COLLEEN MAXCY, MD, MPH
GEORGE PANAGAKOS, MD
11031 Countryway Boulevard
Tampa, FL 33626
813-855-8400 F: 813-855-9200

Name _____ Birth date _____/_____/_____ SS# _____/_____ /_____ (required)

Address _____ City _____State _____ Zip _____

Cell Phone _____ Home Phone_____Email:_____

Sex: M F Married Widow Single Divorced/Separated Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Phone _____

Emergency Contact _____Relation: _____ Phone_____

Primary Physician _____ Phone _____ Fax _____

Who referred you to us? _____Phone _____

Primary Insurance please give receptionist your photo ID and insurance cards
Do you have Health Insurance? YES / NO (If yes, please provide information and card)

Insured Name _____ Relation: _____ DOB _____

Address if different then above _____ Phone _____

City _____ State _____ Zip _____ SS# _____

Insured Employer _____ Phone _____

Health or Auto (PIP) Insurance Company_____

Date of Accident or Injury _____ Subscriber ID# _____ Group #_____

Claim Address _____ ___ Phone _____ Fax _____

City _____ State _____ Zip _____

Do you have secondary Insurance? Yes No Insurance Company _____

Secondary Insurance or Workers Compensation

Claim Number _____ Date of Injury _____

Insurance or WC Company Name _____ Phone _____

Address for Claims _____ City_____ State Zip _____

Adjuster Name _____Phone _____Fax _____

Nurse Case Manager _____Phone _____Fax _____

*If Attorney: Name_____Phone_____ Fax _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize USA Spine or insurance company to release any information required to process my claims.

_____ _____

Patient or Legal Guardian Signature Date

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PATIENT CONSENT FORM

Welcome to USA SPINE. 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, 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 & to release all information pertinent to your health, insurance, or benefits to any & 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 of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document confirms that you have read, understand and agree to comply with all terms & conditions regarding your responsibilities to USA SPINE and that you grant the physician and staff to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern USA SPINE operations and responsibilities.

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

Patient Signature: _____Date:_____

Patient Representative: _____Date: _____

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FINANCIAL POLICY-COMMERCIAL, MEDICARE & SELFPAY

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility and staff are NOT responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligation or arrangements between you and your attorney, insurance company, liable or third party payer are between you and said person or party.

1. Our facility will file initial insurance claims for you. Secondary claims submissions and/or additional reports and/or documents sent on your behalf may result in an additional filing and/or medical report charges, which you will be responsible for paying. (These fees and payments will be discussed prior to so that proper payment can be made prior to any further services being rendered).
2. Co-pays, Deductibles and all Non-Covered Services charges will be due at the time of service. Due to our office being a multi-disciplinary practice all providers are subject to separate co-pays. For your convenience this office accepts: **Cash/Check/Debit/Credit Cards.**
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. A service charge is computed by a "periodic rate" of 1 ½% per month. 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collections related expenses, attorney fees, court & filing fees.
5. Returned checks, debit and credit charges made payable to the facility for insufficient funds, stop payments or other expenses of non-payment will be assessed a $30.00 charge.

MEDICARE PATIENTS/MEDICARE REPLACEMENT POLICIES

Patients who qualify for Medicare and those Medicare replacement policies will be limited to the services that are covered under their healthcare insurance. We try to do our very best to notify these types of patients in advance by having you sign an ABN form (Advance Beneficiary Notice). This form outlines the services that ARE and are NOT covered in our office. Please be sure and inquire with our front desk if you have NOT received one of these forms.

MEDICARE PATIENT CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given to me in applying for payment under Title XVIII and/or Title XI 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 intermediary carriers any information needed for this or related Medicare claim(s). I request that payment of authorized benefits be made on my behalf; I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

ASSIGNMENT OF BENEFITS

I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay. It is further agreed that any credit or balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician by the insured or his/her family.

_____ _____

Signature: Date:

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What is the main reason you are here: _____

Past Medical History (Check all that apply)

__ Diabetes	__High Blood Pressure	__Heart Disease	__Heart Attack
__ Asthma	__Bronchitis or Emphysema	__Pneumonia	__Ulcers
__Hypo/Hyper Thyroid	__Rheumatoid Arthritis	__History of Cancer	__Blood Clots
__High Cholesterol	__Other: _____	type: _____	__HIV/Hepatitis C

Past Surgical History

__Appendix (Appendectomy)	__Breast Surgery	__Tonsillectomy
__Gall Bladder (Cholecystectomy)	__ Back Surgery	__Hysterectomy
__Heart Bypass	__Total Joint Replacement	__Arthroscopy
__Prostate	__ Other: _____	__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 Other family Friends Other _____
Do you smoke tobacco? YES NO How much? _____ packs per day How long? _____ years
Do you drink alcohol? YES NO How much? _____ drinks per day 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? Please circle if yes

Constitutional Symptoms	**Eyes**	**Allergic**	**Ear/Nose/Throat**	**Genitourinary**
Fever	Blurred vision	Hay Fever	Ear Infection	Urine Retention
Chills	Double Vision	Drug Allergies	Sore Throat	Painful Urination
Headache	Pain	Other_____	Sinus Problems	Urinary Frequency

Neurological	**Endocrine**	**Gastrointestinal**	**Respiratory**	**Hematologic/Lymphatic**
Tremors	Excessive Thirst	Abdominal Pain	Frequent Cough	Swollen Glands
Dizzy Spells	Too hot/ cold	Nausea/Vomiting	Short of Breath	Blood Clots
Numbness/Tingling	Tired/sluggish	Rectal bleeding	Wheezing	Bleeding Problems

Cardiovascular	**Integumentary**	**Musculoskeletal**	**Psychological**
Chest Pain	Skin Rash	Joint Pain	History of depression
Varicose Veins	Boils	Neck Pain	History of bipolar disorder
High BP	Persistent Itch	Back pain	History of schizophrenia

Other Medical Conditions: _____Height_____Weight_____

Are you allergic to any medications: YES NO If so what? _____

Patient Name: _____ Date: _____

USA SPINE

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Please specify any prior tests you have undergone for this problem.

Test	Date	Test	Date	Test	Date
Plain X-ray		Nuclear Bone Scan		Myelogram	
MRI		NCS/EMG		Arthrogram	
CT scan		Dexa scan		Discogram	
Other					

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 steroid injection				
Facet injection				
Sacroiliac injection				
Hip injection				
Radiofrequency ablation				
Discectomy				
Vertebroplasty				
Trigger Points				
Nerve blocks				

Please list any other PHYSICIANS (MD, DO, CHIROPRACTIC) you have or are currently seeing for this problem

Physician	Specialty	Treatment/Testing	Phone Number	Date of Last Visit

CURRENT MEDICATIONS (List all medications. Use back of this sheet if you need more room)

MEDICATION	DOSAGE	#PER DAY/FREQUENCY	REASON FOR TAKING

Patient Name: _____ Date: _____

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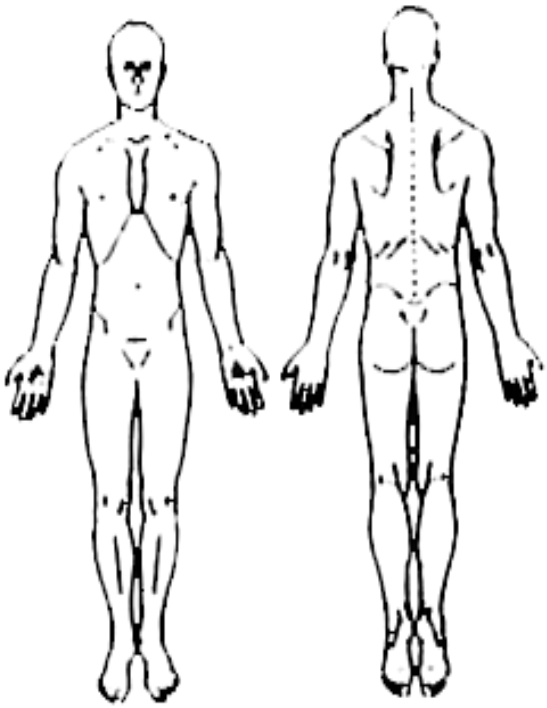
Please use the key below to indicate the location(s) of pain.



Key:

X= PAIN

O= NUMBNESS

/= ACHING

*= PINS/NEEDLES

Patient Name: _____ Date: _____

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Activities of daily living:

Please mark the items which are difficult to perform or you are unable to perform since the injury. Please only mark if you were previously performing the activity.

	Difficult	Unable To Perform
Laundry	_____	_____
Vacuum	_____	_____
Dishes	_____	_____
Mop Floors	_____	_____
Sweep Floors	_____	_____
Dust	_____	_____
Make Bed	_____	_____
Cook Meals	_____	_____
Drive Car	_____	_____
Put On Clothes	_____	_____
Get Into/Out of Bath or Shower	_____	_____
Walk From House to Get Mail	_____	_____
Brush Hair	_____	_____
Shave	_____	_____
Other	_____	_____

Patient Name: _____ Date: _____

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Medical Records Release Authorization

In order to avoid a delay this form must be completed in its entirety. PLEASE PRINT CLEARLY

Patient Name: _____ Maiden Name: _____

D.O.B. **(Required)** _____ SS# **(Required)**_____

Home Phone: _____ Work Phone: _____

Permission is hereby granted to Colleen Maxcy, MD and USA SPINE to release medical information to the individual / organization as noted below or to have records released to Colleen Maxcy, MD and USA SPINE:

Mail ☐ Name:_____

Address:_____

City/State/Zip:_____

☐ Fax to another medical entity (____)_____

☐ Call when ready for pick up (____)_____

☐ Person picking up records _____

Please check information to be released:

☐ All records, excluding records from other physicians.
☐ 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, or by whichever comes sooner.

I understand I have the right to refuse this authorization, in writing, Dr Colleen Maxcy, MD and USA SPINE is released from all legal liability that may arise from the released information requested.

_____ _____
Signature of patient/Legal Guardian Date

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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 USA Spine we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act require 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. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we will want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. 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 of 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. We will mail your files for 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, however, we may charge you a reasonable 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 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.

Patient Name (Printed):_____

Patient Signature: _____ Date: _____

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Pain Management Agreement

The purpose of this agreement is to prevent misunderstanding about certain medicine(s) you will be taking for the control of your pain. This is also to help you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that if I break this agreement which is essential to the trust and confidence necessary in a doctor/patient relationship, based on this agreement, the doctor has the right to discharge me as a patient of the practice.

I understand that if I break this agreement, my doctor will stop prescribing these pain control medicines. In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment program will be recommended.

I have communicated, and will continue to communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve the pain.

I will not use illegal controlled substances, including marijuana, cocaine etc. at any time.

I will inform Dr. Maxcy of all the medications I am presently taking, including all remaining refills. I will not attempt to obtain any controlled medicines which include controlled opium pain medicines and refills, controlled stimulants or anti-anxiety medicines from any other doctor.

I will not share, sell or trade my medication with anyone.

I will safeguard my pain medicine(s) from loss or theft. Lost or stolen medicines will not be replaced.

I understand that Dr. Maxcy reserves the right to terminate my care and treatment if such is the case at anytime.

Medication refill requests should be made at a minimum of 48 hours in advance. By law, some medications require a written prescription or a follow up appointment for refills. Prescriptions will not be called in on the weekends or after hours. If there is an emergency please go to the nearest emergency room.

I agree to use the pharmacy listed below to fill my pain medicine(s).

_____	_____	_____
Pharmacy Name	Location	Phone #

I have read, understand and agree with ALL of the above mentioned

_____	_____	_____
Patient Name (Print)	Patient Signature	Date