iRISE SPINE AND JOINT ™

PATIENT INTAKE INFORMATION

PATIENT INFORMATION

Date: _____ Primary Language: _____

Patient's Name: _____ SS#: _____

Sex: ☐ Male ☐ Female Age: ____ Date of Birth: _____ Marital Status: ☐ S ☐ M ☐ W ☐ D

Local Address: _____
(Street) (City) (State) (Zip)

Phone #s _____ _____ _____
(Home) (Cell) (Other)

Email: _____
Please print clearly

Alt. Address: _____
(Street) (City) (State) (Zip)

Preferred Pharmacy: _____ Phone#: _____

Patient's Employer: _____ Occupation: _____

Employer's Address: _____ Employer's Phone: _____

Nearest Relative (not living in household): _____ Phone: _____

Is illness or injury related to: ☐ Work ☐ Auto Accident ☐ Slip & Fall ☐ Other _____

If yes: Date of Accident: _____ Attorney Name: _____ Phone: _____

INSURANCE INFORMATION: *Must have Insurance card*

Auto Insurance Co: _____ Phone#: _____

Policy #: _____ Claim #: _____

Relation to insured (check one): ☐ Self ☐ Spouse ☐ Child ☐ Other _____

If not the insured, name of insured: _____ Birth date: _____

Health Insurance Co: _____ Phone#: _____

Policy #: _____ Group #: _____

Relation to insured (check one): ☐ Self ☐ Spouse ☐ Child ☐ Other _____

If not the insured, name of insured _____ Birth date _____

I HAVE PROVIDED THE OFFICE WITH A COPY OF MY HEALTH INSURANCE INFORMATION: ☐ Yes ☐ No

SIGNATURE REQUIRED

Patient Signature: _____ **Date:** _____

Front Desk Signature: _____

PATIENT INFORMATION (CONTINUED)

Communication preferences. Please indicate your permission for the following:

Send you text messages (SMS)? ☐ Yes ☐ No

Leave you voice mail messages? ☐ Yes ☐ No

Send email communication regarding appointments and test results? ☐ Yes ☐ No

General Health

Height _____ Weight_____

Smoking: ☐ Never Smoked ☐ Former Smoker ☐ Current Smoker How much per day?_____

Allergies

List allergies to medications _____

Do you have significant environmental or food allergies? ☐ Yes ☐ No

Are you allergic or sensitive to :

Adhesive tape ☐ Yes ☐ No **IV contrast** ☐ Yes ☐ No **Latex** ☐ Yes ☐ No

Iodine ☐ Yes ☐ No **Shellfish** ☐ Yes ☐ No

Prescription Medications

Do you currently take prescription medications, including inhalers, blood thinners or birth control? ☐ Yes ☐ No

List medications_____

_____

Vitamins, Supplements, Over-the-counter Medications

Do you currently take over the counter medication, vitamins or herbal supplements? ☐ Yes ☐ No
(including ibuprofen, aspirin, Vitamin B, CoQ10, fish oil, etc.)

List medications_____

_____

Surgical History (list all surgeries and year performed)

_____ _____
Surgery Date

_____ _____
Surgery Date

_____ _____
Surgery Date

History of cancer? ☐ Yes ☐ No If yes, when? _____

Radiation? ☐ Yes ☐ No **Chemotherapy?** ☐ Yes ☐ No Explain: _____

Do you have problems with or history of substance abuse? ☐ Yes ☐ No

☐ Alcohol ☐ Illicit Drugs ☐ Prescription Drugs_____

Do you drink alcohol? ☐ Yes ☐ No If yes, frequency: ☐ Daily ☐ Social ☐ Occasional ☐ Rarely

I HAVE REVIEWED THE INFORMATION ON PAGES 1-2 AND FIND THE INFORMATION TO BE ACCURATE AND COMPLETE.

SIGNATURE REQUIRED

Patient Signature: _____ **Date:**_____

HEALTH HISTORY

Past Accidents/Injuries (Include Year) _____

_____

Please check any conditions you have had or are currently having:

Condition	Present	Past
Neck Pain	☐	☐
Middle Back Pain	☐	☐
Low Back Pain	☐	☐
Shoulder Pain	☐	☐
Arm Pain	☐	☐
Leg Pain	☐	☐
Chest Pain	☐	☐
Joint Stiffness	☐	☐
Numb Hands/Fingers	☐	☐
Numb Feet/Toes	☐	☐
Arthritis	☐	☐
Jaw Pain	☐	☐
Headaches	☐	☐
Dizziness	☐	☐
Ear Ringing	☐	☐
Fatigue	☐	☐
Tension	☐	☐
Irritability	☐	☐
Loss of Appetite	☐	☐
Nausea	☐	☐
Coughing	☐	☐
Depression	☐	☐
Alzheimer Disease	☐	☐
Parkinson Disease	☐	☐
Emphysema/COPD	☐	☐
Liver Disease	☐	☐
Congestive heart failure	☐	☐
Arrhythmias	☐	☐
Mitral valve prolapses	☐	☐

	Present	Past
Sinus Problems	☐	☐
Bladder Infection	☐	☐
Painful Urination	☐	☐
Abdominal Pain	☐	☐
Diabetes	☐	☐
Cataract	☐	☐
Glaucoma	☐	☐
Hearing Problems	☐	☐
High Blood Pressure	☐	☐
Bowel Problems	☐	☐
Diverticulitis	☐	☐
Hiatus Hernia	☐	☐
Prostate Problems	☐	☐
Heart attack/Angina	☐	☐
Bladder problems	☐	☐
Asthma	☐	☐
Cancer	☐	☐
HIV	☐	☐
Stroke	☐	☐
Heart Disease	☐	☐
Hepatitis	☐	☐
Shingles	☐	☐
Anemia	☐	☐
Kidney Disease	☐	☐
Aneurysm	☐	☐
Bleeding Disorder	☐	☐
Thyroid Disease	☐	☐
Immune Disorder(s)	☐	☐

Other illnesses not listed:

_____

_____

Verification of non-pregnancy

Date_____

Date of L.M.P. _____

By my signature below, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

SIGNATURE REQUIRED

Printed Name: _____ **Patient's Signature:** _____

LETTER OF PROTECTION

Patient Name:_____ Accident Date: _____ Initial Visit Date:_____

I, the above-named Patient, do hereby authorize and direct my present and any future attorney to honor this fee guarantee agreement. This agreement is made in favor of the above-named Medical Provider and shall be termed a "Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above noted accident date.

Consideration. In consideration of the medical treatment provided and the medical provider's willingness to wait until the conclusion of my legal case and finalization of applicable insurance obligations to pay for said medical treatment, I hereby grant a direct lien on any and all funds I may recover in any legal action related to the above accident date.

Protection of Outstanding Charges. In the event that a financial recovery is made on my behalf by any person, attorney or other business entity in connection with any legal action related to the above accident date, I direct and instruct my present, and any future attorney representing me in connect with said legal action(s), to withhold from said recovery, funds sufficient to pay the full outstanding balance of any bill(s) owed to the above named Medical Provider for treatment provided in connection with same. I understand that in accordance with the Medical Provider's Financial Responsibility Policy, my Medical Provider has agreed to work with my Attorney and, as part of my settlement or verdict, may in accordance with §817.234 (7) Florida Statutes, accept a reduced amount or waive my outstanding balance altogether. I hereby irrevocably instruct my present and/or future attorney not to disburse any settlement funds for any reason, including but not limited to attorney's fees, costs, and other medical liens, until my Medical Provider has been contacted and my financial responsibility obligations are resolved.

Patient Responsibility. I understand that it is my responsibility to advise each attorney representing me of the existence of this agreement. I further direct my present attorney and any future attorney to advise the Medical Provider, as soon as possible, about any funds that are recovered in connection with my case. I understand that under certain circumstances, I may not obtain any financial recovery and if that is the case, I am responsible for the payment of the Medical Provider's outstanding balance(s) then the remaining amounts are to be paid by the Patient.

Payment. All payments made pursuant to this agreement shall be made to:

iRISE Spine & Joint
PO BOX 679206
Dallas, TX 75267-9206

Enforcement. I further agree to be fully responsible for reasonable attorney's fees and costs that have accrued due to the pursuance of payment of my account. Also, that in the event of noncompliance to payment agreement I understand the amount of balance due will be subject to a 1% per month service charge.

Approval Required. This agreement becomes effective when the Patient signs the agreement below. This agreement does not need the approval of any present or future attorney for the Patient.

The parties agree that no party shall be considered the drafting party to this contract.

SIGNATURE REQUIRED

Patient's Printed Name: _____

Patient's Signature:_____ **Date:** _____

Attorney Signature: _____ **Date:** _____

RETURN VIA FAX: _____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OIR-B1-1571
Pub. 1/2004

ASSIGNMENT OF INSURANCE BENEFITS & RELEASE OF INFORMATION

The undersigned patient/insured,_____**(print name of patient/insured or parent/guardian if patient is a minor),** knowingly, voluntarily and intentionally assigns the benefits of insurance or Medical Payments policy of insurance or the responsible insurer to the above described medical provider for any and all services rendered to the undersigned patient/insured. It is the intent of this medical provider to accept this assignment of benefits. The undersigned patient/insured directs the insurer to pay the medical provider directly (i.e. payments to be mailed and made payable to the medical provider only and not to me) for the services rendered. The insurer is further directed by the provider and the patient to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured from liability unless there has been a prior written settlement agreed to by the medical provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments made at the discretion of the insurer. Any partial or reduced payment issued by the insurer and deposited by the provider shall be done so under protest 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. In the event the subject medical benefits are disputed for any reason, including but not limited to, medical reasonableness and/or necessity, the undersigned patient/insured hereby instructs the insurer to set aside any amount disputed and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. Any partial payment, regardless of the accompanying language, will be deemed a partial payment and the insurer will be making the payment at its own risk unless there is a prior written settlement agreed to by this provider. I hereby instruct the insurer to notify the above provider immediately of any dispute.

The undersigned patient/insured agrees to pay any deductible, co-payments, for services rendered after the policy of insurance exhausts. I understand this assignment will remain in full force and effect and will NOT be revoked unless the revocation is agreed to by both the medical provider AND the undersigned patient or the patient's attorney. This assignment applies to both past and future medical expenditures. A photocopy of this assignment is to be considered as valid as an original.

Release of information: I hereby authorize this medical provider or their representative to furnish my insurance company or companies and my attorney, as listed on the patient information form, with any and all information, that may be contained in my medical records and obtain any insurance coverage information in my file. I also hereby authorize this medical provider to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, opinions, x-rays, and MRIs, from any other medical provider or any insurance company.

Please read before signing. 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 terms.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information may be guilty of a felony of the third degree.

SIGNATURE REQUIRED

Patient's Signature: _____ **Date:** _____

(If patient is a minor, signature of parent/guardian)

PATIENT CONSENT AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures when warranted. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

AUTHORIZATION FOR MEDICAL TREATMENT: This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under you observation or treatment, including the history obtained, X-ray and physical findings, diagnosis, and prognosis. You are authorized to provide this information in accordance with the Florida "NO FAULT" auto insurance law (Chapter 71-252 F.S.)

AUTHORIZATION TO PHOTOGRAPH OR VIDEO: This authorization or photocopy hereof, will authorize you to be photographed for treatment purposes related to your healthcare, professional activities, insurance claims and patient education.

SIGNATURE REQUIRED

Patient's Printed Name: _____

Patient's Signature:_____**Date:** _____

Witness Signature: _____**Relationship:**_____**Date:** _____

NOTICE OF PRIVACY PRACTICES

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with brief overview of our Notice of Privacy. Our practice is complying with HIPAA regulations.

What is HIPAA and how does the Privacy Rule affect you?

When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996, this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is Individually Identifiable Health Information (IIHI)?

Any health information you provide our practice, including your mailing address. IIHI is any information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

What is the Notice of Privacy Practice?

Our practice has an official Notice of Privacy Practice posted in our waiting room informing our patients about their rights surrounding the protection of you IIHI and our obligations concerning the use and disclosure of your IIHI. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will be posted and a copy is provided in our waiting room and you can take a copy of the current notice at any time.

The following categories describe the different ways in which we may use and disclose your IIHI:

Treatment
Payment
Health Care Operations
Appointment Reminders
Treatment Options
Health-Related Benefits & Services
Release of Information to Family/Friends
Disclosure Required by Law

The following categories describe unique situations in which we may use or disclose your Identifiable Health Information:

Public Health Risks
Lawsuits and Similar Proceedings
Serious Threats to Health or Safety
National Security Inmates
Health
Law Enforcement
Research
Workers' Compensation
Oversight Activities
Deceased Patients
Military
Organ and Tissue Donation

What are your rights concerning your individually Identifiable Health Information (IIHI)?

You have rights regarding the IIHI that we maintain about you. In our Notice of Privacy you can view the policies and procedures you will need to follow for the areas listed below.

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a Paper Copy of this Notice
7. Right to file a complaint
8. Right to provide an Authorization for other uses and disclosures

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

I have read the short notice provided by IRISE Spine and Joint, LLC and have been informed of how to obtain more information regarding our Notice of Privacy.

SIGNATURE REQUIRED

Patient's Printed Name: _____

Patient's Signature: _____ **Date:** _____

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS (1 of 2)

Name of Insurance Company _____

Date_____Our Policy Holder_____Date of Accident_____File #_____

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY. MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Name_____Phone_____Home _____Business_____

Complete Address:_____

Permanent Address, if different:_____

Date of Birth_____Social Security No._____How long have you lived in FL?_____

Date and Time of Accident:_____Place of Accident (Street, City, ST)_____

Brief description of accident and vehicles involved: _____

_____

Describe your motor vehicle: _____Motor vehicle of family member: _____

As a result of this accident, were you injured? ☐ Yes ☐ No If Yes, complete the rest of this form. If no, sign below.

SIGNATURE DATE

Describe your injury below

_____

_____

Were you treated by a doctor? ☐ Yes ☐ No Doctor's name and address: _____

If you were treated in a hospital, were you: ☐ In-patient ☐ Outpatient
Hospital Name and Address _____

Amount of medical bills to date: _____Will you have more medical expenses? ☐ Yes ☐ No

At the time of the accident, were you in the course of your employment? ☐ Yes ☐ No

Did you lose wages or salary as a result of your injury? ☐ Yes ☐ No If Yes, amount of lose to date: _____
What is your weekly wage or salary?_____If you lost wages, date disability work began: _____
Date you returned to work: _____
Have you received or are you eligible for payments under any worker's compensation or employment law?

☐ Yes ☐ No If yes, amount per week_____ Per month_____
List names and addresses of your present employer(s) and give your occupation and dates of employment.

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS (2 of 2)

As a result of your injury have you had any other expenses? ☐ Yes ☐ No If Yes, explain below.

TO BE ELIGIBLE FOR BENEFITS, COMPLETE AND SIGN THIS APPLICATION, SIGN AND ATTACH AUTHORIZATION(S) and RETURN PROMPTLY WITH ANY MEDICAL BILLS RECEIVED TO DATE.

SIGNATURE REQUIRED

Patient's Signature _____ Date _____

INTAKE QUESTIONNAIRE

Details of present incident

Patient's Name: _____ Date of Accident: _____ Today's Date: _____

Contact Phone #s: _____ Attorney Name: _____

Were you the: ☐ Driver ☐ Front Seat Passenger ☐ Back Seat ☐ Passenger ☐ Pedestrian ☐ On the job ☐ Other

Do you own a vehicle of your own? ☐ Yes ☐ No If yes, name of auto insurance: _____

If no, do you live with a blood relative that owns a vehicle? ☐ Yes ☐ No

If yes, name of auto insurance _____

If no, name of auto insurance of vehicle you were in at time of accident _____

Is the Auto Insurance a Florida Policy? ☐ Yes ☐ No If no, what state? _____

Policy# _____ Claim#: _____

Relation to Insured(check one): ☐ Self ☐ Spouse ☐ Child ☐ Other _____

If not the insured, name of insured: _____ Relationship to policyholder: _____

Description of the vehicle you were in? Make _____ Model _____ Year _____

Was your vehicle stopped at the time of the accident? ☐ Yes ☐ No

Was your vehicle moving right before the moment of impact? ☐ Yes ☐ No Estimated speed: _____ MPH

Did the vehicle you were in hit a vehicle(s)/object/person? ☐ Yes ☐ No

If yes, what part of the vehicle/object/person did you hit? _____

Did a vehicle(s) or object hit your vehicle first? ☐ Yes ☐ No

If yes, what part of your vehicle was hit? (I.e. front, back, side) _____

Seatbelt: ☐ Worn ☐ Not Worn ☐ Don't know Air Bag Deployed: ☐ Yes ☐ No ☐ Car does not have airbags

Aware of Crash: ☐ Aware ☐ Surprised ☐ Did you brace yourself? ☐ Yes ☐ No If yes, with ☐ arms ☐ legs ☐ both

After Incident

Unconscious? Yes ☐ No ☐ If yes, unconscious for _____ (unit of time)

After the accident, I had pain in the following areas: ☐ Head ☐ Neck ☐ Mid Back ☐ Low Back

☐ RT Shoulder ☐ LT Shoulder ☐ RT Elbow ☐ LT Elbow ☐ RT Wrist ☐ LT Wrist ☐ Fingers

☐ RT Hip ☐ LT Hip ☐ RT Knee ☐ LT Knee ☐ RT Ankle ☐ LT Ankle ☐ RT Foot ☐ LT Foot

Symptoms first appeared: ☐ Immediately _____ (min/hrs) after the accident ☐ Next Day (min/hrs) after

Did you receive paramedic attention? ☐ Yes ☐ No

Did a law enforcement officer investigate the scene of the accident? ☐ Yes ☐ No

After the accident, I went: ☐ Home ☐ Work ☐ Hospital ☐ Family Physician ☐ Other _____

If you went to the hospital or a medical center:

Name of Hospital/Medical Center _____

How did you get there? ☐ Ambulance ☐ Relative _____ ☐ Friend _____ ☐ Other _____

Did you sustain any broken bones? Yes ☐ No ☐ If yes, which one(s): _____

Did you have imaging done due to accident? ☐ Yes ☐ No If yes, which: ☐ CT scan ☐ MRI ☐ X-rays

What body parts? _____

Were you prescribed: ☐ Pain pills ☐ Muscle Relaxers ☐ N SAIDS (Anti-inflammatory) ☐ Other _____

The information provided above is true and correct to the best of my knowledge.

SIGNATURE REQUIRED

Patient's Signature: _____

Interviewer Signature: _____

VERIFICATION OF NON-OWNERSHIP

Only complete if you DO NOT own a vehicle.

Patient Name_____Date of Birth_____
Please Print

I confirm the following:

1. That I was involved in an automobile accident on_____
2. That I did not own an operable motor vehicle on the date of the accident.
3. That I did not live with any relative who owned an operable motor vehicle on the date of the accident.

SIGNATURE REQUIRED

_____ _____
Patient's Signature **Date**

_____ _____
Witness Signature **Date**

AUTHORIZATION TO RELEASE MEDICAL RECORDS

FOR OFFICE USE ONLY – LEAVE BLANK

Doctor/Hospital: _____

Address: _____

Phone: _____ Fax: _____

Loved one(s): _____

Address: _____

Phone: _____ Phone: _____

PLEASE BE ADVISED THAT WE MAY SEND YOUR MEDICAL RECORDS OR PROVIDE INFORMATION VIA VOICE MAIL, TEXT, EMAIL, FAX, CARRIER, AND USPS. BY SIGNING THIS RELEASE, YOU AUTHORIZE US TO SEND YOUR MEDICAL RECORDS AND INFORMATION.

I hereby authorize and request the release of my medical records pertaining to the dates of services from

_____ to _____.

Please release all records to:

iRISE Spine & Joint

_____

_____

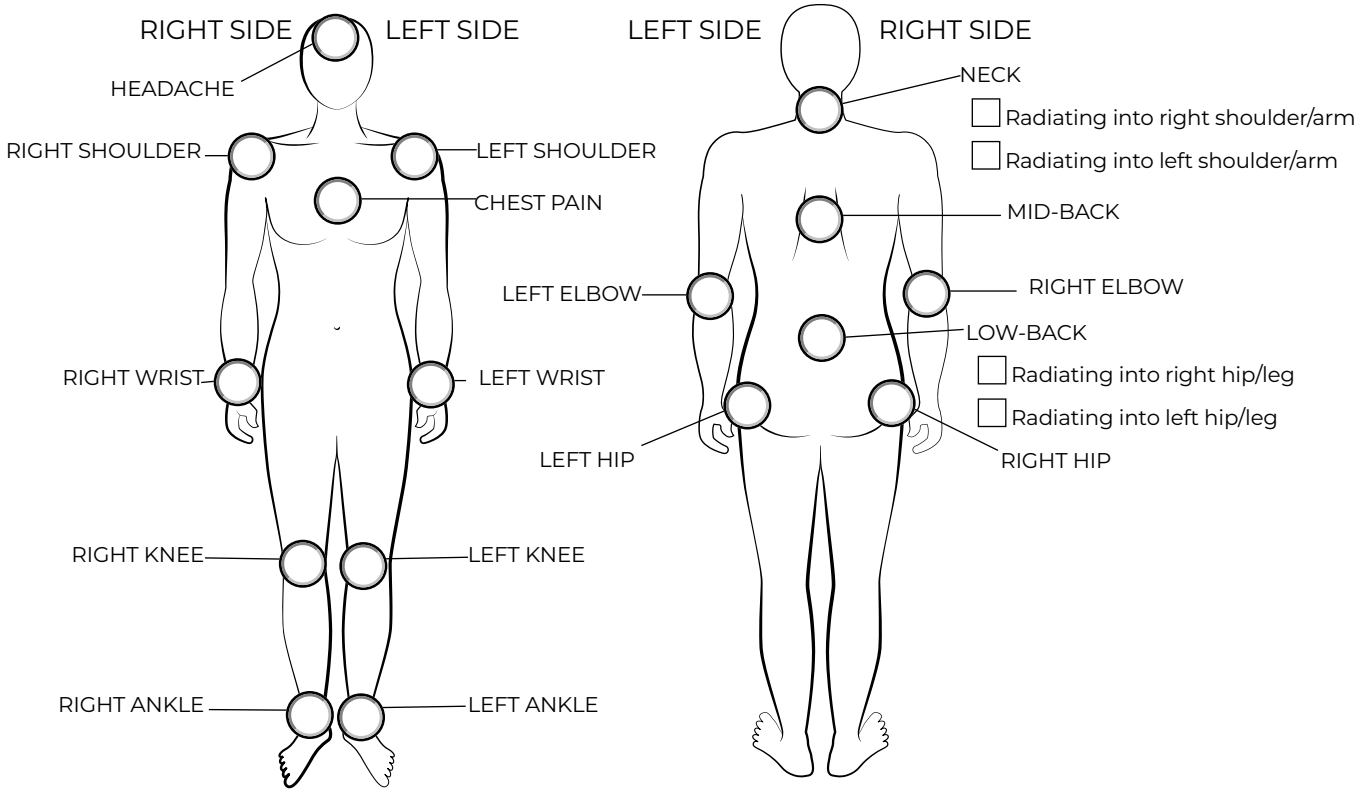
Thank you in advance for your cooperation.

SIGNATURE REQUIRED

Patient's Signature	**Date**	
Patient's Printed Name	**Date of Birth**	**SSN**
If patient is a minor, signature of parent or legal guardian	**Relationship**	
Witness to the above signature	**Print Name**	

PAIN DIAGRAM

On the diagram below, please CHECK the areas where you are experiencing pain. If radiating, check box.



SIGNATURE REQUIRED

Printed Patient Name	Patient Signature	Date

DOCTOR'S NOTES (Internal Use Only)

PHASE OF CARE ☐1 ☐2 ☐3 ☐H+ ☐Pregnant ☐Minor ☐Pacemaker ☐Cancer PT

DOCTOR'S NOTES | EXERCISES | MRI POSITIVE FINDINGS

BODY PART(S) TO BE TREATED (Check all that apply)

☐CSP ☐TSP ☐LSP ☐SHOULDER RT ☐SHOULDER LT ☐ELBOW RT ☐ELBOW LT
☐WRIST RT ☐WRIST LT ☐HIP RT ☐HIP LT ☐KNEE RT ☐KNEE LT ☐ANKLE RT ☐ANKLE LT

TREATMENT

☐EMS ☐U/S ☐HOT/COLD ☐MANUAL ☐HYDRO BED ☐MECHANICAL TRACTION
☐NEURO RE-ED ☐PNF ☐Ball w/bands ☐Wobble Board
☐THERAPEUTIC EXERCISE ☐Bike ☐Treadmill ☐Finger Ladder ☐T-band ☐Other _____
☐THERAPEUTIC ACTIVITY ☐Stretching ☐ROM _____

FLORIDA PATIENT'S BILL OF RIGHTS ACKNOWLEDGMENT

As a new patient at our health care facility, we would like to take this opportunity to advise you of your rights and responsibilities which requires that we adopt and make available to all patients, in writing, a statement of the rights and responsibilities of patients, including the following:

SUMMARY OF THE FLORIDA PATIENT'S BILL OF 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, 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.

By signing below, I acknowledge that I have received a Summary of the Florida Patient's Bill of Rights.

SIGNATURE REQUIRED

Patient's Signature _____ **Date** _____

Witness (Medical Provider) Signature _____ **Print Name** _____

OVERVIEW OF SERVICES PROVIDED AT IRISE SPINE AND JOINT

As a new patient, we want to make sure you have all the information you need about the services you may receive at our facility. Each of IRISE Spine and Joint's friendly and knowledgeable teammates aims to provide all patients with superior medical services. We can achieve this by utilizing our team of experienced specialists, along with progressive treatments and state-of-the-art technology, to give the highest quality of care to patients like you.

We strive to offer comprehensive orthopedic and pain management services, using specialized tools and expertise to care for everything from trauma-related injuries to hip and other fractures, ACL and other knee injuries, arthritis and other joint pain. Whether you're visiting us for interventional pain management procedures, surgery or rehabilitation, we won't settle for anything less than excellence.

The orthopedic care we provide helps our patients reduce their pain, regain their mobility and restore their quality of life. Each of our orthopedic services is focused on you, the patient, and they are built around your specific needs.

After you complete your new patient paperwork, your initial visit will consist of an evaluation by one of our physicians trained in the diagnosis, management and treatment of accident-related and other orthopedic injuries. The physician will ask questions about your particular situation and obtain details as to the specific complaints and injuries that you have. Next, there will be a physical examination and a variety of tests conducted to better diagnose your injuries. Diagnostic X-rays may be ordered to eliminate the possibility of fractured bones, osteoporosis, misaligned vertebral bodies and/or other serious conditions we can't see with the naked eye.

At the conclusion of the initial examination, your doctor will discuss your diagnosis with you, explaining your injuries and suggesting a treatment care plan for you to follow.

A typical treatment care plan is likely to include at least some of the following:

CHIROPRACTIC

- **Chiropractic spinal adjustments** - Utilizing various techniques in conjunction with one or more of the physiotherapy modalities listed below, the goal is to remove structural or nerve root irritation in order to alleviate spinal or extremity pain and to restore or enhance alignment and function of the spine and related joints. Adjustments can also be used to treat other joints including the jaw, shoulders, elbows, wrists, hips, and ankles. ($79.00 to $97.00)
- **Heat and cold.** Chiropractors may alternate between heat and ice therapy to help patients treat spinal and joint pain. Ice therapy are typically used during the "acute" state of treatment to reduce swelling and inflammation. However, ice therapy may also be used to numb certain area for a 10 to 15-minute period followed by a heating pad, heat wrap or hot water bottle to restore blood flow to the area and promote faster healing. Heat is commonly used for this purpose without ice but in combination with electrical muscle stimulation. ($60.00)
- **Ultrasound**. Ultrasound involves sound waves that penetrate the deep muscle tissues to create deep heat therapy. After applying a gel to the affected area, a heated ultrasound wand is moved in a continuous fashion over the soft tissues and joints to break up muscle adhesions and trigger points, reducing cervical and back pain, stiffness, and spasms. In addition, ultrasound increases blood flow to the deeper tissues which accelerates the healing process. ($48.00)
- **Hydrotherapy.** Hydrotherapy uses a dry whirlpool bed that allows for variation of water temperature and/or pressure to relieve muscle tension by relaxing the affected muscles. ($48.00)
- **Electrical muscle stimulation.** During this therapy, electrodes are placed on the skin that send light electrical pulses to different areas of the body involuntarily contracting the muscles to cause fatigue, which, combined with heat, reduces inflammation and muscle spasms. ($48.00)
- **Traction.** Traction is a therapy intended to elongate the spine in an effort to decompress the discs and reduce the pressure on the nerve roots. This treatment is especially helpful to patients that have sustained injuries to cervical, thoracic and lumbar discs. There are many different varieties of traction including rollers, traction beds and tables. ($60.00)
- **Manual therapy** applies direct pressure to specific areas of the spine in an effort to break up adhesions or "trigger points" to restore pain free range of motion and increase functional activity. May also include Myofacial Release and Manual Traction. ($79.00)
- **Therapeutic exercises** are used to develop strength, endurance and flexibility. Examples can include aerobic/cardiovascular exercise, resistance (elastic bands), exercise balls, weight training and core stability. ($84.00)
- **Therapeutic activities** uses dynamic activities designed to help with the activities of daily living such as stretching techniques, proper lifting and bending posture, pushing, pulling lifting and maintenance after activity such as icing, etc. ($99.00)
- **Paraffin ($39.00)**
- **Neuromuscular Re-education Therapy** is a technique that is similar to balance training and can also be used to improve strength, coordination, posture, kinesthetic sense and restore normal soft tissue tone and elasticity. Treatments may include balance exercises on a Thera-ball® with Thera-bands® or balance boards while performing multi-directional tasks in the frontal, sagittal and transverse planes. These activities challenge and strengthen fine and gross muscles to improve core control, kinesthetic (positional) awareness, balance and stability. ($84.00)

OVERVIEW OF SERVICES PROVIDED AT IRISE SPINE AND JOINT (CONTINUED)

ORTHOPEDIC SERVICES

- **History and Physical Examinations:** The medical history, being an account of all medical events and problems a person has experienced is an important tool in the management of the patient. A physical examination is the process by which a medical professional investigates the body of a patient for signs of disease.
- **Interventional Pain Procedure:** Such as Lumbar and Cervical Epidural Injections delivers steroid medication directly to the spinal nerve roots in order to reduce pain. This type of pain can be causes by a spinal condition such as lumbar or cervical herniated disc, which places pressure on nerve roots leading out of the spine. There are many other procedures we offer that may be recommended based on your particular signs and symptoms and your physician will discuss the specific procedure along with the risks and benefits in detail.
- **Surgical consultation:** When your doctor feels it is necessary for you to see a surgeon for evaluation and determine if surgery is the best option, you will meet one of our surgeons who will examine you and review records and recommend a course of treatment or further studies to diagnose. They will explain to you exactly what the problem is, what your options are to resolve it, and what the recovery time and procedure will be for each option. Risk and benefits will be explained in detail.
- **Recommendation for referrals:** Our physicians may write a referral to other outside specialists or facilities for further testing or treatment such as physical therapy, MRI, X-rays, or nerve conduction studies.
- **Patient education:** Our physician will educate you on a variety of lifestyle modifications, including exercise, diet and nutritional programs, self-care and coping strategies to manage acute and chronic pain.
- **Surgical procedures** IRISE Spine and Joint has board-certified surgeons that specialize in spine, knee, shoulder, hip, hand, wrist, foot and ankle injuries. Your surgeon will provide you with extensive education that includes all the risks and benefits of any surgical procedure recommended to you. Some of the most common surgeries include: Lumbar Laminectomy, Anterior Cervical Discectomy and Fusion, Knee or Shoulder Arthroscopy, Rotator Cuff Repairs, and treatment of fractures to the wrist, foot and ankle.
- **Initial Consultation Cost Range** ($400 - $800, dependent on time spent and symptoms)
- **Follow-up Consultation Cost Range** ($150 - $400, dependent on time spent and diagnosis)
- **Epidural Steroid Injections Cost Range** ($1,500 - $3,000, dependent on body part/spine levels treated)
- **Surgical Fees** will be discussed in advance of procedure)

While we feel that our physicians possess the knowledge and skill needed to accurately diagnose and treat a variety of conditions and ailments, we're not able to guarantee that our treatment will be successful. Unfortunately, no medical provider can make that claim due to the way each of our bodies reacts to treatment in its own way. What we can say is that the vast majority of our patients do improve with conservative treatment and therapy, and that automobile-related injuries to the cervical, thoracic and lumbar spine have traditionally responded favorably to these methods.

By signing below, you, or your legal representative, acknowledge that this overview and disclosure of treatment you may receive has been made and that you have also received the estimated charges for our services. Please contact us with any questions regarding your specific case.

By signing below, you will acknowledge that we have provided you with an overview of the treatment you may expect to receive at our facility.

SIGNATURE REQUIRED

Patient's Signature	**Date**
Witness Signature	**Date**

PATIENT FRAUD/SOLICITATION DISCLOSURE

Name of Patient:_____

Insurance Fraud at any IRISE Spine and Joint Clinics will not be tolerated. It is a crime in the State of Florida for any person to offer to pay, and any patient to receive a commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind to induce a patient to be referred to or receive treatment at a health care facility.

It is also a Felony and insurance fraud for a patient to present any statements pertaining to treatment that will result in a claim for insurance benefits that contain false, incomplete, misleading information or documents.

In consideration of and as an express condition to our providing treatment to you, I, the undersigned patient, under the penalty of perjury, hereby acknowledge the following to be true and correct:

1. That I am seeking treatment as a direct result of injuries that I have sustained.

2. That I have not been offered or otherwise promised a commission, bonus, rebate, kickback, or bribe, cash or payment of any kind, directly or indirectly, from anyone as an inducement to seek treatment at IRISE Spine and Joint Clinics. In addition, I have not received any promises at this Clinic that applicable deductibles and co-payments that I may be financially responsible for will be waived in the future as an inducement to receive treatment.

3. That all statements concerning my involvement in a motor vehicle accident, the injures that I have sustained, and any supporting documentation that I have provided in connection with the treatment that I am seeking are true and correct to the best of my knowledge and belief.

SIGNATURE REQUIRED

_____ _____

Patient's Signature **Date**

_____ _____

Witness Signature **Date**

FINANCIAL RESPONSIBILITY POLICY

Name of Patient: _____

As a new patient of our facility, we would like to advise you of our Financial Responsibility Policy. The amount of benefits will depend on your policy and the circumstances of your case. Also, insurance companies may deny claims in whole or part, making it almost impossible to determine how much of your claim will be covered.

Patients are responsible for the payment of all covered medical expenses that are not paid by applicable insurance. Your financial responsibility, if any, cannot be determined until (a) you have completed treatment, and (b) the financial obligations of your insurance company have been determined. In some instances, it will take litigation to obtain insurance company payment which can take months, if not years to resolve. In consideration of and as an express condition to our agreeing to providing treatment to you and waiting to obtain what, if any insurance payments we will receive, our office has d the following policy:

1. At the commencement of treatment, we will obtain a "Letter of Protection" in which you agree to have your Bodily Injury Attorney withhold from any future settlement, verdict or judgment sufficient funds to pay for any patient financial responsibility that you may have.
2. Our office will submit claims for the payment of medical expenses provided to you to your Attorney.
3. Once you have completed treatment, we will contact your Bodily Injury Attorney to resolve any applicable unpaid financial obligations.

Medical providers are not allowed to engage in a general business practice of waiving deductibles and co-payments other otherwise not intend to collect the total amount of its billed charges. This does not apply to instances where a medical provider agrees to waive deductibles, co-payments or otherwise reduce their bills as part of a bodily injury settlement or verdict. For this reason, we will, at the end of your treatment and the determination of any financial responsibility obligations, as part of your bodily injury settlement or verdict, discuss the circumstances of your case with your Bodily Injury Attorney and take the appropriate action as dictated by the facts of your particular case.

By signing below, I acknowledge that I have been explained and understand the above Patient Financial Responsibility Policy.

SIGNATURE REQUIRED

_____ _____

Patient's Signature **Date**

_____ _____

Witness Signature **Date**

PATIENT INSURANCE ELECTION

I, _____ am seeking medical treatment for injuries related to a personal injury accident at the recommendation of my treating physician.

I acknowledge the following by initialing my selection:

_____**I do not have health insurance coverage.**

_____**I do have or have limited health insurance coverage.**

_____**I elect not to use my health insurance.**

I fully understand and acknowledge that due to the risky nature of personal injury litigation, the cost of treatment and care can be higher than other forms of healthcare reimbursement rates.

SIGNATURE REQUIRED

_____ _____

Patient's Signature **Date**

_____ _____

Witness Signature **Date**

PAIN MEDICATION POLICY

The providers at IRISE Spine and Joint understand that many orthopedic conditions can cause pain. We also understand that many of the surgeries we do that result in getting rid of pain over the long-term can cause more pain in the short-term. We will work to safely and responsibly decrease your pain. We will often suggest a combination of pain relieving agents such as ice, heat, rest, elevation, anti-inflammatory medications.

The goal of IRISE Spine and Joint providers is to keep patients off narcotic/opioid medication. However, if you require surgery, it may be necessary to prescribe narcotic/opioid medication for a short period of time. The providers at IRISE Spine and Joint have their patients off narcotic opioid medication as quickly as possible. If you elect to undergo surgical treatment for an orthopedic condition, it must be with the understanding that you may be asked to tolerate some pain when we stop or decrease the use of pain medications. If you feel you still require narcotic/opioid medication past the six week post-operative time period, you may be referred to a pain specialist outside of our practice.

MEDICATION REFILLS

- Refills will not be filled earlier than three days before your prescription runs out.
- We will not be responsible for replacing lost or stolen medications.
- You may be randomly drug tested to ensure compliance with the prescribed medication.
- Refill requests must be made during normal business hours, Monday -Friday from 8 am to 5 pm.
- We do not provide same-day service for narcotic refills. Requests may take up to three days to fill.
- On-call providers are unable to start or refill any pain medications.
- Narcotic/opioid medication will not be prescribed after business hours, on weekdays or holidays.
- According to Florida State law, we can only prescribe a maximum of seven days worth of narcotic medication.

Because of the known risks of narcotic medication use, we try our utmost to provide this medication responsibly. These types of medications have many side effects including physical dependence. A person can develop a tolerance and dependence issues to narcotic/opioid medications in as little as two weeks. Because of this tolerance, we avoid prescribing narcotic/opioid medication before surgery and minimize the time patients take these types of medications, so the medicine works best for the patient when they need it after surgery for post-operative discomfort.

By signing, I acknowledge that I have received a copy of the Pain Medication Policy of IRISE Spine and Joint and agree to abide by the policy guidelines as a condition of my patient responsibility with IRISE Spine and Joint.

SIGNATURE REQUIRED

Patient's Printed Name **Signature** **Date**