Referring Doctor: ___________________________

____

PATIENT REGISTRATION FORM

PATIENT NAME:						DATE:
SS#	DOB		AGE	SEX		MARITAL STATUS
HOME ADDRESS	CITY, STATE, ZIPCODE				HOME PHONE:	
PATIENT'S EMAIL						
EMERGENCY CONTACT (NOT LIVING WITH YOU)		RELATIVE PHONE#:		RELATIONSHIP		
SPOUSE'S NAME		SPOUSE'S CONTACT PHONE # (NOT SAME AS HOME #)				
PATIENT'S EMPLOYER/ WORK PHONE #:						
PATIENT'S RACE	ETHNICITY:	PREFERRED LANGUAGE:		HEIGHT:		
PRIMARY CARE PHYSICIAN:		PHONE#				

INSURANCE INFORMATION

PRIMARY INSURANCY NAME		SECONDARY INSURANCE NAME	
INSURANCE PHONE #		INSURANCE PHONE #	
POLICY #	GROUP #	GROUP #	POLICY #:
SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT	SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT
SUBSCRIBER'S SS#	SUBSCRIBER'S DOB	SUBSCRIBER'S SS#	SUBSCRIBER'S DOB

I hereby irrevocably assign and transfer to the Spine and Wellness Centers of America, Christian Gonzalez MD, LLC and its physicians all right, title and interest in all benefits payable for the healthcare rendered, which are provided in any and all insurance policies and health benefit plans from which I am entitled services or I am entitled to recover, I understand that any payment received from these policies and/or plans will be applied to the amount that i have agreed to pay for services rendered during this admission. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I hereby authorize to release all information necessary to secure payment. A $50 no show fee may be assessed for missed appointments without a 24 hours advanced notice. I certify that I have read, understand and acknowledge the billing policy and agree to make payment in full and/or satisfactory arrangements when asked to do so.

PATIENT SIGNATURE: ____

IF MINOR, PARENT/GUARDIAN SIGNATURE:______________________________ DATE:__________________

WT: _______________
HT: _______________

MEDICAL HISTORY FORM

NAME: ____ DATE: ____________________

Do you have a history of, or are currently under treatment for**:**

Hypertension		Gerd		Diabetes	
Cancer		HIV/STD		Heart Disease	
Stroke		Asthma		Seizures	
Renal Failure		Pain Management		Shoulder/ Knee Injury	
Other:					

List all medications currently taking & use frequency:

DRUG NAME	FREQUENCY
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Are you allergic to any medication? YES_____ NO ______
Please list all allergies, reactions and allergic medications:
____
____
____

Please list recent surgeries and hospitalizations (include dates)
____
____

REASONS FOR VISIT: ____
____

Select pain areas

NECK		UPPER BACK	
SHOULDER		LOWER BACK	
ARMS		LEGS	
WRISTS		KNEES	
HIPS		TOES	

Circle Answer that applies to you

Do you smoke?	YES	NO
Do drink alcohol?	YES	NO
Do You Use Recreational Drugs?	YES	NO
Do You Live Alone?	YES	NO

Other reason for visit: ____
____

PATIENT FINANCIAL RESPONSIBILITIES FORM

Thank you for choosing Spine and Wellness Centers of America (SWCA) as your healthcare provider. **It is important you understand your financial responsibilities.**

Your co-payment, co-insurance, deductible, out of network and/or self-paid payments are due at the time of service. For your convenience we accept cash, checks, and all major credit cards, and in some cases we do have payment plans.

Whether insured, uninsured or out of network, our staff will estimate the out of pocket costs for your procedure. Payment of this estimated amount is **due prior to your surgery**.

Be advised you are responsible for ALL the charges not paid by your insurance company in reference to services rendered.

- A $50.00 will be applied to your account for each returned check we receive from the bank, it is your responsibility to pay this fee, in cash or credit card, as soon as we notify you.
- Patient will also have a $50.00 charge for missed appointments that are not cancelled in a timely manner, within 24 hours.

I, as a patient of SWCA, hereby authorize the release of any medical information required by my insurance carrier(s).

If there is any change in your insurance, it is your responsibility to bring that to our attention immediately. Delays in communicating these insurance changes may result in the balance being uncollectible from the insurance company and the full responsibility for payment failing upon you.

______________________________ ______________________________ ______________________

Patient Name Patient Signature Date

NOTICE TO PATIENTS

Under Florida Law, physicians are generally required to carry medical insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law. We are required by law to give you a copy of this notice to sign.

I ______________________ (name) hereby, acknowledge this notice.

____ ____________________

Patient Signature Date

** This page is available in Spanish upon request.

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

Patient name: ____
Date of Birth: ____________________ Social Security Number: ___________________________

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with legal claims and other instances. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, and any all other record received by the medical providers.
- All physical, occupational and rehab requests, consultations and progress notes.
- All disability, Medicaid or Medicare records including claim forms and record of denial of benefits, and other insurance carriers.
- All employment, personnel or wage records.
- All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films and reports.
- All pharmacy/prescription records including NDC numbers and drug information.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for multiple purposes as determined by the provider and by law.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

I understand the following:

1. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
2. The information released in response to this authorization may be re-disclosed to other parties.
3. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

____________________________________	___________________________	_________________
Patient Name	Patient Signature	Date

*You have multiple rights regarding your health information. Please contact SWCA's **Custodian of Records** at (305) 974 – 5533 if you are concerned that there has been a violation of your privacy right.

PATIENT CONTRACT FOR OPIOID PAIN MEDICATION FORM

This is an agreement between ____ **[PATIENT NAME]** and Spine and Wellness Centers of America [SWCA] concerning the use of Opioid Analgesics (narcotic pain-killers) for the treatment of a chronic pain problem.

The medication will probably not completely eliminate the pain, but is expected to reduce it enough to return to you a better quality of life. The doctors at SWCA will prescribe a multi-disciplinary plan of action for you. The patient agrees to:

1. I, the patient, understand that opioid analgesics are strong medication for pain relief and have been informed of the high risks and side effects involved with taking the medication.
2. I, the patient, agree to routine and random blood, urine, hair or saliva tests to determine my compliance with the opioid medication for my pain, and to determine any other medication or substance that I may be consuming or using. ANY TAMPERING WITH THE TEST OR A DENIAL TO COMPLY WITH THE TEST PROCEDURES AND COMPLETION, WILL BE REASON FOR IMMEDIATE DISCHARGE FROM PRACTICE.
3. I, the patient, understand that opioid analgesics could cause physical dependence, If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like symptoms such as: nausea, vomiting, diarrhea, aches, sweats and chills) that may occur within 24-48 hours of the last dose.
   - **I understand that withdrawal from opioid medication is uncomfortable, could be highly painful and could potentially even be a life threatening condition.**
4. I, the patient, understand that if I'm pregnant or become pregnant, while taking these opioid medication, my child could be physically dependent on the opioids, my behavior including abuse or withdrawal could potentially affect the child's development pre and post birth and could potentially lead to a life-threatening situation for the baby, before, during and after birth.
5. I, the patient, understand that overdose in opioid medication may cause death by stopping the breathing body functions; this could be reversed by emergency medical personnel. It is suggested that I follow strictly all medical advice and in case of doubt wear a medical alert bracelet with your information.
6. **I, the patient, understand that refills of Opioids and other controlled substances are made only at the time of an office visit during normal business hours**. No refills will be made after regular office hours or on the weekends.
7. I, the patient, understand that my opioid prescription plan may cause drowsiness, sedation or dizziness, I must not drive a motor vehicle or operate heavy machinery that could put my life or the life of others in grave risk while under opioid prescription.
8. I, the patient, understand that it is my responsibility to inform the doctor of any and all side effects I have from opioid medication; and any unusual thoughts or behaviors.
9. I, the patient, agree to take the medication prescribed and not to change the amount or frequency of the medication without discussing it with my prescribing doctor of SWCA. Running out early of medication, needing early refills, escalating doses without permission and losing prescriptions may be signs of misuse of the medication and may be reasons for the doctor to discontinue prescribing opioid medications. Please inform about any lost, stolen or misplaced prescription medication at the soonest possible time.
10. I, the patient, agree that the opioids will be prescribed by only one (1) doctor and I agree to fill my prescriptions at only one pharmacy. I agree not to take pain medication or mind-altering medication prescribed by a different physician than the doctors of Spine and Wellness Centers of America.
11. I, the patient, accept and agree that the doctor may verify whether I'm taking any other medication, seeing a different physician for opioid medications and/or visiting different pharmacies for obtaining the prescriptions through multiple formats including regional and national databases and conversations.
12. I, the patient, agree to keep the opioid medication in a safe and secure place, away from children. Lost, stolen or damaged medication will not be replaced. Unused medication, whole or partially, should be discarded in the toilet and flushed away. If not possible, please return to an SWCA doctor.

13. I, the patient, agree not to sell, lend or in any way give away my medication to any other person. Violation of this prohibition must be notified by us to the Aventura Police Department or other legal authority.
14. I, the patient, agree not to drink alcohol or take other mood-altering drugs while under the medication.
15. l, the patient, agree to attend all required office visits with the doctor to monitor this medication and I understand that failure to do so will result in discontinuation of the opioid treatment. I also agree to participate in other chronic pain treatment modalities recommended by my SWCA doctor.
16. l, the patient, understand that there is a risk that opioid addiction or dependency may occur. Addiction or dependency are defined as a psychological effect in the body that causes a change in attitude, behavior, or the loss of control of motor functions and body fluids. People with a past history of alcohol or drug abuse problems are more susceptible to addiction. **If addiction or dependency symptoms are observed and diagnosed, then the opioid medication treatment will be changed or discontinued.**

PLEASE READ BOTH OPTIONS

1. I, ___________________________ (PATIENT NAME) have read the above, asked questions, and understand this agreement in whole, if I violate the agreement, I understand that the doctor may discontinue this form of treatment and I may be discharged as a patient of Spine and Wellness Centers of America

OR

2. I, ___________________________ (PATIENT NAME) have read the above, asked questions, and understand this agreement in whole and have decided to NOT RECEIVE OPIOID treatment, however I understand that the doctor may discontinue this form of treatment and I may be discharged as a patient of Spine and Wellness Centers of America

____	____________________________________	__________________
Patient Name	Patient Signature	Date

Opioid Risk Tool

Mark each box that applies.	Female	Male
1.Family Hx of substance abuse		
Alcohol	☐	☐
Illegal Drugs	☐	☐
Prescription Drugs	☐	☐
2.Personal Hx of Substance Abuse		
Alcohol	☐	☐
Illegal Drugs	☐	☐
Prescription Drugs	☐	☐
3.Age between 16-45 years		
	☐	☐
4.Hx of Preadolescent Sexual Abuse		
	☐	☐
5.Psychologic Disease		
	☐	☐
Scoring Total:		

RECORDS RELEASE AUTHORIZATION

Name of Patient: ____

Address: ____

Social Security # (last four digits):__________________

Date of Birth: __________________________________

I hereby authorize and request you to release my medical file, electronic healthcare, laboratory, imaging or other data including personal information regarding my medical history and future care plans.

_______________________________________ Patient Signature

_______________________ Date

SEND TO:

Fax: (305) 974-5553

Spine and Wellness Centers of America
P.O. Box 223190
Hollywood, FL 33020

**This page is available in Spanish upon request.