BRAIN AND SPINE
NEUROSCIENCE INSTITUTE

New Patient Information Sheet

Patient Name: _____ Date: _____

Primary Care Physician: _____ Referring Physician: _____

Occupation: _____

Reason for your visit: _____

**Symptoms:**

When did symptoms begin: _____

Is this related to an auto accident? __Yes __No OR workers' compensation? __Yes __ No

When does the pain/problem occur (i.e.: morning/night) _____

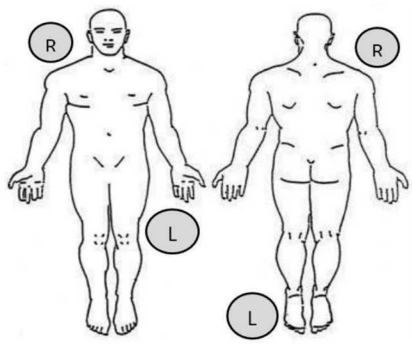
What aggravates the symptoms: _____

What reduced the symptoms: _____

**Please check if you have other symptoms:**

| Symptom | Occurrence | Location |
|---|---|---|
| ☐ Numbness | ☐ Constant ☐ Intermittent | |
| ☐ Pins/Needles/Tingling | ☐ Constant ☐ Intermittent | |
| ☐ Sharp Pain | ☐ Constant ☐ Intermittent | |
| ☐ Dull/Achy Pain | ☐ Constant ☐ Intermittent | |

**Shade the areas you have pain**




| Types of Therapy | Effect on your Symptoms | Month/Year |
|---|---|---|
| ☐ Physical Therapy | ☐ Better ☐ Worse ☐ No Change | |
| ☐ Nerve Blocks | ☐ Better ☐ Worse ☐ No Change | |
| ☐ Medication Use | ☐ Better ☐ Worse ☐ No Change | |
| ☐ Chiropractor | ☐ Better ☐ Worse ☐ No Change | |
| ☐ Other | ☐ Better ☐ Worse ☐ No Change | |

**Rate Your Pain:** Pain Scale 0 = No Pain 10 = Severe Today: ____ Last Week: ____

**Current Medications: List all medications you are taking, including over the counter and vitamins.**

☐ No medications

| Name | Dose/Mg | Frequency |
|---|---|---|
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Allergies: List all known allergies to medications, food and latex.

☐ No known drug allergies

| Name | Reaction |
|---|---|
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**Medical History: List all medical problems for which you are currently being treated for.**

☐ No Medical History

| Medical Problem | Medical Problem |
|---|---|
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## Surgical History: List all surgical procedures and year.

☐ No Surgeries

| Year | Procedure |
|---|---|
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## Family History:

**Is there a family history of: PLEASE CIRCLE YES OR NO**

YES or NO CANCER

YES or NO HYPERTENSION

YES or NO HYPERLIPIDEMIA

YES or NO DIABETES

YES or NO CORONARY ARTERY DISEASE

YES or NO STROKE

YES or NO ALZHEIMER'S

YES or NO DEPRESSION

YES or NO OSTEOPOROSIS

YES or NO DOMESTIC VIOLENCE

## Social History: Circle yes or No

Alcohol Use: Yes or No ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

Tobacco Use: Yes or No_____ Packs per day for _____ # of years. Quit smoking _____ years ago.

Street Drug Use: Yes or No Type: _____Frequency: _____Date of last use: _____

Caffeine Use: Yes or No Soda/Coffee/Tea _____ Cups daily

Weight: _____ Height: _____

BRAIN AND SPINE
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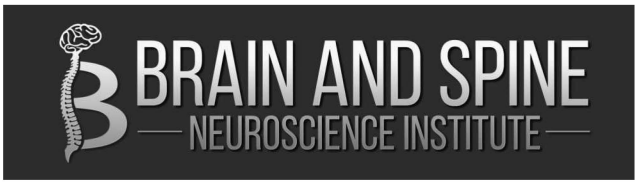
# *Review of Systems*

*Please circle if you have had any of the below symptoms within the last 2 weeks*

| | |
|---|---|
| *Constitutional* | Chills- Fever- Weight Loss- Weakness- Decline in Health- Fatigue- Weight Gain- |
| *Head* | Headache- Injury- Dizziness- |
| *Eyes* | Double Vision- Blurry Vision- |
| *ENT* | Ears- Infection- Dizziness- Pain- Difficulty Hearing-<br>Nose- Nosebleeds-<br>Mouth- Voice Change- Difficulty Swallowing-<br>Throat- Difficulty Swallowing- Swelling- |
| *Respiratory* | Cough- Wheezing- Sputum- Shortness of Breath- |
| *Cardiovascular* | Chest Pain- Heart Murmur- Coolness of Extremities- Shortness of Breath- |
| *Gastrointestinal* | Decrease in Appetite- Difficulty Swallowing- Reflux- Diarrhea- Vomiting- Constipation- Bowel Incontinence- |
| *Musculoskeletal* | Gout- Muscle Cramps- Muscle Stiffness- Restricted Motion- Joint Pain- Weakness- Paralysis- |
| *Skin* | Rashes- Abscess- Bruising- |
| *Neurological* | Memory Loss- Dizziness- Fainting- Head Injury- Loss of Consciousness- Numbness- Paralysis- Speech Disorder- Stroke- Tingling- Tremors- Unsteady Gait- |
| *Endocrine* | Excessive Urinating- Fatigue- Neck Pain- Sweats- Weakness- Weight Loss- Weight Gain- |
| *Hematologic/Lymh* | Anemia- Easy Bleeding- Blood Clots- Easy Bruising- Radiation Exposure- Swollen Glands- Transfusion Reaction- |
| *Allergic/Immunologic* | Coughing- Recurrent Infection- |
| *Urinary* | Awakening to Urinate- Bed Wetting- Blood in Urine- Difficulty Starting Stream- Excessive Urination- Incontinence- Infections- Retention- Painful Urination- Urgency- |
| *Reproductive* | Erectile Dysfunction- Impotence- Sexual Problems- Scrotal Numbness- Groin Numbness- |

_____ _____

Patient name Date




**Patient Information:**

Patient Name:_____Social Security Number:_____-____-_____
Date of Birth:____/____/_____ Sex: M/F (Circle one) Married/Single/Divorced
Race: _____ Ethnicity: _____
Address: _____
(Street) (City/State/Zip)
Home Phone: (_____) _____-_____Cell: (_____) _____-_____
E-mail Address_____
Primary Care Physician: _____ Referring Physician:_____

How did you hear about our practice?_____

Employer Name:_____ Employer Phone: (_____) _____-_____
Employer Address:_____
(Street) (City/State/Zip)

**Person Responsible for this account (if different from the above):**

Patient Name:_____Social Security Number:_____-____-_____
Date of Birth:____/____/_____ Sex: M/F (Circle one) Married/Single/Divorced
Address: _____
(Street) (City/State/Zip)
Home Phone: (_____) _____-_____ Cell: (_____) _____-_____

**First Insurance Information:**

Plan Name: _____ I.D. Number:_____
Group Number:_____ Effective Date:_____
Policy Holder:_____ Policy Holder SS#:_____-_____-_____
Policy Holder's Date of Birth: ____/____/____ Sex: M/F

**Second Insurance Information:**

Plan Name: _____ I.D. Number:_____
Group Number:_____ Effective Date:_____
Policy Holder:_____ Policy Holder SS#:_____-_____-_____
Policy Holder's Date of Birth: ____/____/____ Sex: M/F

**Third Insurance Information:**

Plan Name: _____ I.D. Number:_____
Group Number:_____ Effective Date:_____
Policy Holder:_____ Policy Holder SS#:_____-_____-_____
Policy Holder's Date of Birth: ____/____/____ Sex: M/F

**Pharmacy Information:**

Pharmacy Name: _____ Phone Number: (____) _____-_____
Pharmacy Address: _____
Consent to access your pharmacy for a medication list: (circle one) Yes or No Patient Initials: _____ Date:_____

**IF THIS IS WORKERS COMPENSATION OR PERSONAL INJURY PLEASE NOTIFY THE FRONT DESK.**

BRAIN AND SPINE
NEUROSCIENCE INSTITUTE

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Eric Sincoff, M.D. Board Certified Neurosurgeon
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# FINANCIAL POLICY

We are committed to providing you with the highest quality of care and believe it is important for you to clearly understand your financial commitment to Brain and Spine Neuroscience Institute so that we may focus on what is most important; your quality of care.

We ask that you agree to the following:

- That you, the patient or legal guardian of the patient are personally responsible for all services rendered to you by our offices. Any insurance policies are contracts between you and your insurance company. We may only call or electronically verify the insurance coverage. We accept that the information we are provided is an accurate representation of your coverage at that time. We request that you personally confirm with your insurer all of your benefits, limitations, and policy guidelines.

- That you are considered a SELF PAY patient until YOU produce a copy of your insurance card and this office is able to verify your insurance coverage. If no insurance card is provided at the time of service, payment is forthwith due.

- That your co-payment, co-insurance, and deductibles will be paid in full at the time of service and you will not be billed for them at some future date. Our contracts with the insurance companies mandate our adherence to these policies.

- That a pre-authorization for service and provision of a qualified referring provider is your responsibility. If you are seen and your insurance company denies payment based on a pre-authorization or a lack of a qualified referring provider, the visit will become patient responsibility and therefore: you will be responsible for the full amount of the visit.

- That if your insurance company has not paid a claim within 45 days of submission, you are responsible for taking an active part in the recovery of that claim. After 90 days, you will be responsible for payment in full for any outstanding balance. That all patient accounts 120 past due will accrue 1 ½% interest per month (18% annually) and accounts over 180 days past due without payment arrangements made will be turned over to our collection agency. You may be liable for all legal and collection fees.

- That any patient who requires FMLA forms to be filled out, is aware the cost is $25.00 per person per FMLA packet. It will take up to 10 business days for our providers to complete the paperwork. If you need expedited paperwork, less than 10 business the cost is an additional $25.00 per person per FMLA packet. All fees must be paid in advance.

- That our providers try to accommodate every patient, when you do not show up for an appointment or cancel without notice you take away from patient care. You will be charged $25.00 per Office visit if you do not show up or do not give 24-hour notice. You will be charged $90.00 per EMG/NCV visit if you do not show up or do not give 48- hour notice. You will be charged $150.00 per Injection visit if you do not show up or do not give 48- hour notice.

- That for patients requiring diagnostics and therapeutic injections a Surgical Tray Fee will be charged in place of an administrative fee. This fee will not be billed to health or auto insurance and will be paid in full prior to the injection. A surgical tray includes gloves, needles and other supplies that are used to administer any injections.

- That this office will not rely on the reports of other health care professionals in diagnosing or treatment; and that your insurance will be billed for this office conducting diagnosis. You may have a co-payment or co-insurance that is your responsibility and you may receive a bill for additional cost beyond what you have already paid.

I, _____, have read, understand, and agree to the above noted policies.

Signature: _____ Date: _____

Witness: _____ Date: _____

# HIPAA Notice of Privacy Practices

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## Brain and Spine Neuroscience Institute, LLC

16541 pointe Village Drive,Suite 209 Lutz, FL 33558

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

**Uses and Disclosure of Protected Health information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician and other use required by the law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes coordination or management of your health care third party. For example, we would disclose your PHI as necessary to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay, surgery or diagnostic imaging that may require your PHI be disclosed to the health plan to obtain approval for these services.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support business activities for your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training medical staff/students that see patient in our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal proceeding: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosure: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization or opportunity to object unless required by the law.

**You may revoke this authorization at any time**, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorizations.

Patient Name:_____ Date:_____
Signature:_____
Relationship to patient_____
Witness:_____

## Brain and Spine Neuroscience Institute, LLC

16541 Pointe Village Drive, Suite 209 Lutz, FL 33558

# HIPAA PRIVACY POLICY PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers that are involved in my treatment)
- Obtaining payments from third-party payers (i.e. my insurance company)
- Conduct normal healthcare operations such as quality assessments and physician certifications.

**Patient initial____**

You have informed me of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact the organization at any time to the address above to obtain a current copy of the Notice of Privacy Practices.

**Patient initial____**

I understand that I have the right to request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**Patient initial____**

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____ Date:_____

Signature:_____

Relationship to patient:_____

Witness:_____

## Disclosure to Family Members and/or Friends

**DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? Yes or NO (circle one)**

I give permission for my Protected Health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

**Patient initial____**

| Name | Relationship | Contact Number |
|---|---|---|
| | | |
| | | |
| | | |

# Brain and Spine Neuroscience Institute, LLC

16541 Pointe Village Drive
Suite 209 Lutz, FL 33558

## Consent for Treatment and Payment Agreement

I _____(name of patient), agree and consent to receive a neurosurgical evaluation and medical treatment provided by practitioners at the Brain and Spine Neuroscience Institute. Treatment includes but is not limited to the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medications, the performance of such procedures as may be deemed as necessary or advisable in the treatment of the patient such as diagnostic procedures, the taking and utilization of cultures and of other medically necessary laboratory tests, all of which in the judgement of the attending physician or the assigned designee may be considered medically necessary or advisable.

**Patient initial____**

Payment includes but is not limited to the authorization of payment directly to Brain and Spine Neuroscience Institute, LLC of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to the third party entities or authorized persons to whom describes is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury/personal injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be absorbed electronically and made available through computer networks.
**Patient initial____**

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**FOR MEDICARE PATIENTS ONLY**
**MEDICARE PART B SIGNATURE AUTHORIZATION – LIFETIME**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organizations furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.
**Patient initial____**

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If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of the above named individual and am authorized to initiate and consent for treatment on the behalf of this individual.

Patient name:_____ Date:_____
Signature:_____
Relationship to patient_____
Witness:_____

BRAIN AND SPINE
NEUROSCIENCE INSTITUTE

## IF YOU ARE NOT BEING SEEN FOR AN AUTOMOBILE ACCIDENT OR WORKERS COMPENSATION PLEASE ACKNOLDEGE THE BELOW.

**My visit today is not for an automobile accident or workman's compensation; I want everything to be billed to my health insurance on file.**

_____ _____
PATIENT SIGNATURE Date

## *IF YOU ARE BEING SEEN FOR AN AUTOMOBILE ACCIDENT OR WORKERS COMPENSATION PLEASE FILL OUT THE BELOW.*

### *Automobile Accidents*

**Florida** is a "**No-Fault**" Car Insurance State. Florida follows a "no-fault" when it comes to the payment of auto insurance claims after a car accident. In a no-fault state, drivers are required to carry auto insurance that pays personal injury protection, or PIP, benefits. Because of this BRAIN AND SPINE NEUROSCIENCE INSTITUTE will file your claim for dates of service (the dates you were seen by the DR) to the automotive insurance you provide. If no automotive insurance is provided you will be responsible for the full amount of your bill. If you would like your claim filed in another way you must notify BRAIN AND SPINE NEUROSCIENCE INSTITUTE in writing below.

_____ I do not have automotive insurance I will be responsible for the full amount of my bill
_____ I have automotive insurance; I would like my claim filed to:

_____ _____
Claim Number Auto Insurance

_____ _____
Adjusters Name Phone Number

_____ I have an attorney and I would like all claims sent to them.

_____
Attorney

_____
Address

_____ _____
Phone Number Fax Number

_____ _____
Patient Signature Date

**If you have an attorney BRAIN AND SPINE NEUROSCIENCE INSTITUTE will require a letter of protection signed by you and your attorney. A letter of protection protects you against outstanding charges while your case is in litigation.**

### *Workers' Compensation*

**Workers' compensation** is a form of insurance providing wage replacement and medical benefits to employees injured in the course of employment in exchange for mandatory relinquishment of the employee's right to sue his or her employer for the tort of negligence. http://www.myfloridacfo.com/division/wc/pdf/WC-System-Guide.pdf

_____ _____ _____
Claim Number Case Manager Phone Number

_____
Workers' Compensation

_____
Address

_____ _____
Phone Number Fax Number