



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		Present	Past
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Middle Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Numb Hands/Fingers	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Numb Feet/Toes	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hiatus Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack/Angina	<input type="checkbox"/>	<input type="checkbox"/>
Ear Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Tension	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer Disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	Immune Disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapses	<input type="checkbox"/>	<input type="checkbox"/>	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: _____

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

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

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

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.

Patient's Printed Name: _____

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

**SIGNATURE
REQUIRED**

INTAKE QUESTIONNAIRE**Details of present incident**

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

Medical HistoryPrevious Slip & Fall(s) Yes No If yes, please describe: _____Previous Auto Accident(s) Yes No If yes, please describe: _____Hospitalization(s) Yes No If yes, please describe: _____Surgery(s) Yes No If yes, please describe: _____Current or Prior Disease(s) Yes No If yes, please describe: _____**History of Injury (check all that apply)**Were you: Inside a home Outside a home Inside a business Outside a business On the job In the wilderness

Describe your slip and fall _____

Did you report your fall to any supervisor/manager/employee/owner? Yes No I can't remember Were you stopped (standing still) at the time of the incident? Yes No Were you moving/walking upright before the moment of impact? Yes No Did you collide with another person? Yes No Did any other object(s) hit you? Yes No If so, where? _____Head position at moment of impact: Looking straight ahead Right Left Looking Back Don't KnowOther _____Did you brace yourself? Yes No If yes, with: Arms Legs Both arms and legsDid your body strike any object (i.e. wall, railing, sidewalk)? Yes No If yes, complete all that apply: Head hit _____ Chest hit _____ Right Hip Left Hip hit _____ Right Leg Left Leg hit _____ Right Shoulder Left Shoulder hit _____ Right Arm Left Arm hit _____ Right Knee Left Knee hit _____ Other body part _____ hit _____**After Incident**Did you lose consciousness? Yes No If yes, for how long _____ minutes hours days weekAfter the fall, 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 FootAfter 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 _____Did you report the accident to the police? Yes No I can't remember **The information provided above is true and correct to the best of my knowledge.****SIGNATURE
REQUIRED****Patient's Signature:** _____

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

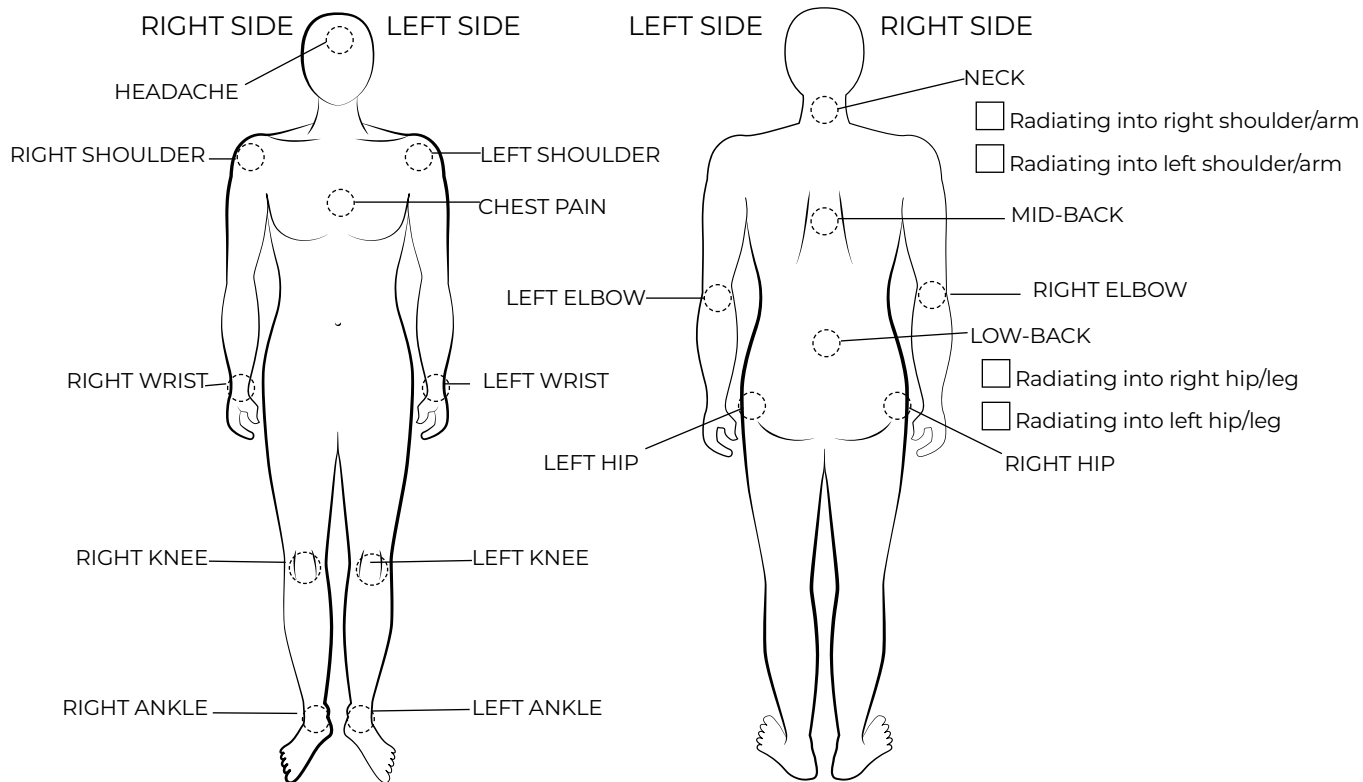
Patient's Printed Name Date of Birth SSN

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 Myofascial 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 caused 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 injuries 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