SPINE, BRAIN AND JOINT INSTITUTE

Confidential Patient Case History DATE: _____/_____/_____

PATIENT INFORMATION

GENDER: MALE /FEMALE AGE: _____ MARITAL STATUS: MARRIED/SINGLE/DIVORCED

LAST NAME_____ FIRST NAME:_____

DOB:_____/_____/_____ SOC SEC # :_____/_____/_____

HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE: (____)_____ CELL: (____)_____

EMAIL:_____

EMERGENCY CONTACT:_____ PHONE (____)_____

INSURANCE INFORMATION

AUTO INSURANCE COMPANY:_____

DATE OF ACCIDENT: ____/____/____ TYPE OF ACCIDENT: ___ AUTO ACCIDENT ___ SLIP/FALL

NAME ON POLICY: _____

POLICY #:_____ CLAIM #_____

ADJUSTERS NAME:_____ PHONE (____)_____

HEALTH INSURANCE NAME:_____

MEMBER ID:_____ EFF DATE:_____

ARE YOU BEING REPRESENTED BY AN ATTORNEY? Y/N

ATTORNEY'S NAME/FIRM NAME:_____

PHONE:(____)_____ EMAIL:_____

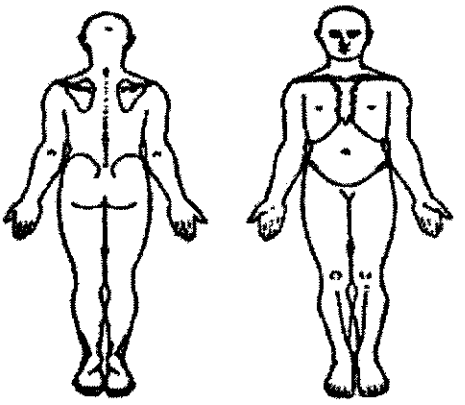
ADDRESS:_____ CITY:_____STATE:_____ ZIP:_____

SIGNATURE:_____ **DATE**:_____

SPINE, BRAIN AND JOINT INSTITUTE

CURRENT CONDITION

PLEASE INDICATE BELOW AREAS OF CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT FOR.



IF INJURED IN A CAR ACCIDENT:

WERE YOU THE DRIVER? Y/N IF NO, INDICATE _____FRONT SEAT _____ BACK SEAT

LOSE CONSCIOUSNESS? Y/N IF SO, HOW LONG? _____

WEARING A SEATBELT? Y/N

PREVIOUS AUTO ACCIDENT? Y/N IF SO, DATE OF ACCIENT: _____/_____/_____

PREVIOUS SLIP AND FALL? Y/N IF SO, DATE OF FALL: _____/_____/_____

DID YOU GO TO THE HOSPITAL Y/N IF SO, HOSPITAL NAME _____

IS THIS CONDITION INTERFERING WITH YOUR DAILY ROUTINE IF SO, INDICATE WHAT AREAS

{__}WORK {__}SLEEP {__} DAILY ROUTINE {__} OTHER:_____

DESCRIPTION OF PAIN: {___} CONSTANT {___} INTERMITTENT

BRIEF DESCRIPTION OF THE ACCIDENT:

_____

_____

_____

_____

5101 GATE PKWY STE 2, JACKSONVILLE, FL (904) 374-3672 FAX (904) 813-7156

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PAIN DESCRIPTION

DESCRIBE THE CHARACTER OF YOUR PAIN (EG: DULL, STABBING, THROBBING, ECT)

_____

HOW OFTER DOES THE PAIN OCCUR?

{___} CONSTANT {___} CHANGES IN SEVERITY BUT ALWAYS PRESENT {___} INTERMITTENT

ON A PAIN SCALE OF 0-10: 0 IS NO PAIN AND 10 IS THE WORST PAIN YOU CAN IMAGINE:

1 2 3 4 5 6 7 8 9 10

WHAT OTHER FACTORS WORSEN YOUR PAIN? _____

WHAT FACTORS RELIEVE YOUR PAIN?_____

ASSOCIATED SYMPTOMS {___} NUMBNESS {___} TINGLING {___} WEAKNESS IF SO WHERE,

_____

ARE YOU EXPERIENCING INCONTINENCE Y/N

HAVE YOU HAD ANY DIAGNOSTIC IMAGING Y/N IF SO, WHERE _____

CURRENT
MEDICATIONS:_____

_____

_____

PREFERRED PHARMACY:_____

ALLERGIES:_____

ALLERGIES TO IV CONTRAST, IODONE OR SHELLFISH? Y/N

ARE YOU CURRENTLY TAKING BLOOD THINNERS? Y/N IF SO NAME_____

SOCIAL HISTORY:

DO YOU SMOKE? Y/N

DO YOU DRINK ALCOHOL? DAILY / WEEKLY / RARELY / NEVER

DO YOU USE RECREATIONAL / ILLICIT DRUGS? Y/N

ARE YOU CURRENTLY EMPLOYED? Y/N LAST DATE WORKED? _____

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PAST SURGICAL HISTORY:

_____

_____

_____

PERTINENT REVIEW OF SYSTEMS – CIRCLE ONLY THOSE YOU ARE CURRENTLY EXPERIENCING.

CONSTITUTIONAL

FATIGUE

WEIGHT LOSS/GAIN

FEVER/CHILLS

CARDIOVASCULAR

CHEST PAIN/DISCOMFORT

SHORTNESS OF BREATH

HEART ATTACK/DISEASE

SWELLING/EDEMA

GASTROINTESTINAL

ABDOMINAL PAIN

NAUSEA/VOMITING

GI BLEED-BLOODY/BLACK STOOL

HISTORY OF ULCERS

ENT

LOSS OF HEARING

RINGING OF EARS/VERTIGO

NEUROLOGIC

WEAKNESS/PARALYSIS

NUMBNESS/TINGLING

HEADACHE

TREMORS/SEIZURES

BALANCE ISSUES

SLEEP DISORDER

PULMONARY

ASTHMA / WHEEZING

PNEUMONIA

BLOOD CLOTS / PE

ENDOCRINE

DIABETES

DIABETIC KETOACIDOSIS

PSYCHIATRIC

DEPRESSION

SUICIDAL THOUGHTS

ANEXITY

MUSCULOSKELETAL

JOINT PAIN/STIFFNESS

RHEUMATOID ARTHRITIS

HISTORY OF BACK PAIN

HISTORY OF NECK PAIN

INFECTIOUS

MRSA/VRE

HIV/AIDS

RECENT INFECTION

HEMATOLOGIC

ITP

LEUKEMIA

BLEEDING DISORDER

BRUISE EASILY

BLOOD THINNERS

SPINE BRAIN & JOINT INSTITUTE

MICHAEL SANDBORN, M.D. FAAPMR
MICHAEL LUPI, D.O. FAAPMR

LETTER OF PROTECTION

ATTORNEY'S INFORMATION

_____ **PATIENT NAME:** _____

_____ **SSN:** _____

_____ **DOB:** _____

I hereby authorize Spine, Brain & Joint Institute to furnish you, my attorney, with a full report of my examinations, diagnosis, treatment, prognosis, etc., in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to Spine, Brain & Joint Institute such sums as may be due and owing for professional services rendered to me and any other bills that are due to Spine, Brain & Joint Institute and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect Spine, Brain & Joint Institute. I hereby further give a lien on my case to Spine, Brain & Joint Institute against any and all proceeds of any settlement, judgement or result of the injuries for which I have been treated for injuries in connection there with.

I fully understand that I am directly responsible to Spine, Brain & Joint Institute for all professional bills submitted by Spine, Brain & Joint Institute for service rendered to me and that this agreement is made solely for Spine, Brain & Joint Institute additional protection and in consideration of Spine, Brain & Joint Institute awaiting payment.

Patient Signature:_____ **Date:** _____

5101 GATE PKWY, SUITE 2 JACKSONVILLE, FL 32258 PH 904-374-3672 FAX 904-813-7156

SPINE BRAIN & JOINT INSTITUTE

MICHAEL SANDBORN, M.D. FAAPMR
MICHAEL LUPI, D.O. FAAPMR

INTITATION OF TREATMENT

To Whom It May Concern:

This is to inform you that I was injured in a motor vehicle accident. This letter is to confirm that I intend to initiate treatment as outlined by the doctors at Spine, Brain & Joint Institute.

CONSENT FOR TREATMENT

I hereby authorize your practice and whomever the doctor may designate to perform examinations, physiotherapy, physical therapy and perform non-invasive diagnostic tests and if any unforeseen condition arises in the course of the procedures calling for judgement, procedures in addition to or different from those contemplated. I further request and authorize this office to perform whatever my treating doctor deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications has been fully explained to me. I acknowledge that no guarantee has been made to me as to the result that may be obtained.

Patient Name:_____ Date: _____

Patients Signature: _____

5101 GATE PKWY, SUITE 2 JACKSONVILLE, FL 32256
(904) 374-3672 FAX 904-813-7156

SPINE BRAIN & JOINT
INSTITUTE

MICHAEL SANDBORN, M.D. FAAPMR
MICHAEL LUPI, D.O. FAAPMR

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, also known as Personal Injury Protection (PIP) and Medical Payments policy of insurance to the above health care providers. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time the services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This assignment of benefits includes overdue interest and any potential claim common law or statutory bad faith. 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 healthcare provider directly without reductions & without including the patient's name on the check.

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 form liability unless there has been a prior written settlement agreed to by the healthcare provider and the insurer as to the amount payable under the insurance policy. 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.

The 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, copayments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The healthcare provider is given the power of attorney to endorse my name on any check for services rendered by the above provider and to request any statements for examinations under oath the patient provider to any insurer.

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 in writing (declaration sheet) 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 statements the patient or anyone else provided to the insurer, obtain copies of 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 and the provider'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 the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is 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 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 (i.e. escrow the money) and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved. The insurer is instructed to immediately explain in writing, to the above 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 health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Print Patient's Name_____ Date_____

Patient's Signature_____
(Signature of parent/guardian for minors)

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ **Account Number:** _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVICE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE or CONSENT FOR DATA TO BE EXCHANGED ELECTRONICALLY BETWEEN PROVIDERS/HOSPITALS**

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgement or Consents

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA?

_____ First Name Only _____ Proper Sur Name Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION and INFORMATION ABOUT MY HEALTH** VIA

Choose Only One Point of Contact

Home Telephone Number

(____)_____

_____ OK to leave message with detailed information
_____ Leave message with call back numbers only

Cell Number

(____)_____

_____ OK to leave message with detailed information
_____ Leave message with call back numbers only
_____ OK to send a text with detailed information

Work Telephone Number

(____)_____

_____ OK to leave message with detailed information
_____ Leave a message with call back numbers only

Office Use Only

I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment ___
- I could not communicate with the patient ___
- The patient refused to sign ___
- The patient was unable to sign ___
- Other (please describe) _____

Signature of SBJI Staff Member _____