



O: (813) 819-0290

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300 State St. East #222

Oldsmar, FL 34677

**New Patient Paperwork**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell: \_\_\_\_\_ Home/Work: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone #: \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

\_\_\_\_\_

Patient or legal Guardian signature

\_\_\_\_\_

Date

## **Patient Consent Form**

Welcome to National Spine Institute. We will strive to help restore and improve your health but there are no guarantees or promises of improvement or complete recovery.

Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability, or religious or political beliefs; these quality healthcare services will be delivered with dignity and concern.

Your signature on this document fully authorizes our doctor and staff to perform any examination, diagnostic tests, and/or treatments as well as we may consider medically necessary and to release all information pertinent to your health, insurance, or benefits to all applicable parties on your behalf.

Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This facility shall not be liable for the loss or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, documents, or any other personal items.

Your signature on this document confirms that you have read, understand, and agree to comply with all terms and conditions of National Spine Institute and that you grant the physician and staff to use and share your confidential health information with other treating physicians to treat you and/ or to arrange for payment of your bill and/or for issues that concern National Spine Institute operations and responsibilities.

As a courtesy to you, we may call you on the telephone when an appointment is missed and/or you have not been in a while.

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Patient or legal Guardian signature

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Date

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

What is the main reason you are here: \_\_\_\_\_

**Past Medical History (check all that apply)**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Heart Attack    |
| <input type="checkbox"/> Asthma/Bronchitis  | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Ulcers          |
| <input type="checkbox"/> Hypo/Hyper Thyroid | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> HIV/Hepatitis C |
| <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> History of Cancer    | Other: _____                             |
|   | Type: _____                                   |  |

**Past Surgical History**

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> Appendix                | <input type="checkbox"/> Breast surgery | <input type="checkbox"/> Arthroscopy  |
| <input type="checkbox"/> Gall Bladder            | <input type="checkbox"/> Back Surgery   | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Heart Bypass/Stents     | <input type="checkbox"/> Tonsillectomy  | Other: _____                          |
| <input type="checkbox"/> Total Joint Replacement |   |                                       |

**Family Medical History**

Has anyone in your immediate family died of heart disease: YES NO

Has anyone in your family had an adverse reaction to anesthesia: YES NO

Has anyone in your family had an adverse reaction to latex: YES NO

List any medical illnesses that run in your family: \_\_\_\_\_  
\_\_\_\_\_

**Social History**

Who do you live with now: By yourself Spouse Family Friends Other: \_\_\_\_\_

Do you smoke tobacco? YES NO How many packs per day? \_\_\_\_\_ How long? \_\_\_\_\_ years

Do you drink alcohol? YES NO How often? \_\_\_\_\_ How long? \_\_\_\_\_ years

Are you currently working? YES NO If yes, where do you work? \_\_\_\_\_

Do you now or have you had any problems related to the following/ **(Circle all that apply)**

**Constitutional**

- Fever
- Chills
- Headaches

**Eyes**

- Blurred Vision
- Double Vision
- Pain

**Ear/Nose/Throat**

- Ear Infection
- Soar Throat
- Sinus Problems

**Genitourinary**

- Urine Retention
- Painful Urination
- Urinary Frequency

**Neurological**

- Tremors
- Dizzy spells
- Numbness/tingling

**Endocrine**

- Excessive thirst
- Too hot/cold
- Tired/Sluggish

**Gastrointestinal**

- abdominal Pain
- Nausea/Vomiting
- Rectal Bleeding

**Respiratory**

- Frequent Cough
- Short of breath
- Wheezing

**Hematologic/Lymphatic**

Swollen Glands  
Blood Clots  
Bleeding

**Cardiovascular**

Chest Pain  
Varicose Veins  
Arrhythmia

**Integumentary**

Skin Rash  
Boils  
Persistent Itch

**Psychological**

Depression  
Bipolar Disorder  
Schizophrenia

Do you have any allergies to medications: YES NO What? \_\_\_\_\_

Please mark any prior treatments that you have had for this problem and the number of times you have had each

TREATMENT	X	HELPFUL YES/NO	# OF INJECTIONS	DATES OF EACH
Epidural Injection				
Facet Injection				
SI Joint Injection				
Radiofrequency Ablation				
Trigger Point				
Nerve Blocks				
Discectomy				

Please list any other physicians you have or are currently seeing for this problem

PHYSICIAN	SPECIALTY	TREATMENT/TESTS	PHONE NUMBER

Current Medications (List all medications. Use the back of this sheet if you need more room)

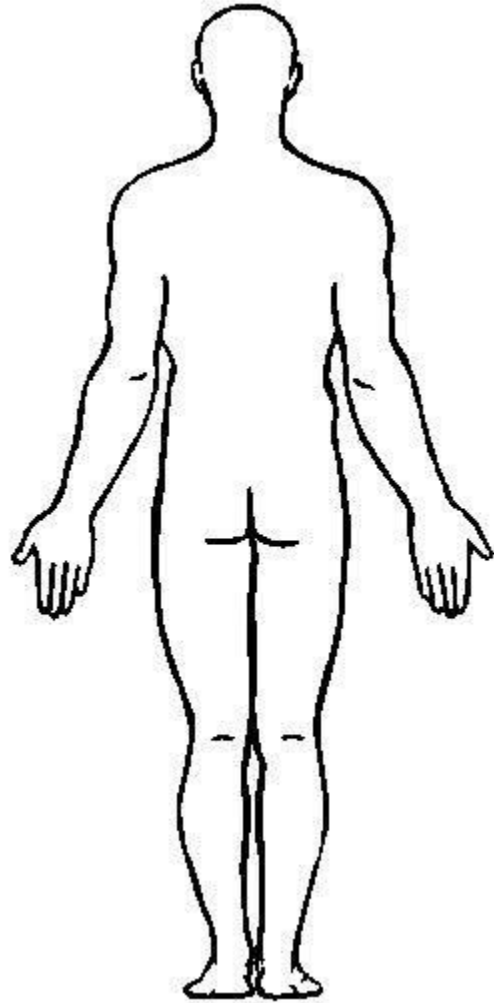
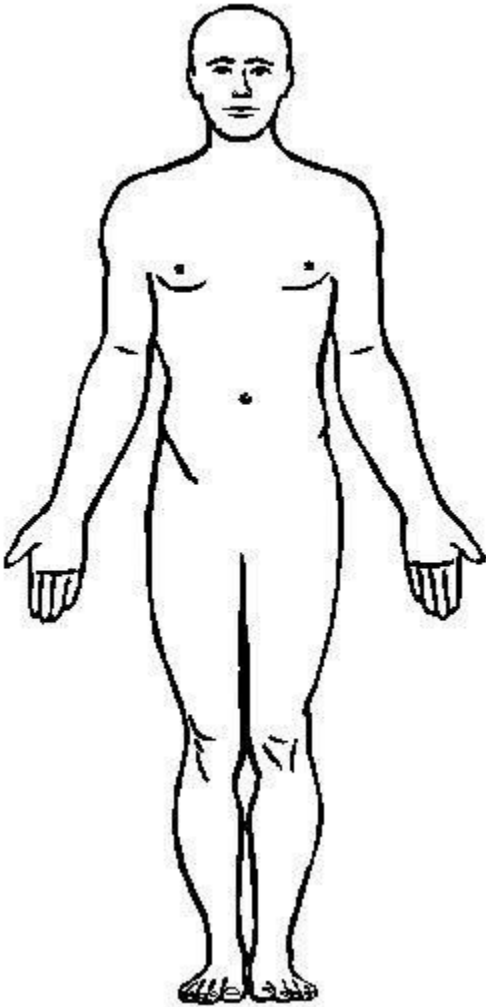
MEDICATION	DOSAGE	#PER DAY	REASON FOR TAKING

**Activities of Daily Living:**

Please list activities that are difficult to perform, or that you are unable to perform since the injury. Please only list if you were previously performing the activity.

_____	_____
_____	_____
_____	_____

Please use the key below to indicate the location(s) of your pain:



Key:

X=PAIN

O=NUMBNESS

/=ACHING

\*=PINS/NEEDLES

On a scale of 0-10, what is your pain level? \_\_\_\_\_

Which of these do you experience (circle all that apply) Shooting Tingling Numbness Aching

Burning Deep Dull Sharp Stabbing Throbbing Other: \_\_\_\_\_

## Medical Records Release Authorization

To avoid a delay, the top, and bottom of this document must be filled in its entirety.

Please print clearly

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_

Permission is hereby granted to Dr. James St. Louis, and National Spine Institute to release medical information to the individual/organization as noted below or to have records released to Dr. James St. Louis and National Spine Institute.

- Mail      Name: \_\_\_\_\_  
                  Address: \_\_\_\_\_  
                  City/State/Zip: \_\_\_\_\_
  
- Fax records ( \_\_\_\_\_ ) \_\_\_\_\_

Please check the information to be released:

- All records
- Surgical Records
- Therapy Reports
- Diagnostic Test Results
- Other
- Office Notes Only
- X-ray/MRI Films
- X-ray/MRI Reports
- Patient Information

This authorization will be valid for two years after the date of the patient's signature as it appears below.

I understand I have the right to refuse this authorization, in writing, Dr. James St. Louis and National Spine Institute are released from all legal liability that may arise from the information requested.

\_\_\_\_\_

Printed name

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

## **Notice of Privacy Practice**

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review carefully.

At National Spine Institute, we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act (HIPAA) requires us to continue to maintain your privacy, to give you this notice, and follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services.

We may use or disclose your health information for our normal healthcare operations. We may use your information to contact you. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all your health information when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your medical records to another practice. You may pick it up in the office or we will mail your files to you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copies of, however, we may charge you a fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request but we will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents but will add new information.

You have a right to receive a copy of this notice.

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Printed name

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Signature

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Date

**Authorization for Provider Lien; Personal Guaranty of Payment; Authorization  
for Release of Information**

I grant National Spine Institute a lien against any recovery I may have now or in the future against any tortfeasor or responsible insurance carrier. I hereby direct that any attorney representing me now or in the future execute this letter of protection in favor of NATIONAL SPINE INSTITUTE. I hereby further give a lien on my case to the NATIONAL SPINE INSTITUTE an amount equal to the outstanding balance for services rendered to me by National Spine Institute. This lien shall be against all proceeds of any settlement, judgment, or verdict that may be paid to my attorney or me due to injuries for which I have been treated or in connection.

I hereby authorize NATIONAL SPINE INSTITUTE to furnish you, my attorney, with a full report of their examination of me regarding the accident or injury that occurred.

I hereby guarantee full payment to NATIONAL SPINE INSTITUTE and agree that I will remain personally responsible for any unpaid charges resulting from a deductible, co-payment, or treatment after the benefits are exhausted.

I hereby authorize and direct any attorney in my past or present employ, to pay directly to NATIONAL SPINE INSTITUTE such sums as may be due and owing to them for professional services rendered to me both because of this accident and because of any other bills that are due to their office and to withhold such sums from any settlement, judgment, or verdict, as may be necessary adequately to protect NATIONAL SPINE INSTITUTE.

I fully understand that I am directly and fully responsible to NATIONAL SPINE INSTITUTE for all professional bills submitted by NATIONAL SPINE INSTITUTE for services rendered to me and that this agreement is made solely for NATIONAL SPINE INSTITUTE additional protection and in consideration of their awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. NATIONAL SPINE INSTITUTE may at its discretion bill me directly at any time for any amounts then due and owing. I further agree to pay any amounts billed to me within ten (10) days of the billing date. If I should fail to pay any amount, NATIONAL SPINE INSTITUTE may put my account into collections, with costs of collection, including a reasonable attorney's fee, to be borne by me.

The attorney shall withhold all amounts necessary to fully compensate NATIONAL SPINE INSTITUTE for services rendered to the patient and shall not distribute funds received in settlement of the patient's claim unless first satisfying NATIONAL SPINE INSTITUTE's full balance or receiving written acceptance of less than the full amount from NATIONAL SPINE INSTITUTE should the below need attorney cease representing the patient, this lien shall be binding on all subsequent lawyers or law firms retained by the patient in this matter.

Any failure of NATIONAL SPINE INSTITUTE to avail itself of any of the protection afforded under this agreement shall not constitute a waiver of that remedy.

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## **No-Show and Cancellation Policy**

Please review carefully. **Initial below** to acknowledge and agree to the no-show and cancellation policy.

\_\_\_\_: Your time is very important to us, to be respectful of the medical needs of our patients please be courteous and call promptly if you are running late or unable to attend an appointment or procedure.

This time will be reallocated to someone who is in urgent need of treatment. If necessary to cancel, we will require that you call **2 business days** before your scheduled appointment or a no-show fee of \$750 will be charged.

\*\*Appointments and procedures dates are in high demand and your early cancellations will give another person the possibility to have access to timely medical care.\*\*

\_\_\_\_: If you show up more than 15 minutes after your scheduled appointment time, you will be considered a "no show" and your appointment could be rescheduled.

\_\_\_\_: To cancel an appointment/procedure, please contact our office at (813) 819-0290. If you're unable to reach someone, please leave a detailed message stating your name, date, and time of your appointment/procedure.

\_\_\_\_: Any surgical appointment cancellations within **5 business days or no-shows** will be considered as an incomplete appointment/procedure and will be subjected to a \$7,500.00 cancellation fee.

\_\_\_\_: For value received, including but not limited to the services rendered, I agree to pay National Spine Institute all charges and expenses incurred in my treatment. This would include those expenses not covered by my attorney. Unless specifically agreed in writing, all charges shall be paid upon presentation of any bills by the National Spine Institute.

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### **Accident Questionnaire**

1. Date of accident: \_\_\_\_\_
  2. Type of Accident: Slip and Fall, Motor Vehicle, or other: \_\_\_\_\_
  3. Type of vehicle you were driving/riding in: \_\_\_\_\_
  4. What type of vehicle hit you?: \_\_\_\_\_
  5. What position in the vehicle were you in (driver or passenger): \_\_\_\_\_
  6. How did the accident happen?: \_\_\_\_\_
- 
- 

- |   |     |    |
|---|-----|----|
| 7. Were you wearing a seatbelt?                               | YES | NO |
| 8. Did police arrive on the scene?                            | YES | NO |
| 9. Were you taken to the hospital by ambulance?               | YES | NO |
| 10. Did you go to the hospital if you didn't go by ambulance? | YES | NO |

If so, where? \_\_\_\_\_

11. If you didn't go to the hospital, where did you seek treatment?: \_\_\_\_\_
- 

- |  |     |    |
|--|-----|----|
| 12. Have you been in a prior accident? | YES | NO |
| 13. Have you had this pain before?     | YES | NO |