O: (813) 819-0290

F: (833) 551-0405

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.

_____ _____

Patient or legal Guardian signature Date

Patient Name: _____ Date: _____

What is the main reason you are here: _____

Past Medical History (check all that apply)

__ Diabetes
__ Asthma/Bronchitis
__ Hypo/Hyper Thyroid
__ High Cholesterol
__ High Blood Pressure
__Rheumatoid Arthritis
__ Heart Disease
__ History of Cancer
Type: _____
__ Heart Attack
__ Ulcers
__HIV/Hepatitis C
Other: _____

Past Surgical History

__ Appendix
__ Gall Bladder
__ Heart Bypass/Stents
__Total Joint Replacement
__ Breast surgery
__ Back Surgery
__ Tonsillectomy
__ Arthroscopy
__ Hysterectomy
Other: _____

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	**Eyes**	**Ear/Nose/Throat**	**Genitourinary**
Fever	Blurred Vision	Ear Infection	Urine Retention
Chills	Double Vision	Soar Throat	Painful Urination
Headaches	Pain	Sinus Problems	Urinary Frequency

Neurological	**Endocrine**	**Gastrointestinal**	**Respiratory**
Tremors	Excessive thirst	abdominal Pain	Frequent Cough
Dizzy spells	Too hot/cold	Nausea/Vomiting	Short of breath
Numbness/tingling	Tired/Sluggish	Rectal Bleeding	Wheezing

Hematologic/Lymphatic	**Cardiovascular**	**Integumentary**	**Psychological**
Swollen Glands	Chest Pain	Skin Rash	Depression
Blood Clots	Varicose Veins	Boils	Bipolar Disorder
Bleeding	Arrhythmia	Persistent Itch	Schizophrenia

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

Please mar 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:

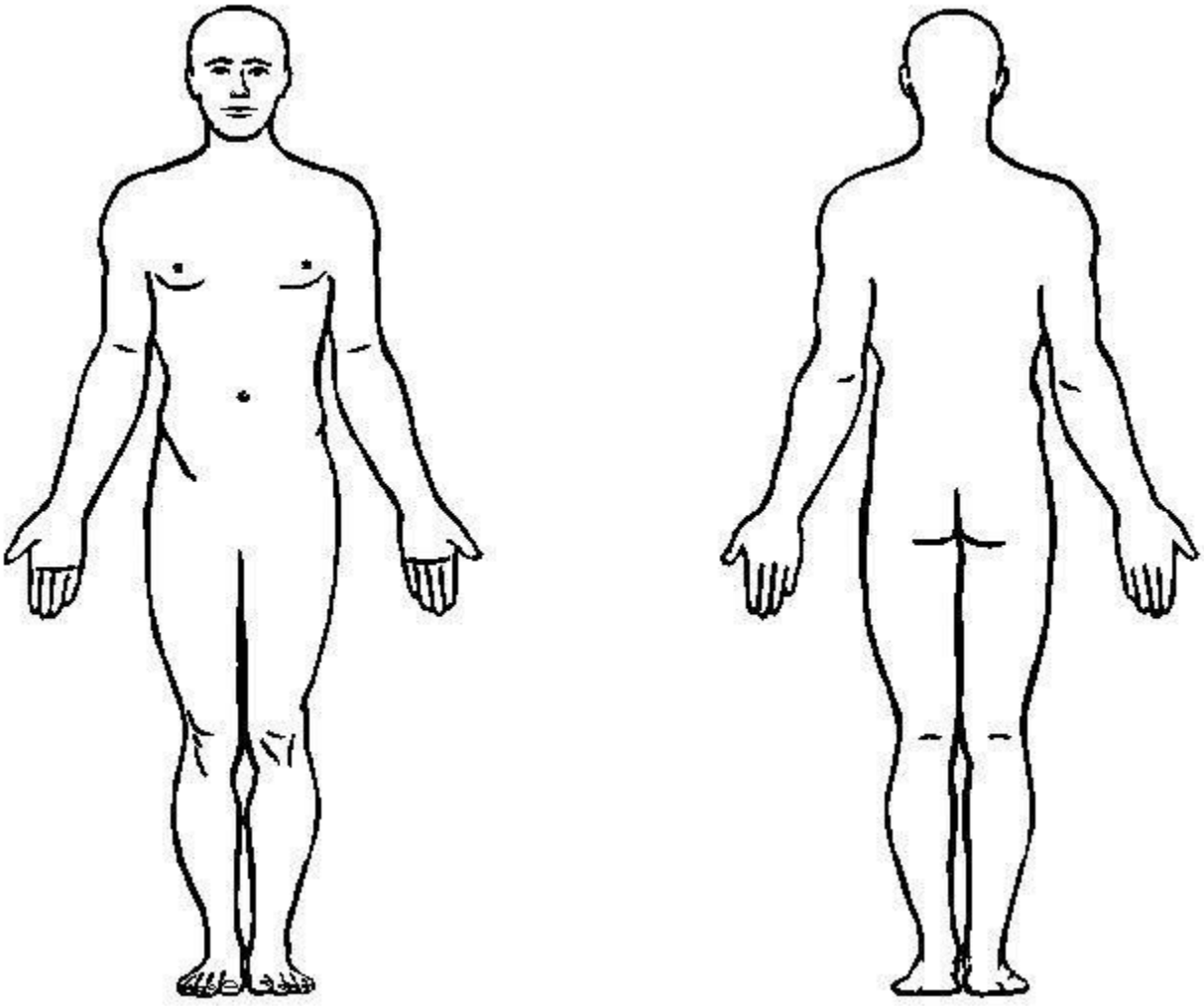
Please list activities that are difficult to perform, or that you are unable to perform since the injury. Please only list if you were previously performing the activity.

_____ _____

_____ _____

_____ _____

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.

_____

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