



## Neurosurgery

New Patient Intake Form

Date: \_\_\_\_\_

### I. Demographic Information

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email address: \_\_\_\_\_ Pref: Text \_\_\_\_\_ Email \_\_\_\_\_

### II. Care Information- please list complete name and address of physicians and pharmacies

**Primary Care Physician:** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**Referring Physician** (if different from PCP) \_\_\_\_\_ **Specialty:** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**III. Chief Complaint (Reason for your visit):** \_\_\_\_\_

Is this related to worker's compensation? Yes \_\_\_\_\_ No \_\_\_\_\_

Is this related to any legal actions? Yes \_\_\_\_\_ No \_\_\_\_\_

Is this problem the result of an accident? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, when did the accident occur? \_\_\_\_\_

Please list **all Medications** you take routinely, prescribed or over-the counter, along with the dosages:

Medication:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you **Allergic** to any medications, latex, X-ray dye, or iodine? (circle one)      Yes      No  
 If yes, please explain (reaction): \_\_\_\_\_

Are you taking any "blood thinning" medications? (Circle one)      Yes      No  
 If yes, check all that apply:    Aspirin \_\_\_\_\_    Anti-inflammatory medication \_\_\_\_\_    Plavix \_\_\_\_\_  
    Coumadin \_\_\_\_\_    Fish Oil \_\_\_\_\_    Other (specify): \_\_\_\_\_

IV. Medical History	Please list all active medical conditions:	Onset of Condition:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. Surgical History	Please list all operations you have had:	Date (Mo/Yr):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VI. Family History		Do you have a family member affected with:					
Condition	Yes	No	affected relative	Condition	Yes	No	affected relative
Cancer (non brain)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding/Clotting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glioma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Meningioma	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brain Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other conditions: _____							
		<b>Alive</b>	<b>Deceased</b>				
Father	<input type="checkbox"/>	<input type="checkbox"/>		No. of Siblings: Brothers	_____	Sisters	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>		No. of Children: Sons	_____	Daughters	_____

## VII. Social History

Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Do you exercise regularly? Yes \_\_\_ No \_\_\_ How frequently? \_\_\_\_\_

Do you smoke? Yes \_\_\_ No \_\_\_ Cigarettes \_\_\_ Cigars \_\_\_ Other \_\_\_ If so, how much? \_\_\_\_\_

Do you use other forms of tobacco? Yes \_\_\_ No \_\_\_ If so, specify type? \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_ No \_\_\_ If so, how much? \_\_\_\_\_

Do you use recreational drugs? Yes \_\_\_ No \_\_\_ If yes, specify type? \_\_\_\_\_

Females: Are you, or could you be, pregnant? \_\_\_\_\_

## VIII. Review of Symptoms

Do you currently, or have you had a problem with:

### Constitutional:

Difficulty sleeping	Yes	No
Excessive fatigue	Yes	No
Fever	Yes	No
History of falls	Yes	No
Weight gain	Yes	No
Weight loss	Yes	No

### Eyes:

Wear glasses	Yes	No
Cataracts	Yes	No
Double/blurred vision	Yes	No
Glaucoma	Yes	No
Infections	Yes	No
Injuries	Yes	No

### Ear, Nose, Throat, & Mouth:

Wear hearing aids	Yes	No
Earpain/infections	Yes	No
Hearing loss	Yes	No
Nasal congestion/drainage	Yes	No
Nose bleeds	Yes	No
Ringing in ears	Yes	No
Sinus pain	Yes	No

### Cardiovascular:

Chest pain or Angina	Yes	No
Heart murmur	Yes	No
High blood pressure	Yes	No
High cholesterol	Yes	No
Irregular pulse	Yes	No
Leg pain while walking	Yes	No
Swelling in hands/feet	Yes	No

### Respiratory:

Asthma	Yes	No
Bloody sputum	Yes	No
Emphysema	Yes	No
Pneumonia	Yes	No
Shortness of breath	Yes	No

### Gastrointestinal:

Abdominal pain	Yes	No
Change in bowel habits	Yes	No
Diarrhea/constipation	Yes	No
Jaundice	Yes	No
Nausea	Yes	No
Ulcers or gastritis	Yes	No
Vomiting	Yes	No

### Endocrine:

Diabetes	Yes	No
Excessive thirst/urination	Yes	No
Thyroid disease	Yes	No

### Genitourinary:

Blood in urine		
Difficulty starting/stopping stream	Yes	No
Incontinence	Yes	No
Kidney stones	Yes	No
Painful urination	Yes	No

### Musculoskeletal:

Arm/leg pain	Yes	No
Arthritis	Yes	No
Joint pain/swelling	Yes	No
Numbness/tingling in extremities	Yes	No
Shoulder pain (left/right/both)	Yes	No
Weakness in arms/legs	Yes	No

### Integumentary:

Skin disease	Yes	No
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### Neurological:

Difficulty with balance	Yes	No
Difficulty with speech	Yes	No
Disorientation		
Dizziness	Yes	No
Fainting spells/black outs	Yes	No
Headaches	Yes	No
Inability to concentrate	Yes	No
Loss of sensation/numbness	Yes	No
Memory loss	Yes	No
Pain in neck/back	Yes	No
Seizures	Yes	No

### Psychiatric:

Anxiety	Yes	No
Depression	Yes	No

### Hematologic/Lymphatic:

Anemia	Yes	No
Bleeding tendencies	Yes	No
Blood transfusions	Yes	No
Hemophilia	Yes	No
HIV	Yes	No
Persistent swollen glands/lymph nodes	Yes	No

### Allergic/Immunologic:

Autoimmune disease	Yes	No
Food and/or inhalant (nasal) allergies	Yes	No

**IX. Pain Assessment**

Do you experience pain as part of your daily life? Yes No

If yes, please describe the location(s), onset, duration, and characteristics of your pain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If yes, on a scale of 0 to 10, (0 = no pain, 10 = the worst pain) how would you rate your pain? \_\_\_\_\_

Have you ever had pain injections? \_\_\_\_\_ If yes, when? \_\_\_\_\_  
What type of injection? \_\_\_\_\_

**X. Handedness**

Are you: Right handed Left handed

**XI. Do you have a Health Care Proxy?**

Yes No

If yes, please list: \_\_\_\_\_

**XII. HIPAA Release (please check one)**

I **do** \_\_\_\_\_ **do not** \_\_\_\_\_ consent to allow Neurepair to share the above information with other providers involved in my care, as well as to disclose and obtain all medical records, including lab tests, diagnoses, treatment, and billing pertinent to my care. I consent to release my medical information to payore involved in my medical care.

**XIII. Emergency Contact**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relation: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

I **do** \_\_\_\_\_ **do not** \_\_\_\_\_ consent to allow Neurepair to share information with my emergency contact, including but not limited to all medical records, diagnoses, and treatment.

**I attest that the information on this form is accurate to the best of my knowledge:**

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date completed

**I have reviewed the above information:**

\_\_\_\_\_  
Provider signature

\_\_\_\_\_  
Date completed



## PATIENT CONSENT AUTHORIZATION

**Consent for Treatment:** I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures when warranted. I understand that I am under the care and supervision of the attending physician, and it is the responsibility of the staff to carry out the instructions of such physician(s). **Yes** \_\_\_\_ **No** \_\_\_\_

**Authorization for Medical Treatment:** This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, X-ray and physical findings, diagnosis, and prognosis. You are authorized to provide this information in accordance with the Florida "NO FAULT" auto insurance law (Chapter 71-252 F.S.) **Yes** \_\_\_\_ **No** \_\_\_\_

**Authorization to Photograph or Video:** This authorization or photocopy hereof, will authorize you to be photographed for treatment purposes related to your healthcare, professional activities, insurance claims and patient condition. **Yes** \_\_\_\_ **No** \_\_\_\_

**Consent to Treat Minor Child:** I am the parent or legal guardian of the patient and do hereby consent to any medical care of the providers of NeuRepair Brain and Spine Wellness Centers to determine what's necessary for the welfare of my child while said child is under their care.

**Yes** \_\_\_\_ **No** \_\_\_\_

**Parent or Guardian Consent to Accompany Minor Child:** I am the parent or legal guardian of the patient (minor child) and authorize the following individual to accompany my child to their medical office visits in my absence: \_\_\_\_\_

First name

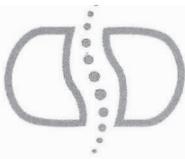
Last name

**(Must provide photo ID that matches this individual's name)**

Patient's Printed Name: \_\_\_\_\_

Patient of Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**NEUREPAIR**  
BRAIN & SPINE  
WELLNESS CENTERS

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### Notice of Office Policies

1) Audio and/or video recording is strictly prohibited without the expressed consent of the provider. It is illegal in the state of Florida to record your provider without his/her/their consent. There are sensitive patient documents (HIPPA) and patient information in the building. If you are observed engaging in illegal activities on the premises, you will be discharged from the practice.

Initials: \_\_\_\_\_

2) Diagnostic images (MRI, CT, X-rays etc.) may be used for teaching or instructional purposes. No personal identifying data will be used.

Initials: \_\_\_\_\_

3) In order to respect and accommodate all patients, patients are allowed a 15-minute grace period if they are running late and provide notice. If a patient is greater than 15 minutes late, he/she/they will be subject to the cancellation of his/her/their scheduled appointment and may be charged a "no-show" fee.

Initials: \_\_\_\_\_

4) No-show fees for follow-up visits are charged based on the type of visit, and range between \$95-\$200. No-show fees for injection appointments are \$250. No-show fees for surgery are \$415.

Initials: \_\_\_\_\_

5) The cancellation and/or rescheduling of 3 office appointments and/or surgeries by the patient may result in the discharge of that patient from the practice.

Initials: \_\_\_\_\_

**I have read and understand the above information:**

\_\_\_\_\_

Patient Signature

Date: \_\_\_\_\_

\_\_\_\_\_

Printed Name

## Florida Patient's Bill of Rights Acknowledgement

As a new patient at our health care facility, we would like to take this opportunity to advise you of your rights and responsibilities which requires that we adopt and make available to all patients, in writing, a statement of the rights and responsibilities of patients, including the following:

### Summary of the Florida Patient's Bill of Rights and Responsibilities

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect your health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

#### **A patient has the right to be treated with courtesy and respect, with appreciation of this or her individual dignity, and with protection of his or her need for privacy.**

- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an Interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health care.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for keeping for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

**\*By signing below, I acknowledge that I have received a Summary of the Florida Patient's Bill of Rights.**

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Witness (Medical Provider) Signature

\_\_\_\_\_  
Print name

## Notice of Privacy Practices

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) along with brief overview of our Notice of Privacy. Our practice is complying with HIPPA regulations.

### What is HIPPA and how does the Privacy Rule affect you?

When the Health Insurance Portability and Accountability Act (HIPPA) was passed in August of 1996, this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The privacy Rule was created to protect your rights as a patient of our practice, and we are required by law to be compliant with this regulation. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

### What is Individually Identifiable Health Information (IIHI)?

Any health information you provide our practice, including your mailing address. IIHI is any information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

### What is the Notice of Privacy Practice?

Our practice has an official Notice of Privacy Practice posted in our waiting room informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure of your IIHI. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will be posted, and a copy is provided in our waiting room, and you can take a copy of the current notice at any time.

### The following categories describe the different ways in which we may use and disclose your IIHI:

Treatment	Appointment reminders	Release of Information to Family/Friends
Payment	Treatment Options	Disclosure Required by Law
Health Care Operations	Health-Release Benefits & Services	

### The following categories describe unique situations in which we may use or disclose your Identifiable Health Information:

Public Health Risks	Health	Oversight Activities	
Lawsuits and Similar Proceedings	Law Enforcement	Deceased Patients	Organ and Tissue Donation
Serious Threats to Health or Safety	Research	Military	
National Security Inmates	Workers' Compensation		

### What are your rights concerning your individually Identifiable Health Information (IIHI)?

You have rights regarding the IIHI that we maintain about you. In our Notice of Privacy, you can view the policies and procedures you will need to follow for the areas listed below.

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a paper copy of this Notice
7. Right to file a complaint
8. Right to provide an Authorization for other uses and disclosures

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

I have read the short notice provided by NeuRepair Brain and Spine Wellness Centers, and have been informed of how to obtain more information regarding our Notice of Privacy.

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Patient's printed name: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



### Fee Transparency Attestation

NeuRepair Brain and Spine Wellness Centers provides various services and consumable products. Services include professional fees such as office visits, procedures, surgery fees, and independent opinions. Consumable products include medications used for injections, braces or collars for neck and back fractures or for after surgery, and certain medications useful and pertinent to your clinical scenario. There are also fees for X-ray services, stem-cell injections, and other therapies which are employed where clinically appropriate in your treatment.

Fee schedules for some of the most common office visit types, therapies, medications, braces injections and surgeries are readily available to you. You also have a choice when it comes to Healthcare and are entitled to more than one opinion. You are also entitled to more than one quote for any proposed surgery, injection, or medication.

I understand that if I am being treated in relation to a liability injury, my health insurance may not be billed unless appropriate.

I understand that I have the right to take a prescription to an outside pharmacy to fill some of my pertinent medications.

I understand that I have the right to take a prescription to a different facility to get my cervical collar/lumbar brace.

I understand that the prices for consumable products, medications, professional fees, and other fees which NeuRepair Brain and Spine may be higher or lower than some other options available to me.

I understand there is a fee schedule for all products, medications, and professional fees available to me.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name**



## FINANCIAL RESPONSIBILITY POLICY

**Name of Patient:** \_\_\_\_\_

**Medical Provider:** NeuRepair Brain and Spine Wellness Centers,  
5083 Little road Trinity, FL. 34655

As a new patient of our facility, we would like to advise you of our Financial Responsibility Policy. The number of benefits will depend on your policy and the circumstances of your case. Also, insurance companies may deny claims in whole or part, making it almost impossible to determine how much of your claim will be covered.

Patients are responsible for the payment of all covered medical expenses that are not paid by applicable insurance. Your financial responsibility, if any, cannot be determined until (a) you have completed treatment, and (b) the financial obligations of your insurance company have been determined. In some instances, it will take litigation to obtain insurance company payment which can take months, if not years to resolve. In consideration of and as an express condition to our agreeing to providing treatment to you and waiting to obtain what, if any insurance payments we will receive, you agree to pay any remaining balances owed for services rendered.

***\*By signing below, I acknowledge that I understand the above Patient Financial Responsibility Policy.***

\_\_\_\_\_

**Patient or Guardian Signature**

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Witness Signature**

\_\_\_\_\_

**Date**

