safety.

- I understand that changing date, quantity or strength of medications or altering a prescription in any way, shape or form is against the law. Forging prescriptions or the provider's signature is against the law. We will fully cooperate with law enforcement agencies locally as well the Drug Enforcement Agency (DEA) regarding any infractions involving prescriptions medications. Violation of the law will be reported to the patient's pharmacy, local authorities and the DEA.

- If I receive any opioid medication from Spine Institute of Central Florida, I will discontinue and properly dispose of all prior pain medications in my possession. Additionally, if I receive and fill any opioid medication prescription(s) from Spine Institute of Central Florida, I agree to inform my other treating physicians that I am under a controlled substance agreement at Spine Institute of Central Florida.

- I agree to address any concerns or issues regarding my treatment with my physician or authorized associate.

By initialing here, I am indicating that I have READ and FULLY UNDERSTAND every single line on this page of the Medication Management Agreement. _____

PLEASE CONTINUE TO NEXT PAGE

- I agree to obtain my prescriptions from one pharmacy. The pharmacy I have selected is:

  Name:_____

  Locations:_____ Phone:_____
- I understand that any violation of the policies contained herein may result in my permanent and irreversible discharge from the Spine Institute of Central Florida.

These protocols are per recommendations of the DEA

I, _____, understand, accept and agree to the protocols listed above, and agree with each item of this contract, and understand that I may choose to seek care elsewhere if I am not willing to follow this agreement. I understand that failure to comply will lead to immediate termination of all prescription medications.

This consent was signed by:

_____
Printed Name – Patient or Representative

_____ _____/_____/_____
Signature Date

Witness:

_____
Name

_____ _____/_____/_____
Signature Date

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Authorized Designee (s)

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

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of the designated parties must be verified before the release of any information.

Authorized Designees	Relationship	Telephone #	Able to leave message on Voicemail	Release Medical Information (treatment and/or operative information)	Appointment Information	Billing Information
			Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N

Privacy/Appointment Reminders

To be able to communicate your scheduled upcoming treatments, any relevant co-payment information, or any important medical information or finding(s), it is important to be able to have your best contact number, and authorization to contact you to leave a message on your voicemail at a specified phone number and/or to notify you of any important information as needed.

Patient Signature **Date**

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Appointment Cancellation/No-show Policy Agreement

Spine Institute of Central Florida is committed to providing every patient with exceptional care. When an appointment is made with our office, the provider blocks up to an hour of time on their schedule**.** When a patient cancels without giving sufficient notice, it prevents another patient from being seen. Late cancellations/no-shows not only prevent other patients from receiving help, but it also globally leads to an increased cost of healthcare for everyone.

The following cancellation policy applies to the appointment type(s) listed below:

- Physical Therapy Appointment
- Clinical Psychology Appointment
- Advanced Imaging (MRI) Appointment
- Any Office Visit Appointment

To help ensure that patients receive appointments as soon as possible, please call us at (863) 688-3030 by 12:00 PM at least two days prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 12:00 PM on Thursday. If prior notification is not given, you may be charged $50.00 for the missed appointment.

Major Surgery and Small Procedure Cancellation Policy

A) Major surgery- Any surgery performed at a Hospital (not including Spinal injections)

- Cancellation 4-7 days from scheduled surgery date - $300 cancellation fee will be assessed.
- Cancellation 3 days or less from scheduled surgery date - $600 cancellation fee will be assessed.

B) Minor procedures- (Example: Injection, Rhizotomy/RFA, Kyphoplasty Procedure)

- Cancellation 3 days or less from procedure/injection date - $300 cancellation fee will be assessed.

I have been given these instructions and I fully understand them. All questions were answered to satisfaction.

Patient Name: _____ Patient Signature_____

Date of birth: _____ Date: _____

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Patient Name: _____ Date: _____

During the examination, the doctor may feel that X-Rays will be needed inorder to diagnose my condition. I understand the risk of harm to body/organs from radiation exposure. My doctor may in addition require x-rays (which may include very special spine spine or extremity views) in order to properly and most effectively administer treatment(s).

By signing below, I consent to having the diagnostic x-rays performed, which the doctor determines is clinically necessary.

_____ _____
Patient Signature Date

Below ONLY For **FEMALE PATIENTS < 50 YEARS OLD**

To the best of my knowledge, I am NOT pregnant. I have been advised that there can be risk of harm to a fetus with x-rays. I do not wish to undergo a pregnancy test, and refuse to have one performed.

I authorize Spine Institute of Central Florida to perform x-rays.

Female Patient Signature: _____

Witness Signature: _____

****FEMALE PATIENTS <50 YEARS OLD:** PLEASE FILL OUT BOTH SECTIONS ON THIS FORM.