JAX SPINE&PAIN CENTERS

NEW PATIENT INFORMATION PACKET

Visit date: ___ /___ / ____

PATIENT INFORMATION

Name: _____ DOB: ___ /___ / ____ Sex: ☐ M ☐ F

Address: _____ City: _____ State: ____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

SSN: ____ -____ - _____ Marital Status: _____ Ethnicity: _____

GUARANTOR INFORMATION

Name: _____ DOB: ___ /___ / ____ Relation to Pt.: _____

Address: _____ City: _____ State: ____ Zip: _____

PATIENT INFORMATION

Primary Insurance: _____

ID#: _____ Grp #: _____

Address: _____

City: _____ State: ____ ZIP: _____

Phone #: ___-___-_____ Effective date: _____

Policyholder's Name: _____

Policyholder's Date of Birth: ___ /___ / ____

Policyholder's Employer: _____

EMP Phone: _____

Secondary Insurance: _____

ID#: _____ Grp #: _____

Address: _____

City: _____ State: ____ ZIP: _____

Phone #: ___-___-_____ Effective date: _____

Policyholder's Name: _____

Policyholder's Date of Birth: ___ /___ / ____

Employ Address: _____

Emp City, State, Zip: _____

AUTO/WORKER'S COMP INFORMATION

Date of Accident: ___ /___ / ____ Insurance Co Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Claim # _____ Contact Person: _____ Tel#: _____

Policyholder Employer: _____ Employer's Address: _____

Employee Phone: ___-___-_____ Emp City, St, Zip _____

EMERGENCY CONTACT

Name: _____ Relation to Patient: _____

Tel #: _____ Work #: _____ Cell #: _____

I hereby authorize Jax Spine & Pain Centers to release to my insurance company any information acquired in the course of my examination or treatment which is necessary to process claims for services rendered. I hereby authorize and direct my insurance carrier to pay directly to Jax Spine & Pain Centers any benefits due me under my insurance plan. I certify that the information above is correct and I understand that any remaining unpaid balance after contractual discounts are taken into consideration will be my responsibility.

Signature: _____ **Date:** _____

JAX SPINE & PAIN CENTERS
10475 Centurion Parkway North, Suite 201 Jacksonville, FL 32256
Telephone: (904)223-3321 Fax: (904)223-2169
Christopher Roberts, M.D. | Claudio Vincenty, M.D. | John Carey, M.D., M.S.
Michael Hanes, M.D. | Justin Mann, M.D. | Hares Akbary, M.D. | Aravind Reddy, M.D.

Accident and/or injury details:_____

Is this an auto accident? YES NO

If so, please give the name of your auto insurance company:

Adjustor's name:_____

Claim number: _____ Date of accident: _____

Have you retained an attorney for this accident? YES NO

If so, please give name and phone number or your attorney:_____

Have you ever filed for disability? YES NO

Were you referred by a physician for this visit? YES NO

If yes, please write his name

Primary Care Physician's name

Write the name of the physician you would like us to update regarding your care

_____ _____

How did you hear of Jax Spine and Pain Centers?		
☐ Web (Please specify below)	☐ Print (Please specify below)	☐ Radio (Please specify below)
☐ Family/Friend	☐ Other	

Did you visit our website before your visit? YES NO

Was it helpful? YES NO

Any suggestions for improvement? _____

_____ _____

_____

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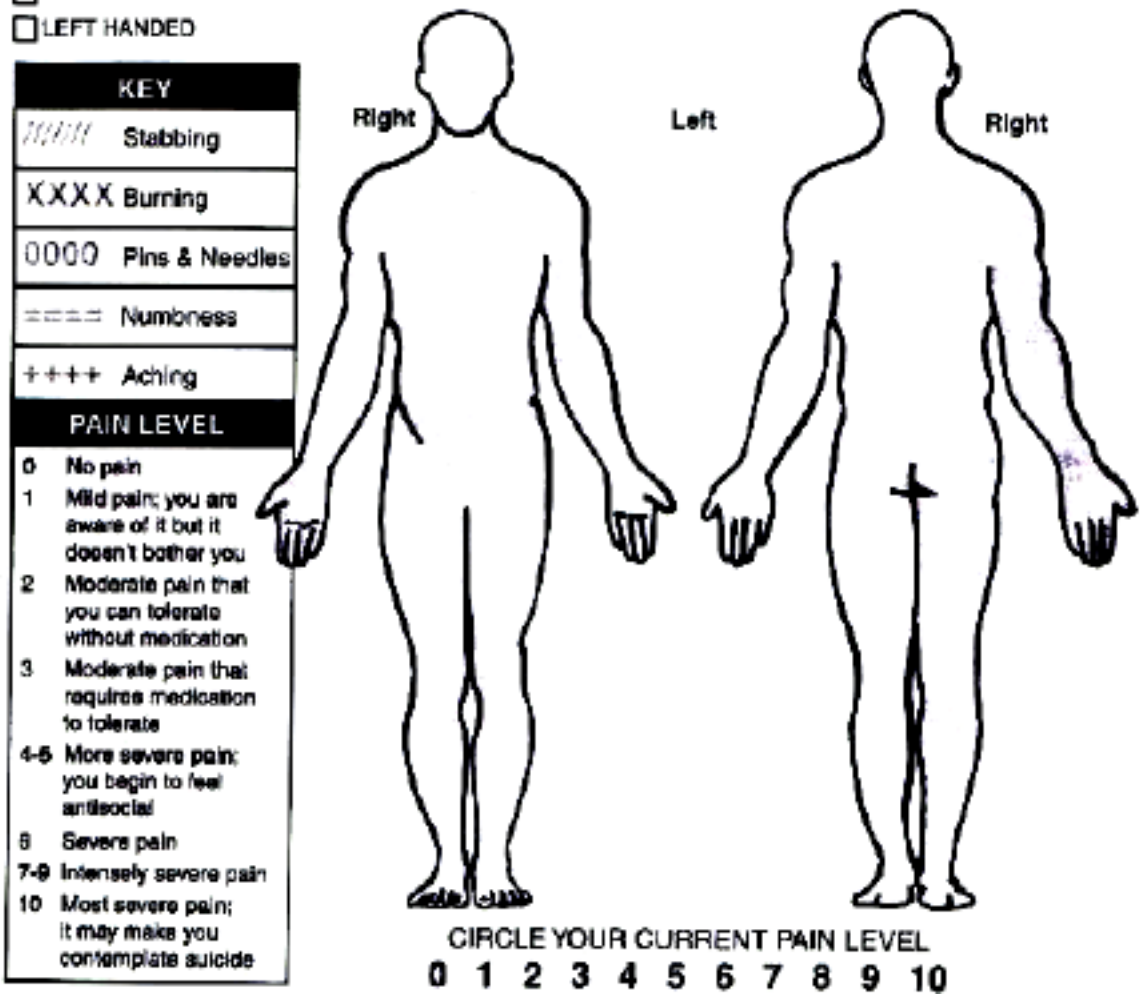
Describe the main reason for your visit today:_____

Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

☐ RIGHT HANDED
☐ LEFT HANDED



When did your pain start? _____

How did your pain start? _____

Is the pain constant? YES / NO

What makes your pain worse? _____

_____ _____

What makes your pain better? _____

_____ _____

Do you experience any weakness? YES / NO If yes, where? _____

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Do you experience any numbness? YES / NO f yes, where? _____

Have you had this pain before? YES / NO If yes, what caused it before?_____

How many physicians have you seen for this problem over the past 12 months? _____

How many times have you been to the emergency room for your pain? _____

✓	Previous Treatments
☐	Medications
☐	Physical therapy
☐	Psychological counseling/Group therapy
☐	Biofeedback
☐	Acupuncture
☐	Chiropractor
☐	TENS unit
☐	Relaxation techniques/Massage therapy
☐	Trigger point injections
☐	Nerve blocks
☐	Epidurals
☐	Facet blocks
☐	Radiofrequency ablation
☐	Other (please specify):

✓	Previous studies
☐	X-rays
☐	CT scans
☐	MRI
☐	Myelogram
☐	Nerve conduction studies
☐	Discogram
☐	Bone scan
☐	Special injections
☐	Other (please specify):

Have you tried any of the following pain medications?

✓	Medication Helpful?	Helpful?	Side effects (please specify)?
☐	Neurontin (Gabapentin)	YES / NO	
☐	Lyrica (Pregabalin)	YES / NO	
☐	Topamax (Topiramate)	YES / NO	
☐	Cymbalta (Duloxetine)	YES / NO	
☐	Milnacipran (Savella)	YES / NO	
☐	Elavil (Amitriptyline)	YES / NO	
☐	Pamelor (Nortriptyline)	YES / NO	
☐	Ultram (Tramadol)	YES / NO	
☐	Zanaflex (Tizanidine)	YES / NO	
☐	Flexeril (Cyclobenzaprine)	YES / NO	
☐	Robaxin (Methocarbamol)	YES / NO	
☐	Skelaxin (Metaxalone)	YES / NO	
☐	Other:	YES / NO	

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Past Medical History	✓
Alcoholism	☐
Allergies	☐
Asthma	☐
Alzheimer's/Dementia	☐
Anemia	☐
Arthritis	☐
Birth defects	☐
Bleeding disorder	☐
Cancer	☐
Connective tissue disorder	☐
COPD/Emphysema	☐
Depression/Anxiety	☐
Diabetes	☐
Drug addiction	☐
Glaucoma	☐
Heart attack	☐
Heart disease	☐
Hepatitis C	☐
High blood pressure r	☐
HIV/AIDS	☐
Irritable bowel syndrome	☐
Kidney Disease	☐
Liver disease	☐
Migraine headaches	☐
Osteoporosis	☐
Peripheral neuropathy	☐
Seizure disorder	☐
Sickle Cell Anemia	☐
Stroke	☐
Vascular disease	☐

Family Medical History	✓	Family Members Affected
Alcoholism	☐	
Allergies	☐	
Asthma	☐	
Alzheimer's/Dementia	☐	
Anemia	☐	
Arthritis	☐	
Birth defects	☐	
Bleeding disorder	☐	
Cancer	☐	
Connective tissue disorder	☐	
COPD/Emphysema	☐	
Depression/Anxiety	☐	
Diabetes	☐	
Drug addiction	☐	
Glaucoma	☐	
Heart attack	☐	
Heart disease	☐	
Hepatitis C	☐	
High blood pressure r	☐	
HIV/AIDS	☐	
Irritable bowel syndrome	☐	
Kidney Disease	☐	
Liver disease	☐	
Migraine headaches	☐	
Osteoporosis	☐	
Peripheral neuropathy	☐	
Seizure disorder	☐	
Sickle Cell Anemia	☐	
Stroke	☐	
Vascular disease	☐	

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MEDICATIONS

Please list all medications and dosage:

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES / NO
IF YES, PLEASE LIST

DO YOU TAKE ANY BLOOD THINNERS? YES / NO
IF YES, CHECK ALL THAT APPLY:

☐	Aspirin	☐	Xarelto (Rivaroxaban)
☐	Plavix (Clopidogrel)	☐	Eliquis (Apixaban)
☐	Warfarin (Coumadin)	☐	ReoPro (Abxicimab)
☐	Lovenox (Enoxaparin)	☐	Integrilin (Eptifibatide)
☐	Effient (Prasugrel)	☐	Aggrastat (Tirofiban)
☐	Brilinta (Ticagrelor)	☐	Plital (Cilostazol)
☐	Pradaxa (Dabigatran)	☐	Persantine (Dipyridamol)

Pharmacy Information

Pharmacy Name	
Pharmacy Address	
Pharmacy Phone/Fax	

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REVIEW OF SYSTEMS

Have you had a weight loss or gain of more than 10 pounds in the last 12 months?	YES	NO
Do have trouble with nausea or vomiting?	YES	NO
Do you have trouble with diarrhea?	YES	NO
Do you have hepatitis, jaundice or cirrhosis?	YES	NO
Do you have blood in your urine?	YES	NO
Do you have a kidney infection?	YES	NO

SURGICAL HISTORY:
List name and year of major surgeries:

Date of your last menstrual period: _____

Are you taking birth control pills?	YES	NO

HEMATOLOGY:

Do you experience any excessive bleeding/bruising?	YES	NO
Are you on any blood thinners?	YES	NO

IMMUNE SYSTEM:

Do you constantly experience dry mouth?	YES	NO
Do you have any swollen glands in your neck?	YES	NO
Do you catch infections easily?	YES	NO
Have you ever taken any recreational drugs?	YES	NO
Do you have any skin problems?	YES	NO

NEUROLOGICAL:

Have you ever had seizures or taken medication to control seizures?	YES	NO
Do you have fainting spells or dizziness?	YES	NO
Do you have weakness or numbness in your arms or legs?	YES	NO
Have you ever experienced a head injury?	YES	NO

If so, explain when and how. _____

WELLNESS PROFILE:

Have you been less social lately?	YES	NO
Have you been feeling sad or depressed?	YES	NO
Are you being treated by a psychiatrist or psychotherapist?	YES	NO
In the past twelve months, have you had thoughts of suicide?	YES	NO

SLEEP PROFILE:
How many hours per night do you sleep?_____

Do you have trouble falling asleep?	YES	NO
Do you have trouble staying asleep?	YES	NO
Does pain awaken you?	YES	NO

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What is your: Height_____ Weight_____

What are the ages of your children and their current health condition?

_____

_____

_____

How many people live in your household?_____

What is your current occupation? _____

How do you spend an average day? _____

Do you smoke? YES NO If so, how much? ____ pack(s) per _____day

Have you ever smoked in the past? YES NO When did you quit?_____

Do you consume alcohol? YES NO How often? ____ drink(s) per _____week

Have you experienced any problems related to alcohol consumption (DUI, injury)? YES NO

If so, please explain:

_____

_____

Is there any other information you would like to provide that would help us to better understand the problems that you are experiencing?

_____

_____

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PRESCRIPTION LOG

I hereby authorize the following person(s) to pick up prescriptions on my behalf from: Jax Spine & Pain Centers

Name:	Relationship to Patient:	Ph:
Name:	Relationship to Patient:	Ph:
Name:	Relationship to Patient:	Ph:

Patient Signature: _____ _Date:_____

Witness: _____ Date:_____

Patient Prescription Pick-Up Log

Date	Prescription	Person

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FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the office, we have adopted the following financial policy. If you have any questions, please discuss them with one of our patient billing representatives. We are dedicated to providing the best possible care to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- Payment is due at the time of service unless other arrangements have been made in advance. For your convenience, we accept cash, check, MasterCard, Visa, Discover, and American Express credit cards.

- Your insurance is an agreement between you and your insurance company. As a courtesy to you, we will file your insurance claims for you if you assign benefits to the physician. If your insurance company does not pay within a reasonable period, we will look to you for payment, If we later receive a check from your insurer, we will refund any overpayment to you.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered”; you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. We highly recommend that you READ YOUR INSURANCE BOOKLET or a copy of the contract your policy falls under to determine your benefits.

- You will be responsible for promptly responding to your insurance company to provide any additional information they may request regarding your treatment, pre- existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in your account becoming due and payable, in full immediately.

- Be prepared to present your insurance card and proof of identity (e.g. driver’s license) at each visit. You will be responsible for providing a change of address, telephone number and/or insurance information anytime a change occurs.

- A prepayment of your deductible and coinsurance will be required for your portion of our fees, based on our contract with your insurance agreement. Any balance remaining, after your health plan pays, is your responsibility. Payment is due upon receipt of a statement from our office.

- We will look to the adult accompanying a minor for payment of all services rendered to minor patients.

I/we understand and agree that any unpaid charges shall be paid promptly In accordance with terms of this agreement. Jax Spine & Pain Centers may add one and one half percent (1.5%) per month to any balance owed, and in the event of default, I/we agree to pay reasonable collection charges, not to exceed 30% of the unpaid balance at the time the account is assigned to a collection agency, and/or attorney fees, court costs and post judgment and interest as allowed by state law

Patient Printed Name _____ Patient Signature_____

Witness Signature _____ Date_____

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PATIENT/DOCTOR TREATMENT & MEDICATION AGREEMENT

The Jax Spine & Pain Centers is primarily an interventional practice as opposed to a pain medication management practice. The purpose of this Agreement is to prevent misunderstandings about certain medicines you might be prescribed for a pain management. This is to help both of you and your doctor to comply with the law regarding controlled pharmaceuticals. This Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and the trust that my doctor undertakes to treat me based on this Agreement.

By signing this agreement you will have read, understood, and agreed to these rules:

I will submit to an evaluation by an addictionologist, which may include a psychiatric evaluation and subsequent treatment.

If I break this Agreement, my doctor may stop prescribing these pain-control medicines and I may be DISCHARGED from the practice.

I will keep Jax Spine & Pain Centers notified OF MY CURRENT PHARMACY AND THEIR PHONE NUMBER.

I agree to use only this pharmacy for ALL OF MY PRESCRIPTIONS.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use ANY ILLEGAL controlled substances, including but not limited to: marijuana, cocaine, methamphetamines, etc.

I will not SHARE, SELL, or TRADE, my medication with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor or practice.

I will SAFEGUARD my pain medicine from loss or theft. Lost or stolen medicines WILL NOT be replaced.
Refills of my prescriptions for pain medicine will be made only during regular office hours. ALL refill requests must be made THREE business days in advance. NO REFILLS WILL BE AVAILABLE DURING EVENINGS, WEEKENDS, OR HOLIDAYS.

I understand that I MUST BE SEEN EVERY NINETY DAYS to request a refill or my refill will be denied until I am seen.

I authorize my doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation or any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I will submit to a blood or urine test if requested by my doctor to determine compliance with my program of pain control medicine.

I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

If at any time I break my medication contract, I am aware that the Jacksonville Sheriff's Office may be notified and my records could be released to them.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment and medications have been adequately answered. A copy of the Agreement has been given to me.
This Agreement has been reviewed and signed on this _____ day of _____ in the year of _____.

Patient Name: _____ Patient Signature: _____

Witnessed by: _____ Doctor Signature: _____

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SUMMARY OF THE FLORIDA PATIENT'S BILLOF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider. A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, also known as Persona Injury Protection (hereinafter PIP), and Medical\Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. I understand the provider may file a lawsuit against my insurer for payment and if the provider's bills are paid or applied to a deductible I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

The insurer is directed by the provider and the undersigned not to issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

If the insurer schedules a defense examination or examination under oath {hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. 1 agree to pay any applicable deductible, co-payments, for services rendered after the proof of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of Information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax , or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and un-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay any bills within 30 days without reductions and to mail the latest un-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care: I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. Please ask to view a copy of our charges. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name:_____Patient's Signature:_____Date_____(Please Print)