ORTHOPEDIC
& LASER SPINE SURGERY

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Phone: 855-853-6542 Fax: 561-318-8746

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize Orthopedic and Laser Spine Surgery to Obtain healthcare and/or medical information via mail, facsimile, verbal communication, written communication or other appropriate source to:

Name: Physicians of Orthopedic and Laser Spine Surgery

Address: 3970 RCA Blvd. , Suite 7004

City: Palm Beach Gardens State: FL Zip Code: 33410

Phone: 855-853-6542 Fax: 561-318-8746

I. This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: **ALL RECORDS**

II. The purpose or need for the disclosure of information:

X Continued medical care ☐ Legal Case ☐ Personal Use ☐ Other, please explain:

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION *_____
NO, DO NOT DISCLOSE THIS INFORMATION * _____

1. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
2. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
3. My purpose/use of the information is for _____.
4. This authorization expires on _____, 200___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws prohibit a fee to be charged for transmitting of patient records to another physician for continuation of care.

_____ _____ _____

Signature of Individual* **Date of Individual's Signature** **Relation to Patient**

ORTHOPEDIC & LASER SPINE SURGERY

SCOTT S. KATZMAN, M.D.
Tel: 855-853-6542 Fax: 561-318-8746

Controlled Substance Acknowledgement and Agreement

The purpose of this agreement is to help both the patient and doctor comply with the law regarding controlled pharmaceuticals.

I understand that:
___this agreement is essential to the trust and confidence necessary in a doctor/patient relationship, my doctor undertakes to treat me based on this agreement. Also, the doctor and staff require that I communicate fully regarding the character and intensity of my pain, the effects of pain on my daily life, and how well the medication helps relieve my pain.

___if I break this agreement, my doctor will stop prescribing these pain control medications. In this case, my doctor will taper off of the medication over a period of several days, as necessary to avoid withdrawal symptoms. A drug-dependence treatment program may be recommended.

___safeguarding my medication from loss or theft is my responsibility. Lost or stolen medications will not be replaced, and all unused medications will be brought to the office.

___refills of medication will not be given early. Refills will be available only when you are due for a refill. Making and keeping timely appointments is my responsibility for ongoing medication management. Medications will be used at a rate no greater than the prescribed rate. Use of medication at a faster rate will result in my being without medication for a period of time.

___I will not share, sell, or trade my medications with anyone. I will not attempt to obtain any controlled medications, including opioid pain medicines, controlled stimulants, or antianxiety medications from any other doctor, unless coordinated through this office.

___I will not use any illegal controlled substances, including but not limited to marijuana, cocaine, etc.

___refills of my prescriptions for medications will be made only at the time of an office visit or during regular office hours.
No refills will be available during evenings or on weekends.

___I understand that it is a criminal offense in the State of Florida to acquire, obtain, or attempt to acquire or obtain, possess a controlled substance by misrepresentation, fraud, forgery, deception, or subterfuge, and that if I make false statements in this agreement I may be subject to criminal prosecution.

I agree to use _____ Pharmacy, located at _____,
telephone number_____, for filling all of my pain medications.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

Patient name printed: _____ Signature: _____

DATE: _____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE

Orthopedic & Laser Spine Surgery will make every attempt to ensure the confidentiality of your Protected Health Information (PHI) as set forth by HIPAA.

You have the right to be notified of our Privacy Policies. Notice is posted in the main lobby area of our waiting room. You also have the right to receive a written policy of the privacy practices from **Orthopedic and Laser Spine Surgery**.

I have read and understand the above notice. I understand I have the right to request a written policy from **Orthopedic and Laser Spine Surgery**.

Patient Signature _____ Date _____

Witness _____ Date _____

Name the people and/or organizations that you are authorizing to receive and use your protected Health Information.

_____

_____

_____

_____

_____

_____

_____

_____

ORTHOPEDIC AND LASER SPINE SURGERY

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, also known as PIP (Personal Injury Protection), and/or Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept the assignment of the benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. I understand the provider may file a lawsuit against my insurer for payment and if the provider's bills are paid or applied to a deductible. I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and a potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without reductions and without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for the insurance resulting in the policy of insurance is declared voided, rescinded or cancelled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider, and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of Information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all Explanation of Benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to; documents, reports, scans, notes, bills, Opinions, X-rays, IMEs and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay bills in the order they are received. However, if a bill from this provider and a claim from anyone else are received by the insurer on the same day then the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and a claim from anyone else are received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event of the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to; set aside the entire amount disputed or reduced; escrow the full amount at issue; and must pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that, I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving healthcare; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services. Treatment and supplies are reasonable, usually and customary.

_____
PATIENT'S NAME

_____ _____
SIGNATURE OF POLICY HOLDER DATE
(If patient is a minor, signature of parents/guardian)

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PATIENT'S INFORMATION

NAME: _____
Last First MI

ADDRESS: _____

_____
City State Zip

HOME PHONE: _____ WORK PHONE : _____

NEXT OF KIN: _____ CELL PHONE: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

DRIVERS LICENSE #: _____ (Photocopy Will Be Needed)

EMPLOYER: _____

ADDRESS: _____

_____
City State Zip

MEDICAL PHYSICIAN: _____ PHONE: _____

REFERRING PHYSICIAN: _____

PRIMARY INSURANCE: _____ PHONE: _____

ADDRESS: _____ POLICY #: _____

GROUP #: _____ POLICY #: _____

SECONDARY INSURANCE: _____

_____ POLICY #: _____
Address Phone

GROUP #: _____ GROUP NAME #: _____

RELATIONSHIP TO POLICY HOLDER: ☐ Child ☐ Spouse ☐ Self ☐ Other

METHOD OF PAYMENT TODAY: ☐ Cash ☐ Check ☐ VISA/Mastercard

I authorize release of any and all information of my insurance companies or Medicare and permit a copy of authorization to be used in place of the original.

I authorize my doctor to act as my agent to file claims, assist in obtaining payment from my insurance company (ies) and authorize payment directly to my physician or to the party who accepts assignment.

I understand that I am responsible for my billing, including co-payments and deductibles. I further understand and agree to pay all costs and reasonable attorney's fees if any charges for services rendered are placed with an attorney or collection agency. In the event of non-coverage, I agree to assume responsibility for payment should my insurance decline payment or if Medicare payment is denied.

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if minor)

PATIENT HISTORY QUESTIONNAIRE

DATE:

NAME: _____ AGE: _____ DATE OF INJURY: _____

REASON FOR TODAY'S VISIT: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? Yes ___ No ___ List any Medications that you are allergic to:

HEIGHT: WEIGHT:

PAST MEDICAL HISTORY Check YES or NO, do not leave any blanks.

CONDITION	YES	NO	CONDITION	YES	NO
Gallstones	Yes	No	Stroke	Yes	No
Pneumonia/Bronchitis	Yes	No	Liver Disease	Yes	No
Hypertension	Yes	No	Diabetes	Yes	No
Anemia	Yes	No	Emphysema/Asthma	Yes	No
Heart Attack	Yes	No	Heart Murmur	Yes	No
Tuberculoses	Yes	No	Hepatitis	Yes	No
Mitral Valve Prolapse	Yes	No	Arthritis	Yes	No
Cancer	Yes	No	Kidney Disease	Yes	No
Intestinal Disease	Yes	No	Weight Loss	Yes	No
Rheumatic Fever	Yes	No	Lung Disease	Yes	No
Blood Clots Lungs/Legs	Yes	No	Lupus	Yes	No
Other Disorders	Yes	No			

LIST ANY OTHER MEDICAL CONDITIONS THAT ARE NOT NOTED ABOVE:

HAVE YOU HAD ANY SURGERIES? Yes ___ No ___ Please List _____

LIST ALL MEDICATION YOU ARE CURRENTLY TAKING: (Use the back of the page if needed)

MEDICATION **DOSE** **HOW OFTEN PER DAY** **REASON FOR TAKING**

ARE YOU RIGHT OR LEFT HANDED? _____

DO YOU SMOKE? Yes ___ No ___ Pipe ___ Cigar ___

DO YOU CHEW TOBACCO? Yes ___ No ___ How much per day? _____

ARE YOU AN EX-SMOKER? Yes ___ No ___ If YES, when did you quit? _____

DO YOU DRINK ALCOHOL? Yes ___ No ___ Do you drink Daily? ___ Weekly? ___ Occasionally? ___

DATE OF LAST TETANUS SHOT: _____

FAMILY MEDICAL HISTORY

	CURRENT	AGE	AGE OF DEATH	SIGNIFICANT MEDICAL PROBLEM
MOTHER				
FATHER				
SIBLING				

PHYSICAL EXAMINATION REPORT

RACE: White___ Black___ Hispanic___ Asian SEX: Male___ Female___

DATE: _____

EXAMINING PHYSICIAN: _____

NAME: _____ AGE: _____

EVERY QUESTION MUST BE ANSWERED.

1. Chief complaints related to the accident: _____

_____

_____

2. Date of accident/injury: _____

3. Type of accident:

Your Vehicle: (A) Car (B) Bus (C) Taxi (D) Van (E) Truck (F) Motorcycle
(G) Other _____

Other Vehicle: (A) Car (B) Bus (C) Taxi (D) Van (E) Truck (F) Motorcycle
(G) Other _____

4. Were you hit from the: (A) Front (B) Rear (C) Right Side (D) Left Side

5. Were you the: (A) Driver (B) Passenger (C) Pedestrian (D) Other: _____

6. When the accident occurred, did you hit: (A) Seat (B) Window (C) Door (D) Dashboard
(E) Steering Wheel (F) Ground/Street (G) Pole (H) Other: _____

7. When the accident occurred, were you wearing your seatbelt? (A) Yes (B) No

8. When the accident occurred, did the airbag(s) deploy? (A) Yes (B) No (C) Not Applicable

9. Did you or were you: (A) Slip (B) Trip (C) Fall Down (D) Mugged
(E) Hit by a falling object (F) Not Applicable (G) Other _____

10. Was your neck or back injured? (A) Yes (B) No If yes: (A) Neck (B) Back (C) Both

11. Did you hit your head in the accident? (A) Yes (B) No

12. Were you cut or bruised? (A) Yes (B) No
If yes, where? Cut: _____ Bruised: _____

13. Did you lose consciousness? (A) Yes (B) No
If yes, for how long? _____

14. Did you go to the hospital? (A) Yes (B) No
If yes, name of the hospital: _____
Date: _____ Were you taken by ambulance? (A) Yes (B) No

15. Were you kept overnight at the hospital? (A) Yes (B) No
If yes, for how long? _____

16. What treatment did you receive at the hospital?
(A) Medication (B) Cane (C) Crutches (D) Arm Sling (E) Surgery (F) Neck Collar
(G) Ace Bandage (H) Cast (I) Told to use ice (J) Told to use heat (K) Advised to rest
(L) Other _____

17. Were X-rays taken at the hospital? (A) Yes (B) No
If yes, what was x-rayed? _____
What were the results? _____

18. Did you see any doctors since the accident? (A) Yes (B) No If yes:

NAME OF DOCTOR	SPECIALTY	LENGTH OF TREATMENT

19. What treatment did the doctors provide? (A) Medications (B) Neck Collar (C) Physical Therapy
(D) Chiropractic Treatment (E) Heat Treatment (F) Cast (G) Ultrasound
(H) Other _____

20. Were additional x-rays taken? (A) Yes (B) No
If yes, what was x-rayed? _____
What were the results? _____

21. Since the accident, have your symptoms become: (A) Completely Recovered (B) Much Better
(C) A Little Better (D) No Improvement (E) Worse

22. Due to the accident, what are your present symptoms?
(A) None (B) Nausea (C) Vomiting (D) Dizziness (E) Fainting
(F) Blurred Vision (G) Double Vision (H) Nervousness (I) Weakness in the arms or legs
(J) Numbness of the _____

Pain in the: (K) Head (L) Neck (M) Back (N) Chest (O) Abdomen
(P) Shoulders (Q) Arms (R) Hands (S) Legs (T) Knees (U) Feet (V) Hips
Difficulty with: (W) Walking (X) Bending (Y) Sleeping (Z) Moving Arms or Legs
(AA) Other: _____

23. Were you employed when the accident occurred? (A) Yes (B) No
If yes, what type of work? _____

24. Did you miss work due to the accident? (A) Yes (B) No
If yes, for how long? _____

25. Have you ever been under chiropractic treatment prior to this accident? (A) Yes (B) No
If yes, what were your treatment dates? _____
What were you treated for? _____

26. Have you ever had a similar accident before? (A) Yes (B) No
If yes, when? _____
What were your injuries? _____

27. Are you: (A) Right-handed (B) Left-handed

28. Do you have any serious illnesses? (A) Yes (B) No
If yes, what are they? _____

29. Do you currently take any medications? (A) Yes (B) No
If yes, please list them:

30. Have you ever had surgery? (A) Yes (B) No

TYPE OF SURGERY	DATE(S)