FLORENCE
NEUROSURGERY
& SPINE CENTER
1204 E Cheves Street, Florence SC 29506
Phone (843) 673-0122 / Fax (843) 673-0227

Andrew Rhea, MD • William Naso, MD • James Brennan, MD • Christopher Paramore, MD

Welcome New Patients……

Thank you for choosing our practice for your care. The staff at Florence Neurosurgery & Spine would like to make your experience with our office a pleasurable one.

In order to better serve you, we ask our patients to bring the completed attached forms, their current insurance cards and driver's license or other picture identification. **Our physicians require that you bring the actual x-rays and/or other films or disc with you before they are able to see you.** If you have any questions regarding this matter, please call before your appointment.

For patients with HMO's or PPO insurances that require referrals, we must have an insurance referral from you primary care physician before you can be seen by our physicians.

If you were injured at work, we require a letter of authorization from your workman's compensation carrier which includes the carrier name, address, phone number. This should also include the name and phone number of a contact person/claims adjuster. This information can also be mailed or faxed to our office prior to your visit.

We do not file automobile insurance or accept letter of protection from attorneys. If you do not have health insurance, please contact our office prior to your visit to discuss payment arrangements.

Our office requires payment for services rendered before leaving our office. Please bring any co-pay or deductibles that your insurance requires with you to your visit. If you are uninsured, please contact our office to discuss our payment policies and arrangements BEFORE your visit. Monthly payment arrangements may be offered to insure that your account is not sent to an outside collection agency or attorney.

As a courtesy to you, our office accepts case, personal checks, money orders, VISA and MasterCard.

If you have any questions regarding your appointment or our office policy, please feel free to contact our office.

Thank you,

Florence Neurosurgery and Spine, P.C.

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Account #:_____

PATIENT REGISTRATION / AUTHORIZATION / CONSENT FORM

Please Present Insurance Card(s) and photo I.D. for copying

Patient Information

First Name_____ M.I___ Last Name_____ SS# _____

D.O.B_____/_____/_____ Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ SEP

Address _____ City_____ State/ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Employer _____

Primary Care Physician_____ Referring Physician_____

Pharmacy Name and Phone Number _____

Emergency Contact_____ Relationship _____ Phone_____

☐ CHECK HERE TO DECLINE ANSWERING THE FOLLOWING 3 QUESTIONS

1) My preferred Language is:
- A. English
- B. Spanish
- C. Other _____

2) My Race is: (please circle one)
- A. American Indian
- B. Asian
- C. Black/African American
- D. Hawaiian/Pacific Islander
- E. White/Caucasian
- F. Other _____

3) My Ethnicity is: (please circle one)
- A. Hispanic or Latino
- B. Not Hispanic or Latino

Insurance Information

Primary Insurance _____

Policy Holder Name_____ ID# _____

Primary Holder D.O.B. _____/_____/_____SS# _____

Primary Card Holder Employer _____

Secondary Insurance _____

Policy Holder Name_____ ID# _____

Primary Holder D.O.B. _____/_____/_____SS# _____

Other _____

Were you injured at work or is your complaint related to an accident? ☐ Yes ☐ No

Name and Relationship, other than Emergency Contact, allowed to discuss your health information

Name and Relationship, other than Emergency Contact, allowed to discuss your health information

1. _____ 2. _____

PLEASE SEE REVERSE SIDE

Consent for Treatment, Payment, and Healthcare Operations

I AUTHORIZE FLORENCE NEUROSURGERY AND SPINE TO FURNISH INFORMATION TO INSURANCE CARRIERS, REFERRING PHYSICIANS, FAMILY PHYSICIAN, ANESTHESIA PROVIDERS, LABORATORY SERVICES, RADIOLOGY SERVICES, PEER REVIEW, COMMITTEES FOR PERFORMANCE, IMPROVEMENT OF QUALITY, FEDERAL, STATE AND LOCAL REGULATORY AGENCIES. I ALSO HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO FLORENCE NEUROSURGERY AND SPINE, REALIZING THAT I AM PERSONALLY RESPONSIBLE FOR CO-PAYMENTS, DEDUCTIBLES, CO-INSURANCES AND ANY OTHER NON-COVERED SERVICES. I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY MY INSURANCE COMPANY. IN THE EVENT THAT MY ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY, I AM ADVISED THAT I MAY BE BILLED THE ADDITIONAL COLLECTION FEES, ATTORNEY FEES AND COURT COSTS.

I consent to the uses or disclosure of my protected health information by Florence Neurosurgery and Spine, P.C. For the purpose of diagnosing or providing treament to me, obtaining payment for my health care bills or to conduct health care operations of Florence Neurosurgery and Spine, P.C. I understand that diagnosis or treatment of me by Andrew H. Rhea, M.D., William B. Naso, M.D., James J. Brennan, M.D., Christopher G. Paramore, M.D., and Barbara Sarb, D.O. as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Florence Neurosurgery and Spine, P.C. is not required to agree to the restrictions that I may request.

I have the right to revoke this consent, in writing, at any time, except to the extent that Andrew H. Rhea, M.D., William B. Naso, M.D., James J. Brennan, M.D., Christopher G. Paramore, M.D., and Barbara Sarb, D.O. or Florence Neurosurgery and Spine, P.C. has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected by me and created or received by my physician, another health provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Florence Neurosurgery and Spine, P.C.’s Notice of Privacy Practices prior to signing this document. The Florence Neurosurgery and Spine, P.C.’s Notice of Privacy has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Florence Neurosurgery and Spine, P.C.

The Notice of Privacy Practices for Florence Neurosurgery and Spine, P.C. is also provided in the lobby of our office. This Notice of Privacy Practices also describes my rights and Florence Neurosurgery and Spine, P.C.’s duties with respect to my protected health information.

Florence Neurosurgery and Spine, P.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Patient Signature Date

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ACCIDENT/WORKER'S COMPENSATION QUESTIONNAIRE

The healthcare services you receive may be related to an accident. Your insurance company may evaluate your responsibility, please complete, sign and return this form

Name _____ D.O.B. _____ Age _____

Was the injury or illness: **Auto/Motorcycle Accident** _____ **Work Related** _____

Other Accident _____ **No Accident** _____

Date of injury or illness: _____

Describe the injury or illness and how it happened: _____

_____

_____

If you checked "Auto/Motorcycle Accident" or "Other Accident", please answer the following:

Did another person cause this accident? ❑ Yes ❑ No

If yes, name and address of person causing injury: _____

Insurance Company of person causing injury: _____Policy/Claim # _____

Address and Phone #:_____ Adjuster's Name: _____

If auto or motorcycle related, was the patient wearing a seatbelt? ❑ Yes ❑ No a helmet? ❑ Yes ❑ No

If auto or motorcycle related, was the patient the driver? ❑ Yes ❑ No or a passenger? ❑ Yes ❑ No

Auto Insurance Company of Patient:_____Policy/Claim # _____

Address and Phone #:_____ Adjuster's Name: _____

If you checked "Work Related," please answer the following:

Name and address of patient's employer at the time of injury: _____

Have you filed a Workers' Compensation claim? ❑ Yes ❑ No

If yes, name of Workers' Compensation carrier: _____

Policy/Claim # _____ Adjuster's Name: _____

Address and Phone # _____

Has the emplyer or the Workers' Compensation carrier accepted or denied liability? ❑ Accepted ❑ Denied

Name, address, and telephone number of your attorney (if applicable):_____

I agree that the above information is correct, and I will not settle a claim before contacting the Subrogation/Workers' Compensation Department of my Insurance Company.

_____

_____

Account #:_____

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Name of Patient _____ Date of Birth _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication made by alternative means. Florence Neurosurgery & Spine, PC is authorized to release protected health information about the above named patient in the following manner and to persons identified below.

I wish to be contacted in the following manner (check all that apply):

Home Telephone

- ☐ Leave message with medical information
- ☐ Leave message with billing information

Written Communication

- ☐ Mail to my home address
- ☐ Mail to my work/office address

Work Telephone

- ☐ Leave message with medical information
- ☐ Leave message with billing information

Emergency Contact

- ☐ Leave message with medical information
- ☐ Leave message with billing information

Other Entities Allowed to Receive Information. List each person/entity that you approve to receive information.		**Type of Information Allowed to Disclose** (Check one or both)		**Method of Disclosure** (Check one or both)	
Name	**Relationship**	**Medical**	**Billing**	**By Phone**	**In Person**
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation must be provided in writing and is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient upon written notice.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

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HEALTH HISTORY QUESTIONNAIRE

The Following information is very important to your health. Please fill out correctly.

Name _____ D.O.B. _____ Age _____

Home Phone _____ Cell Phone _____ Work Phone _____

Handedness ❑ Right ❑ Left Weight _____ Height _____ Sex: M or F

Vitals: HR _____ BP _____ R _____ T _____

Primary Care Physician _____ Referring Physician _____

Pharmacy Name and Phone Number _____

Chief Complaint _____

_____

Date of Onset _____ Related to injury or accident? ❑ Yes ❑ No

Therapy to Date: ❑ Epidural Steroid Injection ❑ Oral Steroid ❑ Pain Medication ❑ Non-Steroids
❑ Physical Therapy ❑ Chiropractor ❑ Brace/Collar ❑ Muscle Relaxer ❑ Surgery related to complaint
❑ TENS Unit ❑ Nerve Block ❑ Other _____

Past Medical History:

Please Check All that Apply – To self or family

	Self	Family		Self	Family
High Blood Pressure	❑	❑	Cancer	❑	❑
Diabetes	❑	❑	Stomach Ulcers	❑	❑
Asthma	❑	❑	Bleeding Disorders	❑	❑
Heart Disease	❑	❑	Alcoholism	❑	❑
Heart Attack	❑	❑	Liver Disease	❑	❑

Other _____

Past Surgical History _____

_____

Medications (including dosage) _____

_____

_____

Allergies _____

Social History:

Marital Status: S M W D SEP Occupation _____

Children? ❑ YES ❑ NO If yes, how many _____

Do you smoke? ❑ YES ❑ NO If yes, how much _____

Previously smoke? ❑ YES ❑ NO If yes, how much _____

Do you drink Alcohol? ❑ YES ❑ NO If yes, how much _____

Previously drink? ❑ YES ❑ NO If yes, how much _____

PLEASE SEE REVERSE SIDE

Patient Review of Systems Questionnaire

Constitutional Symptoms	Yes	No
fever	_____	_____
weight loss	_____	_____
night sweats	_____	_____
chills	_____	_____

Eyes		
recent visual loss	_____	_____
double vision	_____	_____
blind spots	_____	_____
tunnel vision	_____	_____
trauma	_____	_____

Ears, Nose, Mouth, Throat		
recent hearing loss	_____	_____
ear pain	_____	_____
nose bleeds	_____	_____
sore throat	_____	_____

Cardiac / Circulatory		
chest pain	_____	_____
swelling of feet / ankles	_____	_____
pain in lower legs when walking	_____	_____
abnormal heart rhythm	_____	_____

Hematologic		
bleeding problems	_____	_____
frequent / recurrent infections	_____	_____
previous bleeding problems w/ surgery	_____	_____

Genitourinary	Yes	No
blood in urine	_____	_____
pain with urination	_____	_____
involuntary loss of urine	_____	_____

Gastrointestinal		
abdominal pain	_____	_____
vomiting	_____	_____
dark or bloody stools	_____	_____
diarrhea	_____	_____
involuntary loss of stools	_____	_____

Musculoskeletal		
joint pain	_____	_____
which?	_____	
joint swelling	_____	_____
which?	_____	
inflammation / redness joints	_____	

Endocrine		
breast discharge	_____	_____
irregular / absent menstrual cycle	_____	_____
heat / cold intolerance	_____	_____
recent severe weight gain	_____	_____
possible pregnancy	_____	_____

Respiratory		
shortness of breath	_____	_____
cough	_____	_____
cough with bleeding	_____	_____

Patient Signature **Date** **Physician Signature** **Date**

_____ _____ _____ _____

The information provided on my Health History Questionnaire form is true and correct to the best of my belief.

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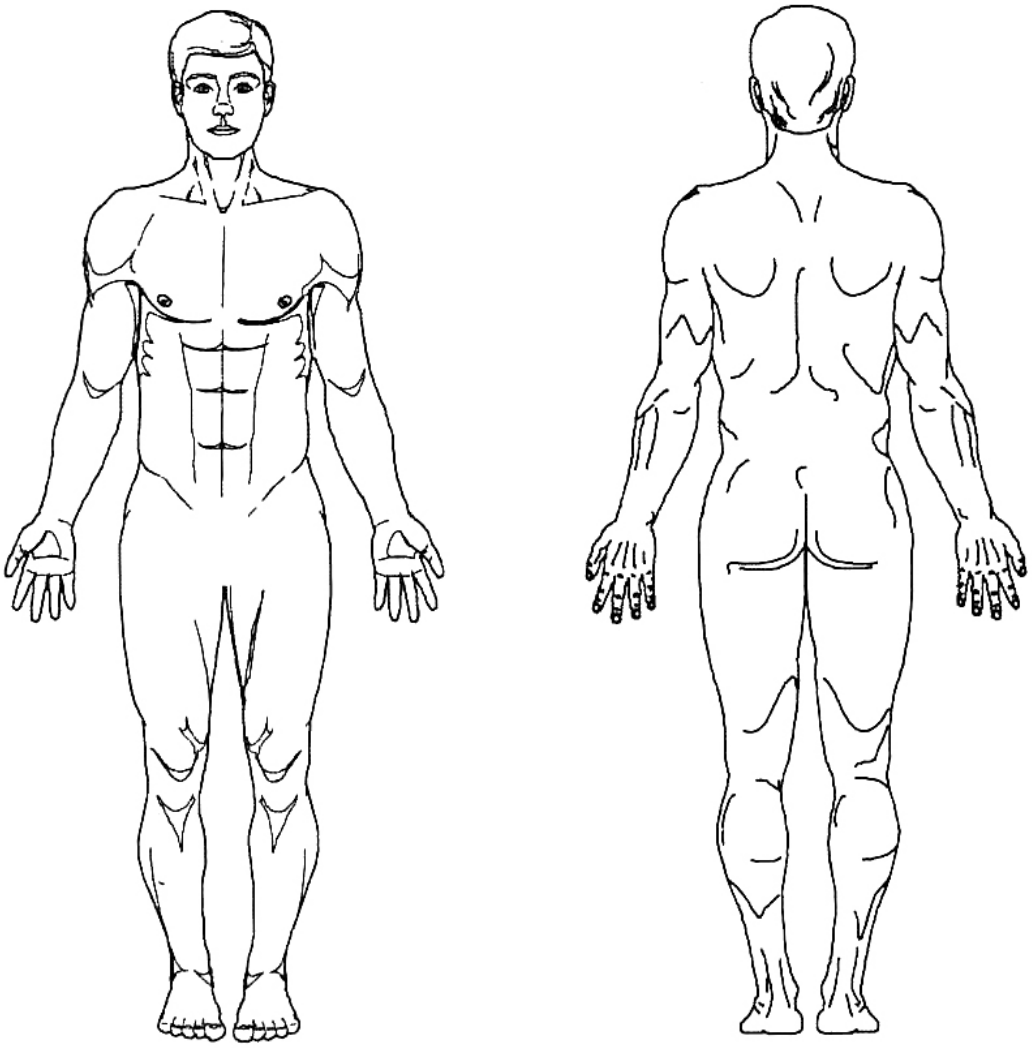
DESCRIPTION OF PROBLEMS

Name _____ D.O.B. _____



Please rate the intensity of your pain, on **scale from 1 to 10**, with 10 being the worst pain.
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

- Please draw in the pattern of your pain (XXX), numbness (OOO) or tingling (----) on the man above
- History of Injuries, associated symptoms _____

_____

_____

_____ _____

Patient Signature Date