COMPREHENSIVE SPINE CENTER PLLC
PATIENT MEDICAL HISTORY

Name: _____ Date of Visit: ___/___/___

SS: _____ Date of Birth: ___/___/___

A. *CHIEF COMPLAINT*

1. Describe your current problem or injury: .

_____

_____

2. (Circle all that apply): Left: Arm/Leg/Foot/Other_____ Right: Arm/Leg/Foot/Other_____

3. Current Problem is the result of (check all that apply):

   a. Car Accident _____ Work Accident _____ Injury_____ Other (Explain)_____

4. Date of Injury or Onset of Problem: _____/_____/_____

5. Describe Symptoms:

_____

_____

6. Have you been treated for this problem before: Y N (circle one)

   a. If Yes, Where? _____

7. What type of treatment was provided: _____

8. Who referred you to Dr. Cameron? _____Physician/Friend/Relative (printed name of person)

9. Who is your Primary Care Physician? _____

B. *MEDICATION LIST*

Name of Medicine Dose How Long Side Effects If Any

_____

_____

_____

C. *MEDICATION ALLERGIES*

_____

_____

D. *SURGERIES/HOSPITALIZATIONS* Date Complications

_____

_____

_____

E. *MEDICAL PROBLEMS (Please List)*

_____

_____

_____

F. *REVIEW OF SYSTMES*

Are you currently receiving treatment or have you ever received treatment for any of the following: (circle all that apply)

Anemia
Arthritis
Asthma
Bladder Problems
Bleeding Problems
Blackout Problems
Blood Clots
Bowel Problems
Cancer
Depression
Diabetes
Digestion
Drug Dependency
Ear/Nose/Throat
Epilepsy/Seizures
Eyes
Heart Problems
High Blood Pressure
Lungs/Breathing
Numbness
Prostate
Stroke
Weight Gain
Weight Loss
Fever/Injection

Other (Please Explain): _____

_____

G. *FAMILY MEDICAL HISTORY*

Member	Living/Deceased		Age	Health Status/Cause of Death
Father	L	D	_____	_____
Mother	L	D	_____	_____
Sister	L	D	_____	_____
Brother	L	D	_____	_____
Other	L	D	_____	_____

H. *SOCIAL HISTORY*

Employed_____Student_____Retired_____Home Worker_____Profession_____

Marital Status: Married____ Single_____ Divorced _____ Widowed _____

Children: Y N How Many: _____

Alcohol Use: Y N Occasional_____ Daily_____

Smoke Cigarettes: Y N How many per day:_____

COMPREHENSIVE SPINE CENTER PLLC

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other_____

Patient's Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined

Language Preferred ☐English ☐Spanish ☐Creole

Race ☐White ☐Asian ☐Black (African American) ☐American Indian or Alaskan Native

☐Native Hawaiian or Other Pacific Islander ☐Other_____

Social Security Number ___-___-___ ☐ Female ☐ Male Date of Birth___/___/___

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Cellular_____

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship to Patient_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insurance Company/Phone Number_____ (___)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Insured Date of Birth___/___/___ Insured's Social Security Number ___-___-___

Only for Auto Accident Patients:

Auto Ins. Name:_____ Claim Number: _____Date of Accident:_____

Adjuster Name: _____ Phone: _____ Ext: _____

Attorney Name: _____ Phone: _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insurance Company/Phone Number_____ (___)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Insured Date of Birth_____ ___//_____ Insured's Social Security Number_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

Comprehensive Spine Center PLLC

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in my treatment
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that signing below may include consent at satellite offices under common ownership.

I, the undersigned, authorize the physicians of Comprehensive Spine Center to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) Signature ***Date***

Revision Date: December 22, 2014

Comprehensive Spine Center
Julian A. Cameron, M.D.
Tosca Kinchelow, M.D.

AUTHORIZATION TO RECEIVE MEDICAL RECORDS/INFORMATION

I authorize the release of my medical records to the organization or physician listed below:
Physician's Name: _____
Physician's Address: 7710 NW 71 CT # 205, TAMARAC FL,33321
Physician's Phone #: (954) 747-1221 Fax # of Physician: (954) 747-1231
Reason for Records Release: _____
These records are to be sent to Comprehensive Spine Center at the fax number listed above.
Patient's Name: _____ Date Of Birth: _____
Address: _____ State: _____ Zip Code: _____
Social Security #: _____ Phone#: _____
The type and amount of information to be disclosed is initialed as follows: (specify dates where appropriate)

____ X-Ray films (Specify type/date)
____ Radiology Report
____ Most recent 3 years of Records
____ Entire Medical Record
____ Substance and Drug Abuse, if any
____ AIDS/HIV, if any
____ Genetic testing, from date
____ Psychological or psychiatric conditions, if any

Other: _____

I understand this authorization will expire, without my revocation, two years from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I accept full financial responsibility for any copying or shipping fees and any applicable sales tax that may be charged.

Patients Signature _____ **Date** _____
Patient Name (Print) _____

Authorization to Discuss Medical Information

I hereby authorize you to use or disclose my medical condition/treatment/appointments/surgery/Misc. information to the parties listed below.

Patient Name: _____ Date of Birth: _____

Information to be given to:

Name: _____
Relationship: _____
Phone: _____

Name: _____
Relationship: _____
Phone: _____

This authorization shall remain in effect from the date signed below until (please check one):

□ NO EXPIRATION DATE
□ (specify expiration date or event) _____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting Comprehensive Spine Center, attention Medical Records.
- This authorization is giving Comprehensive Spine Center the right to discuss my medical information with the one or more people listed above.
- I may refuse to sign this authorization and the provider will not condition treatment on my providing this authorization

Signature: _____ **Date:** _____

Public Domain Disclosure and Anti-Defamation Mutual Agreement

_____ (collectively, "Physician")

agree to provide treatment to: _____ ("Patient").

Physician agrees not to sell or otherwise provide identifying information regarding Patient for purposes of third-parties to market directly to Patient. By signing this agreement, Patient does authorize Physician to provide Patient's contact information to limited third-parties for purposes of providing additional services to Patient in conjunction with treatment recommendations from Physician. Such third-parties may include, but not be limited to, pharmacies, diagnostic facilities, licensed attorneys, and other medical providers. However, Physician shall not offer for sale and/or sell directly Patient's identifying information solely for direct marketing purposes even if Physician is authorized to do so by applicable law.

In consideration for the above-noted protection of patient identifying information, Patient agrees to refrain from directly or indirectly publishing, airing, and/or otherwise dissemination commentary regarding Physician and/or Physician's practice to third-parties, unless such communication is being made to a confidential peer-review body, to another healthcare provider, to a licensed attorney, to a governmental agency, in the context of legal proceeding, or unless mandated by law. "Publishing" is intended to include attribution by name, by pseudonym, or anonymously. If Patient does prepare commentary for publication concerning Physician and/or Physician's practice with Physician's prior written consent, the Patient exclusively assigns all intellectual property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

Patient hereby acknowledges that Physician has invested significant financial and marketing resources to develop Physician's practice. Published commentary on web pages, blogs, and/or mass correspondence, however well intended, could severely damage Physician's practice and/or Physician's reputation in the community. Accordingly, Patient acknowledges that a breach of this agreement may result in serious, irreparable harm to Physician and/or Physician's practice. In addition to recovering any consequential damages, Patient agrees that Physician may seek equitable relief (including by not limited to injunctive relief). Patient further agrees that the prevailing party in any litigation arising out of or related to this agreement shall be entitled to recover reasonable costs, expenses, and attorney's fee associated with any such litigation.

By signing this agreement, Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

So agreed this _____ day of _____, 20_____.

Patient Signature: _____

ASSIGNMENT OF BENEFITS

Between

Client Name: _____ Date of Birth: _____

Primary Insurance Company: _____

And Comprehensive Spine Center

I have voluntarily agreed to be treated at Comprehensive Spine Center, I give Comprehensive Spine Center permission to bill and collect directly from my insurance company, and I am assigning my benefits to Comprehensive Spine center. I give Comprehensive Spine Center permission to release any information requested by my insurance company.

Ancillary charges included psychiatric consultations, medications, special therapies, and any outside medical care. These charges are not included in Comprehensive Spine Centers inclusive rate. I understand that the provider rendering care will be given my insurance information, and that I am responsible to that provider for services rendered.

I fully understand and agree that I am directly responsible to Comprehensive Spine Center for all bills submitted to my insurance company from Comprehensive Spine Center for treatment for services rendered to me. I understand that payment is not contingent on any insurance payment. I understand that I am personally responsible for my account. I agree that, should this account be referred to a collection agency that I would directly be responsible for all collections costs, attorney fees and court costs.

Patient: _____ Date: _____

Policy Holder Name: _____

FINANCIAL POLICY

As your physician(s), we are committed to giving you the best possible medical care. To achieve this goal, we need your assistance and understanding of our payment policy. We must emphasize that our concern is with you and your health, not with your insurance company. We realize that emergencies do arise and may effect timely payment of your account. If such extreme cases do occur, please contact our office promptly for assistance in the management of your account.

You will be required at each visit to present the office with your insurance card. You are also expected to notify of any changes in name, address, phone, or insurance information. Prior to your appointment, please check your insurance information so you can be informed about referrals, co-payments, and any deductibles required at the time of visit.

Unless arrangements have been made in advance, co-payments, co-insurance and any outstanding balances are expected at the time of service. Patient may be financially responsible for payment of all services, even if their insurance company does not pay. Patients accounts not paid promptly are the subject to third part collections and/or legal procedures.

If your insurance carrier has not responded to a claim within 90 days, we reserve the right to formally transfer all associated liability for the claim to the patient/guarantor. Failure to promptly resolve this balance may result in third party collections procedures.

MEDICARE PATIENTS: Any service routinely not covered by Medicare (i.e. Preventative Exams) we request that the services be paid at the time of service. We request the payment for the 20% of the allowable Medicare charges and any deductibles (if applicable) that has not been met at your time of visit.

If we are not participating providers with your plan, we will provide you with a receipt for you to file with your insurance company.

Any checks returned from the bank will result in a ($20) charge that will appear on your account.

If at any time you have an unanswered questions or concerns, please feel free to address those issues directly with our Office Manager.

By signing below I acknowledge I have read and understand the Comprehensive Spine Center financial policy.

Patient Signature: _____ Date: _____

Julian A. Cameron, M.D.

Patient Name: _____

Re: Lien and Medical Reports

I hereby authorize the treating physician referenced below to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident/injury which I was involved in .

I hereby authorize and direct you, my attorney, to pay directly to said doctor sums as may be due and owing him for medical services rendered me both by reason of this accident/injury and reason of any other bills that are due to his office and to withhold such sums from my settlement, judgment or verdict as may be necessary to adequately protect such doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said treating physician for all medical bills submitted by him or his office for services rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration for his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I eventually may recover said fee.

Date: _____

Patient Signature: _____

Patient Name: _____
(Print)

The undersigned, being attorney of record, for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such amount from any settlement, judgment, or verdict as may be necessary to adequately protect treating physician.

Date: _____

Attorney Signature: _____

Attorney Name: _____
(Print)

Palm Beach: 6080 W. Boynton Beach Blvd. · Suite 100 · Boynton Beach, FL 33437
Phone: 561-790-0031 · Fax: 561-790-0032
Broward: 7710 NW 71st Court. • Suite 205 • Tamarac, FL 33321
Phone: 954-747-1221 Fax: 954-747-1231

Comprehensive Spine Center

7710 NW 71 Court Suite 205
Tamarac, Fl. 33321
Ph: (954) 747-1221
Fax: (954) 747-1231

6080 W. Boynton Beach Blvd Suite 100
Boynton Beach, Fl. 33437
Ph: (561) 790-0031
Fax: (561) 790-0032

AFFIDAVIT OF FRAUD STATEMENT

STATEOF FLORIDA

1. I was involved in an automobile accident on _____

2. As result of said accident. I suffered bodily, including pain, suffering and discomfort to_____

3. Since the accident I voluntary sought medical treatment for such injuries

4. I have performed the selection of my medical doctors, hospitals, and/or clinics, freely and without duress, urging or coercion

5. I have not been unlawfully assisted or urged by any person or attorney to make any fraudulent or false civil damages claims.

6. The personal injury claim presented is due to bodily injuries suffered by me, as a result of this automobile accident.

7. No one as conspired with me or in behalf to induce, assist or urge me to take any fraudulent civil action damage claim or fraudulently violate the Laws of the State of Florida

8. I hereby declare, for the benefit of any and all insurance companies involved or other persons related to this accident. I have been legitimately injured.

9. I have read and understood the content of this "Fraud Statement" and, to the best of my belief; it expresses the truth of the facts contained herein.

AFFIANT SIGNITURE_____ DATE_____

PRINT NAME_____

FURTHER AFIANT SAYETH NAUGHT

Sworn and subscribed before me this ____day of_____ , 2017 the above Affiant who is personally known to me or who has produced his or her Drivers' License as Identification.

Notary Public_____ My Commission Expires_____

OFFICE PRACTICES AND POLICIES

Cancellation, Rescheduling and Missed Appointment Policies:

- Appointment and cancellations:
  - Our office will confirm your appointment in advance by phone. If you are unable to keep your appointment as scheduled please make our office aware so that other patients may have the opportunity to take any available slots.
  - To cancel an appointment, please call our office at (954)-747-1221. Our regular office hours are Monday-Thursday, 9am-5pm, and Fridays, 9am-3pm.
    - If you cannot reach us in person or by phone, you may leave a message with your name, date and time of your scheduled appointment and your request to cancel or reschedule.
- Prescription Refills Policies
  - If you call to request a refill but are overdue for a follow-up, the provider may agree to call in enough medication to a local pharmacy to last until we are able to schedule an office visit. It is your responsibility to schedule an appointment before you run out of medication. Please schedule and keep all appointments as directed by your physician. Periodic office visits are required to continue to receive medication in order to evaluate for possible side effects and provide continuity of care. Failure to keep regular office visits may result in the denial of medication refills.
- Disability Forms/ Reports
  - To cover the time that it takes the physician and staff to complete these requested forms, there may be an applicable fee. If the forms are presented and can be completed as part of your scheduled visit, there will be no charge. For the completion of forms and/or reports for someone other than your insurance company that are to be faxed outside of your appointment, there will be a charge of $10.00
- Duplication of Records
  - For the copy of your complete chart, our office will reserve the right to charge for the duplication of records per the Florida Statute fee schedule.

The Signature of the patient and/or patient representative below acknowledges that I have read and understand the office practices & policies.

Signature of Patient and/or Guardian: _____ Date: _____

Print Full Name: _____

HIPPA NOTICE OF PRIVACY PRACTICES

This notice is effective as of ____/____/____

I have read the privacy notice and understand my rights contained in this notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____

Patients Name (Print)

_____ _____

Patients Signature Date

_____ _____

Authorized Facility Signature Date