SOUTHERN ORTHOPEDIC SPECIALISTS, P.A.

1827 Harrison Avenue
Panama City, FL 32405

PATIENT INFORMATION

1. **INTRODUCTION**

Welcome to Southern Orthopedic Specialists, P.A. This pamphlet provides information that we hope will foster a pleasant and effective relationship between patient and physician and contribute to better understanding of how to serve you, the patient. If you have further questions, please do not hesitate to ask any member of our staff.

2. **APPOINTMENTS**

A. If you are unable to keep your appointment please call the office and cancel it at least 24 hours in advance, otherwise we charge a $25 no-show fee.

B. The physicians and staff work hard to see patients on time. If you have to wait to be seen it is for an unavoidable reason. We are obliged to see emergencies and patients referred on an urgent basis by other physicians. Some patients require an unexpected amount of time due to unforeseen complications or problems. For these reasons, we are occasionally behind schedule. We ask for your understanding in those situations.

C. Please complete our new patient forms and bring them with you at the time of your first visit.

3. **CHARGES**

A. Charges made for surgical procedures cover post-op office visits for a period of time determined by your insurance company, varying from 7 to 90 days. The surgery charges do not cover x-rays or cast changes made relative to the surgery.

B. Charges for fracture treatment cover all office visits related to the fracture for a period of time determined by your insurance company, varying from 7 to 90 days. The fracture charges do not cover x-rays or cast changes.

C. If it is determined that you are going to need to have surgery, our office will call your insurance company to determine what portion of the surgery your insurance will cover. Someone from our insurance department will then contact you and inform you of approximately how much you will owe the physician. Patients will be expected to pay their portion of an elective surgery prior to it being performed. Self-pay patients will also be responsible for paying a portion of their surgery in advance as well.

4. **BILLING**

A. Statements are sent out at the end of each month.

B. A statement will be sent to you even though your insurance company may be responsible for the payment. This allows you to keep track of how well your insurance company is serving you. Your statement will reflect the date on which your charges are filed to your insurance company. This will give you some idea as to how long it takes your insurance company to process your claim.

5. **TREATMENT POLICIES**

A. Most orthopedic problems can be treated by non-surgical means and every such means available that is indicated in the treatment of your particular illness will be exercised before surgical treatment is recommended.

B. Satisfactory results are not guaranteed for any type of surgical procedure as there is not a single operation that is 100% successful. Results of surgery are affected by genetics, life style and patient cooperation as well as surgeon skill. Medicine is also not an exact science. If surgery is recommended to you, the probability of a successful outcome will be explained to you. If you do not understand the reasons for the surgical procedure, its chances of success, or its possible complications, please ask us. Also, do not hesitate to ask us the charge for a particular operation if you desire that information.

C. An adult must accompany all patients under 18 years of age.

6. **MEDICATIONS**

Narcotic medications are prescribed only for patients in severe pain. Narcotic medications are not kept in the office. Requests for all prescription refills should be made before 3:00p.m. Requests received after 3:00p.m. will be addressed the next business day. We do not prescribe prescriptions after business hours, on weekends or holidays.

7. **MEDICAL RECORDS**

A. Medical records will be sent to your insurance companies, attorneys, other physicians, etc. upon request of that person in writing.

B. You must sign a statement authorizing the release of information before this information can be sent to anyone.

8. **X-RAYS**

As a way to better serve you, Southern Orthopedic Specialists converted to digital x-ray. We are now able to make a disc of the x-rays that are taken at our office. If you would like a copy of these x-rays there will be a charge of $15 to make a disc. If your x-rays were taken before we converted to digital x-ray and you would like a copy please let us know at least 24 hours in advance. There will be a charge of $5 per sheet of film copied.

9. **DME**

In an effort to serve you faster and more thoroughly we have an on-site durable medical equipment department. For those patients that are in need of a brace and have a qualifying insurance policy we carry the most commonly used orthopedic braces. To insure that you are getting a quality brace we have a no return policy on all of our DME.

FINANCIAL PAYMENT POLICY

In our effort to provide quality health care to our community, it is important to establish a clear credit policy to avoid any misunderstandings. Our primary responsibility is to help our patients experience good health, and we wish to spend our time and energy toward that end. All accounts are payable at the time of service. We accept VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS for your convenience. Payment arrangements are available through our trained Insurance Specialists in accordance with our Credit Guidelines. If you feel that you will not be able to pay your bill, please inform one of our receptionists so that a representative in the billing department can make payment arrangements.

As a service to our patients, we will bill your primary and secondary insurance carriers provided you supply the name, address, group and ID# and the name of the policyholder. If you prefer to bill your own insurance, we will furnish you with a complete itemized statement. We do not negotiate disputed claims with your insurance company. If you have questions regarding your coverage or any special arrangements, please contact your insurance carrier directly.

All patients will be required to sign an insurance release form that allows us to file their insurance to their carriers. Patients will also be required to sign a statement stating that they have read our Financial Payment Policy and will be responsible for their bill.

A. **Patient Responsibility. With Insurance**

1. Co-pays are due at the time of visit.
2. Deductibles must be paid at the time of service, if not paid prior to your visit.
3. For surgery, arrangements for patient responsibility must be made in advance. Of course emergency surgery will be handled in manner applicable to the need.
4. All insurance payments will be monitored closely to assist you in experiencing the highest possible payout under your plan.
5. Portions not paid by your insurance carrier will become your responsibility.

B. **Patient Responsibility. Without Insurance**

1. Payment is due upon receipt of the service. We accept all major credit cards for your convenience.
2. When considering payment arrangements, the following guidelines will be used:
   a. A Patient Responsibility Agreement form must be on file.
   b. The full balance must be arranged at the time of the first statement.
   c. All balances must be cleared within 12 months from the date of service.
   d. A Minimum monthly payment will be required.
   e. A Financial Agreement may be required when circumstances require arrangements beyond our standard guidelines.
   f. When surgery is scheduled, financial arrangements must be completed prior to the date of surgery.

C. **Managed Care**

Many insurance companies now have PPO and Participating Physician fee schedules. Contracts are negotiated on an annual basis. If you are part of one of these plans, please be sure to verify whether Southern Orthopedic Specialists, PA. participates with your particular plan. We also try to verify this information and alert you prior to your visit if at all possible, however, it is ultimately the patient's responsibility. If your managed care plan requires a referral from your primary care physician (PCP), you are responsible for obtaining it prior to making your appointment. If you do not have a referral by the time of your visit, you will be asked to sign a disclaimer and the charges for the visit will be your responsibility.

D. **Worker's Compensation Claims**

If your visit involves a worker's comp claim, notify the receptionist immediately. Authorization must be obtained prior to being seen. Please indicate if this is a new claim, open claim or if it has been some time since you spoke with your claims adjuster. Any charges not accepted as part of your claim become your responsibility.

E. **Motor Vehicle Accident Claims**

All motor vehicle accidents are billed to your auto insurance carrier. Once PIP is exhausted, the balance becomes your personal responsibility. We will bill your primary health insurance carrier, if applicable. Many times auto insurance will pay 80% of the charges. Patients will be responsible for the remaining 20%. Payment will be expected within our usual credit guidelines.

F. **Medicare**

As Medicare Participating Physicians, we accept the Medicare fee schedule. The patient is responsible for the annual deductible and 20% coinsurance at the time of service.

G. **Medicare and Supplement**

As Medicare Participating Physicians, we accept the Medicare fee schedule. After Medicare pays, your supplement will be filed. Only one Medicare supplement will be filed.

H. **Medicaid**

Southern Orthopedic Specialists, PA. is not a participating provider for Medicaid. We are not able to bill Medicaid and any patient with Medicaid insurance is considered self-pay. Payment is due at time of service.

I. **Disability Insurance**

Disability insurance forms will be completed for a small fee. Patients are asked to complete their portion of the form and leave it with the office. The forms can be mailed directly to the insurance company or be picked up, depending on preference. Please bring the forms in early to allow for adequate processing time.

Thank you for allowing us to serve your healthcare needs. If you need any assistance, please do not hesitate to ask. We are here to serve you.

Patient Registration Form

Today's Date: _____

Patient Last Name: _____ First: _____MI: _____ Sex: ☐ M ☐ F

Guardian (If Applicable): _____

Social Security #: _____ - _____ -_____ Birthdate: _____ E-mail:_____

Address: _____ City: _____State: ____ Zip Code: _____

Mailing Address (If different):_____ City: _____State: ____ Zip Code: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____Ext:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Work Status**: ☐ Employed ☐ Retired ☐ Unemployed ☐ Student

Race: ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Caucasian ☐ African American ☐ American Indian/Alaskan Native

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino **Primary Language**: ☐ English ☐ Other: _____

Primary Insurance: _____ Policy Number: _____

Subscriber Name: _____Subscriber DOB: _____Subscriber SS#: _____ - _____ -_____

Employer (if applicable):_____ Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance: _____ Policy Number: _____

Subscriber Name: _____Subscriber DOB: _____Subscriber SS#: _____ - _____ -_____

Employer (if applicable):_____ Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Tertiary Insurance: _____ Policy Number: _____

Subscriber Name: _____Subscriber DOB: _____Subscriber SS#: _____ - _____ -_____

Employer (if applicable):_____ Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

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Are you here due to an automobile accident? ☐ Yes ☐ No If yes, please indicate auto insurance: _____

Are you here due to a work accident? ☐ Yes ☐ No If yes, please indicate worker's comp carrier: _____

Do you currently reside in a nursing home? ☐ Yes ☐ No If yes, please indicate name: _____

Preferred Pharmacy: _____ Phone: _____

Primary Care Physician: _____ Referring Physician (If applicable):_____

Emergency Contact: _____ Relation: _____ Phone: _____

FINANCIAL PAYMENT POLICY
Southern Orthopedic Specialists, P.A.

1. **REGARDING INSURANCE:** The physician's service is provided directly to you and you are responsible for payment of services rendered. Our office participates with Medicare and many other insurance companies. Should your insurance coverage be with one or more of these companies we will, as a courtesy to you, bill your insurance along the guidelines of our contract. However co-payment, deductibles, and non-covered charges are the responsibility of the patient and payment is expected at the time services are rendered.
2. **SPECIAL ARRANGEMENTS:** There are times when making payments can be a financial hardship. It may be necessary to set up a payment plan for a patient who cannot comply with our financial policy. If you are in need of special payment arrangements, please advise our billing department as soon as possible.
3. **COLLECTION FEES:** In consideration of the services to be rendered to the patient, I individually promise, whether signing as the patient, patient's agent, or as guarantor, to pay the account of Southern Orthopedic Specialist not later than the time treatment is rendered, unless specific account payment arrangements have been previously approved by SOS. Should the account be referred to an attorney or other third party collections, the undersigned shall pay reasonable attorney fees, third party collection fees and collection expenses. I waive notice of demand as a prerequisite to the commencement of legal proceedings for medical charges. No delay or omission by the hospital shall be considered a waiver of any right. I agree that venue in any action brought against me for medical charges shall be in Bay County, Florida. The law prescribes all delinquent accounts bear interest at the highest legal rate or in the event no maximum rate, at eighteen percent (18%) per annum.

Informing our patients about our financial policy assists us in providing the best services to our patients. Thank you for taking the time to read this policy statement. Should have further questions or comments, please contact our billing department.

I hereby understand the financial policy of this office: _____
PATIENT NAME (Please Print)

_____ _____
PATIENT or LEGAL GUARDIAN'S SIGNATURE **DATE**

INSURANCE AUTHORIZATION

(Please sign if we are filing <u>any</u> insurance company on your behalf)

I request that payment of authorized insurance benefits be made on my behalf to the provider for any services furnished to me by the listed provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim(s). If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claims forms of electronically submitted claims, my signature authorized release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the insurance companies.

_____ _____
PATIENT or LEGAL GUARDIAN'S NAME (PRINT) **PATIENT or LEGAL GUARDIAN'S SIGNATURE**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on January 1, 2014 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $1.00 for each page and the staff time charged will be $10.00 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). **"**Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for each page and the staff time charged will be $10.00 per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name: Southern Orthopedic Specialists, P A

Privacy Officer: Sherri Sullivan

Telephone: (850) 785-4344

Fax: (850) 785-6568

Address: 1827 Harrison Ave, Panama City, FL 32405

Email: info@southernorthopedic.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of Southern Orthopedic Specialists, P.A. Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Patient Printed Name

_____

Patient or Legal Guardian Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

❒ The patient refused to sign.

❒ Due to an emergency situation it was not possible to obtain an acknowledgement.

❒ We weren't able to communicate with the patient.

❒ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee Signature *Date*

_____ _____

Employee Printed Name *Title*

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.

SOUTHERN ORTHOPEDIC SPECIALISTS, P.A.

Samuel L. Combs, III, M.D.
Hip and Knee Replacement
Board Certified
(850) 785-6029

Thomas C. Mitchell, M.D.
Pediatric Orthopedics
Sports Medicine
Board Certified
(850) 769-KNEE

Cory R. Gaiser, D.O.
Spine Surgery
Board Certified
(850) 785-6980

Michael C. Noble, M.D.
Family Practice and Sports Medicine
Board Certified
(850) 785-6397

David R. Dietrich, M.D.
Adult Reconstruction
Board Certified
(850) 785-0095

James C. McLoughlin, M.D.
Spine Surgery
Orthopedic Surgery
Board Certified
(850) 785-8480

Mark N. Awantang, M.D.
Hand Surgery
Orthopedic Surgery
Board Certified
(850) 522-HAND

1827 Harrison Avenue
Panama City, Florida 32405
(850) 785-4344

Authorization to Release Medical Information

Patient Name: _____DOB: _____

I hereby give my authorization and permission for the following members (other than legal guardian) to speak with my physician(s) at Southern Orthopedic Specialists, PA concerning my medical condition.

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do it in writing. I understand that this authorization will expire in two (2) years from the date signed.

_____ _____
Signature Date

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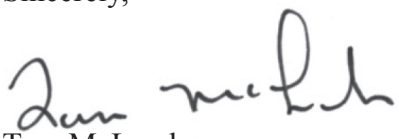
Dear Patient,

Thank you for choosing Southern Orthopedic Specialists, P.A. for your medical needs. We pledge to give you the best medical care possible and treat you with friendliness, respect, and dignity. We appreciate your business.

Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

Sincerely,



Tom McLendon
Administrator

Patient / Legal Guardian Signature: _____

Date: _____

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GENERAL PATIENT/PHYSICIAN AGREEMENT

Please read the following paragraphs, initial below each paragraph that you have read, understand and agree to the same.

In an effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints. Appropriately, the patient understands and authorizes treating physician and/or staff to communicate with previous physicians by any method, to include a "physician only" web site and/or any physician that can assist with the care of the patient as long as confidentiality is kept at the professional level. I have read, understand, and agree with the above.

Patient/Legal Guardian Initials: _____

The patient understands that he or she is not required to use treating physician or any other physician employed by or under the direction of this facility or practice for general healthcare and/or surgery. The patient understands medicine is not an exact science and there is risk involved in any medical procedure. The patient understands he or she is being treated at his or her own risk. It is further understood that in the event of any controversy or dispute which might arise between the patient and the physician, regardless of whether the dispute concerns the medical care rendered by the treating physician or any manner whatsoever, then the patient agrees that the controversy or dispute shall be resolved by arbitration as provided by the Florida Arbitration code, Chapter 682 & 684, Florida Statutes. This arbitration shall be binding and shall be in lieu of and instead of any trials by judge or jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. Each party shall be entitled to the discovery provided for under rules 1.280-1.390, Florida Rules of Civil Procedure. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court of competent jurisdiction. I have read, understand and agree with the above.

Patient/Legal Guardian Initials: _____

"Physician Orders" are meant to improve and/or resolve the patient's medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician's care and/or facility thus releasing the treating physician and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can include but is not limited to missing, postponing or refusal of additional tests to rule out, confirm or discover illnesses and misusing medications. I have read, understand and agree with the above.

Patient/Legal Guardian Initials: _____

I _____, as the patient/guardian, have read and understand all paragraphs above by initialing below each paragraph. I have agreed to abide by their content by signing below.

In witness whereof, I have set my hand this date ____/____/____.

_____ _____
Print Patient's Name Physician or Authorized Agent

_____
Patient or Legal Guardian Signature

DATE: _____

SPINE EVALUATION

Please take a moment to fill out this questionnaire. Please answer all the questions to the best of your ability. Your response will allow us to assess how your back is doing and track your progress.

NAME: _____ **REFERRING M.D. :** _____
AGE: _____ **SEX: M** ___ **F** ___ **OCCUPATION:** _____

PAIN PROFILE

1. Where is the primary location of your pain?
_____ Neck ___ Upper Back_____ Arm _____Mid Back_____ Lower Back_____ Legs

2. How long ago did your current episode begin:
_____ Less than 2 weeks ago
_____ 2 weeks to less than 8 weeks ago
_____ 8 weeks to less than 3 months ago
_____ 3 months to less than 6 months ago
_____ 6 to 12 months ago
_____ More than 12 months ago

3. How did your current episode begin?

_____ Suddenly
_____ Gradually

4. Briefly describe your current pain when it first started:_____

_____

_____

5. Has your current pain changed in any way since it started? If so, describe:_____

_____

_____

6. Have you had back or neck problems in the past? Yes_____ No _____ (If no, please go to question 10). If so, please describe:_____

_____

7. If injured, did it occur at work? Yes_____ No _____

8. Did you receive Worker's Compensation for your past back symptoms?
No_____Yes _____ Not Applicable _____

9. How much work did you miss because of your worst prior episode?
_____ None
_____ 1 day to 2 weeks
_____ More than 2 weeks to 4 weeks
_____ More than 4 weeks to 12 weeks
_____ More than 12 weeks to 24 weeks
_____ More than 24 weeks

10. Your current pain is: (Check where appropriate)

Better	Worse	No Change	
( )	( )	( )	When coughing or sneezing
( )	( )	( )	Bending forward
( )	( )	( )	Bending backward
( )	( )	( )	Using the bathroom

11. What do you do in order to ease your pain?_____

_____

12. If 0 (zero) is no pain and 10 (ten) is the worse pain you can imagine:
At the most severe (on a bad day), you would rate your pain as a:_____
At the least severe (on a good day), you would rate your pain as a: _____
Today, you would rate your pain as a: _____

13. Have you ever had surgery on your spine?
Neck: Yes_____ No _____ Number of times:_____
Back: Yes _____ No _____ Number of times:_____

14. Have you had any of the following tests:

	Yes	No	# of times	Dates (Roughly)
CT Scan (Computerized Axial Tomography)	( )	( )	_____	_____
MRI (Magnetic Resonance Imaging)	( )	( )	_____	_____
Myelogram (X-ray of spine with dye injected)	( )	( )	_____	_____
EMG/NCV (Nerve Conduction Velocities)	( )	( )	_____	_____

If you have had any of these tests, did you bring the results with you? _____
Is this visit for a second opinion? _____

15. Within the last 6 months, which of the following types of treatment have you had:

		DID IT HELP?		
	DIDN'T HAVE	**NO**	**YES**	**NO CHANGE**
Physical therapy	( )	( )	( )	( )
Traction	( )	( )	( )	( )
Chiropractic Manipulation	( )	( )	( )	( )
Formal exercise program	( )	( )	( )	( )
Aquatic (water) therapy	( )	( )	( )	( )
Cortisone injections	( )	( )	( )	( )
Steroid treatment with pills	( )	( )	( )	( )
Anti-inflammatory medication	( )	( )	( )	( )
Muscle relaxers	( )	( )	( )	( )
Epidural steroid injections	( )	( )	( )	( )

16. What other members of your family have significant back or neck problems: _____

_____

17. Do you have any of the following:

YES	**No**	
( )	( )	Loss of bowel control
( )	( )	Loss of bladder control
( )	( )	Weakness in arms or legs
( )	( )	TB
( )	( )	Weight loss without trying
( )	( )	Prostate or female organ problems
( )	( )	Bladder or kidney infection

Past Medical History

1. If female, last normal menstrual period: _____

2. Drug allergies: Yes _____ No _____
   If yes, please list: _____

_____

3. List all current medications: _____

_____

4. List all current medical problems: _____

_____

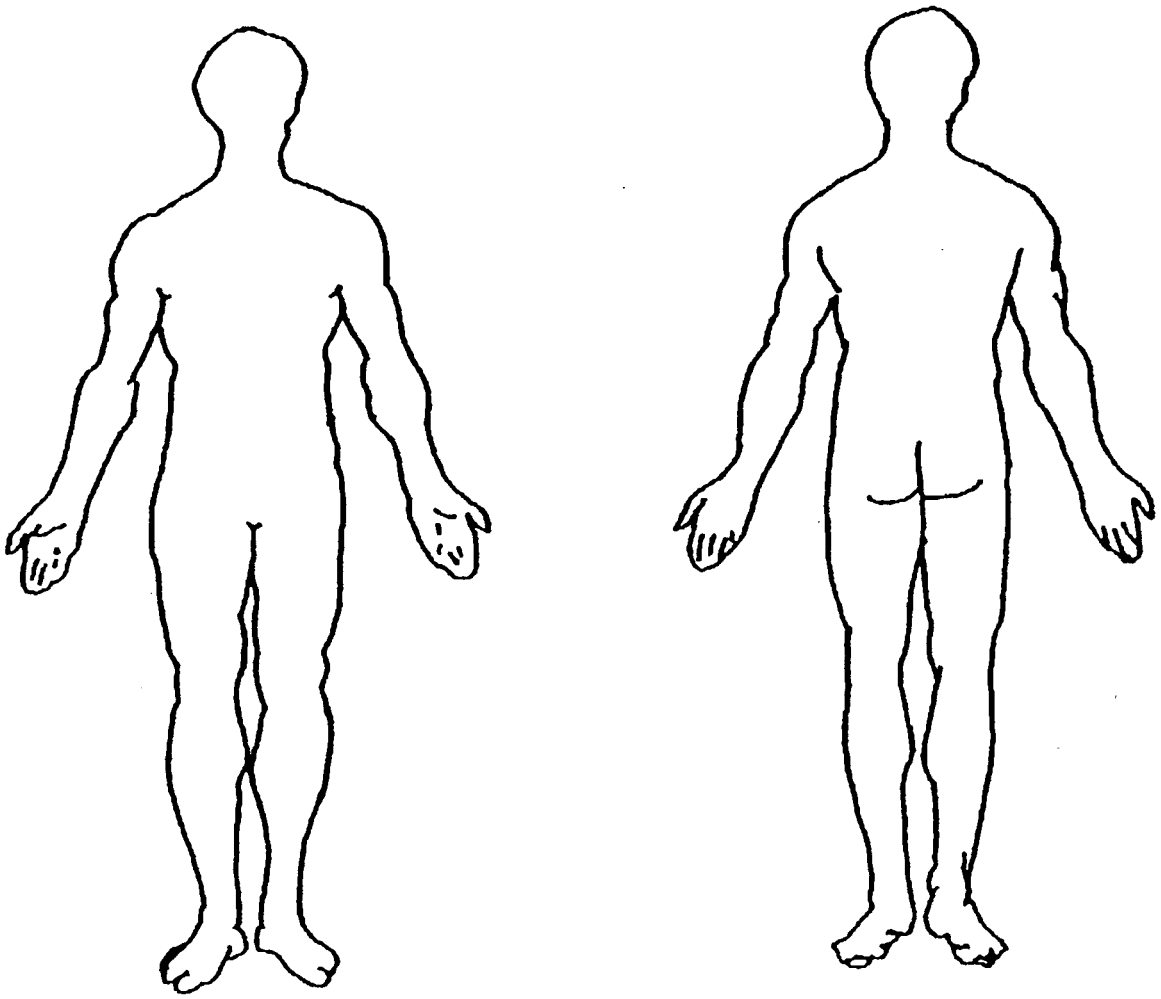
Patient Pain Drawing

Name:_____ Date: _____

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.
Mark the areas of radiation, include all affected areas.

Aching	Numbness	Pins and needles	Burning	Stabbing
▲▲▲	- - -	OOO	✖✖✖	/ / /



FRONT BACK

How bad is your pain now?

Please mark with an ➔ on the body from where the pain is the worst now.
Please rate your current pain on the scale below:
No pain _____ Worst possible pain