2102 SW 20 Place, Building 100
Ocala, FL 34471-0856

17820 SE 109th Avenue
Summerfield, FL 34491

(352) 873-7770

Thank you for choosing Central Florida Spine Institute for your spine needs. We look forward to helping you return to an active lifestyle.

Please review the new patient paperwork and complete it prior to your appointment. **Please remember to bring the completed paperwork, your current insurance card(s) and your driver's license or identification card to your new patient appointment.**

New patients must bring a CD or disk of imaging studies (MRI, CT scans and X-Rays) that have been performed within the last year. This is available from the place of service that performed the study and is necessary to have at the initial appointment. By providing this information, Dr. Paraiso and his care team will be able to evaluate and treat your condition. If there are no current studies, please make sure you notate that on your new patient paperwork

Please fill out the enclosed new patient paperwork in its entirety. Central Florida Spine Institute is committed to providing quality, efficient care for every patient. Please be advised that incomplete paperwork may delay or even cancel your appointment.

We thank you in advance for your cooperation and look forward to caring for you.

If you have any questions or need clarification, please contact our office at
(352) 873-7770.

CENTRAL FLORIDA
SPINE INSTITUTE
Minimally Invasive Spine Surgery

Patient Registration, Financial Policy and Privacy Statement

Name: _______________________________________ Sex: M F DOB:_____/_____/_____ SSN:_______________
Address: ____ City: _______________ State/Zip:_______________
Home Phone: ( )_______________ Cell Phone: ( )________________ Work Phone: ( )________________
Email: _______________________________________ Contact Preference: ___ Home ___ Cell ___ Work

Race: African American/Black Alaskan Native/American Indian Asian Pacific Islander/Native Hawaiian White
Ethnicity: __ Hispanic ___ Other ___ Decline Language: ________________________ Marital Status: M S D W

How did you hear about us?

___ Advertising ___ Family Friend ___ Self-Referral ___ Website ___ Hospital Emergency Room ____ Insurance Company

Primary Care Physician: ____

Other Routine Physicians: ____

Assignment of Benefits/Release of Billing Information

I authorize Central Florida Spine Institute and/or their staff to leave medical information pertaining to my care by phone, voicemail, and to contact me via email for appointment remainders and other important office information.

I request that payment of services from Medicare benefits be made to Central Florida Spine Institute, PLLC. I authorize any holder of medical information about me be released to all providers involved in my care and to my insurance company for the purpose of processing and reimbursement for services rendered. I acknowledge that I am responsible for payment of any balance not covered by my insurance company. **Central Florida Spine Institute makes great effort to respectfully ask patients if your spine condition is due to an automobile accident, or worker's compensation incident and if you have retained an attorney for your spine condition. Failure to notify Central Florida Spine Institute at your initial visit (or any subsequent visit) that your injury is due to an automobile accident, worker's compensation incident, or if you have retained an attorney may result in your appointment being canceled. Your openness is greatly appreciated**.

Guardian (if patient under 18): Last Name: ___________________________ First Name: _________________
Emergency Contact Name: ______________________________________ Relationship: ___________________
Home Phone: ( )___________________ Cell Phone: ( )____________________
Next of Kin Name: ____ Relationship: __________________
Phone: ( ) ________________________________
Employer Name: __________________________________ Name of Insured: ____________________________
DOB: _____/________/______ Relationship to Patient: Self Child Spouse Other: ____________________
Patient Condition Related to: Employment, State ______ Auto Accident, State_______ Other Accident _______ N/A

Consent for Treatment – I hereby authorize Central Florida Spine Institute to provide evaluation and medical treatment necessary, including diagnostic, surgical, and/or therapy interventions, by authorized member(s) of the practice or their designee.

* Central Florida Spine Institute complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex

X

Patient Name Signature Date

Patient Registration, Financial Policy and Privacy Statement

General Policy – As a participating provider, we will accept the carrier's allowable amount. Patients are responsible for co-payments, co-insurance amounts and/or deductibles and payment for services not covered by the carrier. Copays will be collected at each visit. If you are insured under a plan that we do not participate with and you choose to receive your care with us, we can make arrangements to bill the carrier; however, the patient is responsible for the bill in it's entirety.

Please remember that your insurance plan is a contract between you and your insurance carrier. This contract usually requires a shared responsibility between the insurance and the patient for services rendered. While we will act on your behalf to obtain payment for our services, once we have exhausted all efforts, the patient is responsible for the balance due. Our office also accepts Visa, MasterCard and Discover in addition to cash and personal checks as method of payment. The billing department can also develop a payment plan to suit your needs to ensure that your account remains in good standing, should this become necessary. There will be a charge of $25.00 for all returned checks for insufficient funds.

Referrals – If your insurance requires a referral from your PCP for your visit, their referral must be obtained and presented at the time of the visit. If a referral is not present at the time of visit, the visit can be rescheduled to allow time to contact your PCP to obtain.

No Show Appointments – Patients that do not show for their scheduled appointment and do not call the office at least 24 hours in advance, a 25.00 no show fee will apply.

Secondary Insurance – We will submit your bill to your secondary; however, failure to obtain payment within 60 days will result in the balance being billed to you, Our office will not file to tertiary insurances, but will provide you the necessary documents to do so upon request.

Self-Pay Policy – Patients without insurance coverage who wish to receive care with us must establish a payment plan with our billing department prior to receiving services.

Legal/Third Party Payor - Central Florida Spine Institute makes great effort to respectfully ask patients if your spine condition is due to an automobile accident, or worker's compensation incident and if you have retained an attorney for your spine condition. Failure to notify Central Florida Spine Institute at your initial visit (or any subsequent visit) that your injury is due to an automobile accident, worker's compensation incident, or if you have retained an attorney may result in your appointment being canceled. Your openness is greatly appreciated.

Surgeries – When you choose to schedule a surgery with Central Florida Spine Institute, we will check with your insurance carrier with any outstanding deductible, co-pays or coinsurance amounts. If there is a deductible amount not yet satisfied for that benefit period, co-pay or coinsurance for the procedures, you be asked to pay a portion of that amount.

Collection – Our office will make every effort to communicate with you about your account and will present reasonable options for payment. In the event that we involve a third party for collect of an account, you will not be permitted to return for a new episode of care until you have satisfied the old debt.

Disability Forms (Short – term and FMLA) - Our office will complete your disability insurance claim forms; however, it is the patient's responsibility to provide the office with the forms, job description and contact information, **The fee for each form is $25 and must be paid in advance.**

Authorization to Release Information – I authorize for medical information about me to be released to all providers involved in my care and to my insurance company for the purpose of processing and reimbursement of services rendered. I also authorize the release of my medical information pertaining to my medical care to the following individuals:

____

____

Medical Records – Medical records are processed on a weekly basis. Upon written request, medical records will be processed and completed within 5-7 business days. Payment for medical records must be paid in full in order to complete the request.

I have read the Financial Policy as outlined above.

Privacy Statement – I have received a copy of the protected health information. I give permission to Central Florida Spine Institute to use and disclose my health information in accordance with it.

X

Patient Name Signature Date 2FO (2018)

(Office use only: _____ Refused to sign _____ Refused Copy of Privacy Notice)

MR # ____________________

CENTRAL FLORIDA
SPINE INSTITUTE
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FIRST VISIT QUESTIONNAIRE

Central Florida Spine Institute is a spine only specialist office, therefore due to insurance purposes we will focus on one part of the spine at each visit. If you have any questions, please ask for assistance.

Name: ____ **DOB:** ___________________ **Date of Visit:** ______________

Sex: Male Female

Referred By: ____ **Is this a second opinion?** YES NO

Primary Care Physician: ____

Pharmacy Preference: ____

Please choose areas that are affecting and circle all that apply:

A. **Neck Area: headaches, arm pain, arm numbness, shoulder pain, right side, left side, both**
B. **Upper back: thoracic pain, rib area pain, right side, left side, both**
C. **Lower back: buttock pain, thigh pain, leg pain, leg numbness, hip pain, pain in feet, pain in toes, right side, left side, both**

Is the condition you are being seen for a result of a motor vehicle accident / slip and fall / or a work related injury? Please indicate .

A. **Yes, please list date of accident:** ____
B. **No**

Has an attorney or adjuster been retained? Please indicate.

A. **Yes, Adjustors or attorneys name/phone number**
B. **No**

IF pain is due to an accident, please describe circumstances regarding accident below.

____

____

____

____

____

____

MR # ____________________

TREATMENT HISTORY for CURRENT SPINE CONDITION (HPI)
(Please circle all that apply)

What type of treatment have you tried currently or in the past to relieve your symptoms for the specific area we are evaluating today?

Prescribed physical therapy: NO YES Currently Receiving within Past year

Did physical therapy relieve your symptoms? No help Helped a little Helped temporarily Helped significantly

Spinal Epidural Injections: NO YES Currently Receiving within Past year

How many injections have you had in the last 12 months? ________

Physician whom performed your injections? _________________________

Did the injections relieve your symptoms? No help Helped a little Helped temporarily Helped significantly

Have you had any recent radiological diagnostic studies for the spine condition that we are seeing you for today?

Please check any/all that apply.		**Where performed?**		
CERVICAL __________	**CT __________**	**Lake Medical Imaging**	**DOC's**	**Radiology Associates of Ocala**
LUMBAR __________	**MRI ________**	**MIT**	**Advanced Imaging**	**The Villages Hospital**
THORACIC ________	**X-RAYS _____**	**Sand Lake Imaging**	**Care First**	**Other: ______________________**

ALLERGIES

Do you have any known drug or other allergies (including iodine/contrast dye or shellfish)?

PLEASE CIRCLE ONE:

A. **NO known drug allergies**
B. **YES, Please list**

Allergy	Reaction
___________________________________	____
___________________________________	____
___________________________________	____
___________________________________	____
___________________________________	____

MR # ____________________

CURRENT MEDICATIONS

Are you currently taking ANY medications (prescribed or over the counter)? If you have a prepared list, please mark see attached.

A. **None**
B. **Yes** **See Below** **See Attached List**

Name	Dose	Reason for Taking
______________________	____________________	____
______________________	____________________	____
______________________	____________________	____
______________________	____________________	____
______________________	____________________	____
______________________	____________________	____
______________________	____________________	____
______________________	____________________	____
______________________	____________________	____

FAMILY HISTORY

Has mother, father, brother, sister been diagnosed with the following condition(s)?

Arthritis	Heart Disease	Scoliosis
Cancer/Malignant neoplastic disease	Hypertension/High Blood Pressure	Stroke
Diabetes	Musculoskeletal Disease	Other:_____________________
Disorder of the Back	Osteoarthritis	____________________________
Disorder of the Neck	Osteoporosis	____________________________
Heart Attack – Cardiovascular Incident	Rheumatoid Arthritis	

MR # ___________________

SOCIAL HISTORY

Do you currently smoke? **NO** **YES: Packs Per day____________** **Number of Years: _______**

Tobacco Use? **NO** **YES: Amount per day__________**

Did you ever smoke regularly before? **NO** **YES: Packs Per day____________** **Number of Years: _______**

How many years did you smoke? ____________ **When did you quit smoking? ___________________________**

Education: ___Did not complete high school ___High School ___ College ___ Graduate school

Occupation: ____

Marital Status: ___Single ___ Married ___ Divorced ___ Widowed

Live: ___ Alone ___ With others

Home: ___ Single level ___ Multi level

Alcohol Consumption (per week): NONE < 6 drinks 6-12 drinks 12-24 drinks 24-48 drinks 48 drinks or over

Illicit Drugs: **NO** **YES: Specify: _______________________________________**

Exercise Level: ___ None ____ 2 x a week ___5 x a week ____ Everyday

Sporting Activities: Please list.

____

Advanced Directive: **NO** **YES**

Are you currently Employed? **NO** **YES, Employer: _______________________________________**

What is your current work status? (please circle and specify if needed)

- **Full time with / without restrictions**
- **Part time with / without restrictions**
- **Retired by choice**
- **Unemployed**
- **Student**
- **Other: ____**

MR # ____________________

SURGICAL HISTORY

Have you had Spine Surgery in the past? Neck or Back, please specify.

- **A. NO**
- **B. YES, Please list below**

Date	Procedure & Levels	Surgeon Name
________________	____________________________________	____________________________________
________________	____________________________________	____________________________________
________________	____________________________________	____________________________________
________________	____________________________________	____________________________________

Have you had any other surgical procedures (other than the spine)?

- **A. NO**
- **B. YES, Please list below**

Date	Procedure	Surgeon Name
________________	____________________________________	____________________________________
________________	____________________________________	____________________________________
________________	____________________________________	____________________________________
________________	____________________________________	____________________________________

PAST MEDICAL HISTORY

Anemia

Arthritis

Asthma

Bleeding disorder

Blood clots

Cancer: Type ______________________

Circulation problems

Coronary artery disease

Depression

Diabetes: Type ____________________

HIV/AIDS

Heart attack: When ________________

Heart Disease

Heart problems

Hepatitis: Type ___________

High blood pressure

High cholesterol

Immune disorder

Kidney disease

Leg or foot ulcers

Liver disease

Mental Disorder: _________________

Migraines

Osteoarthritis

Osteoporosis

Pacemaker

Pulmonary embolism

Peripheral vascular disease

Rheumatoid arthritis

Seizures/epilepsy

Stroke: When _______________

Tuberculosis

Ulcers

UTI

Other: _____________________

____

MR # ___________________

REVIEW OF SYSTEMS

Have you recently experienced any of the following? Please circle all that apply.

Constitutional: Fever Night sweats Weight Gain Weight Loss

Eyes: Dry Eyes Irritation Vision Changes

ENMT:

Ears: Difficulty Hearing

Nose: Frequent nose bleeds Nose or sinus problems

Mouth/Throat: Sore throat Bleeding gums Snoring Dry Mouth Oral Abnormalities Mouth Ulcers Teeth Abnormalities Mouth Breathing

Cardiovascular: Chest Pain on Exertion Arm Pain on Exertion Shortness of Breath when walking Shortness of Breath when lying down Palpitation Known Heart Murmur Lightheaded on standing

Respiratory: Cough Wheezing Shortness of Breath Coughing up Blood Sleep Apnea

Gastrointestinal: Abdominal Pain Vomiting Change in Appetite Black tarry stools Frequent diarrhea Vomiting Blood

Genitourinary: Urinary loss of control Difficulty urinating Increased urinary frequency Hematuria Incomplete Emptying

Musculoskeletal: Muscle aches Muscle weakness Back Pain Arthralgia/joint pain Swelling in extremities

Integumentary: Abnormal mole Jaundice Rash Itching Dry skin Growth/lesions

Neurologic: Loss of consciousness Weakness Numbness Dizziness Seizures Frequent headaches/migraines Restless legs

Have you had any problems bowel, bladder or sexual functions since this condition began?

NOYES, Please explain

____

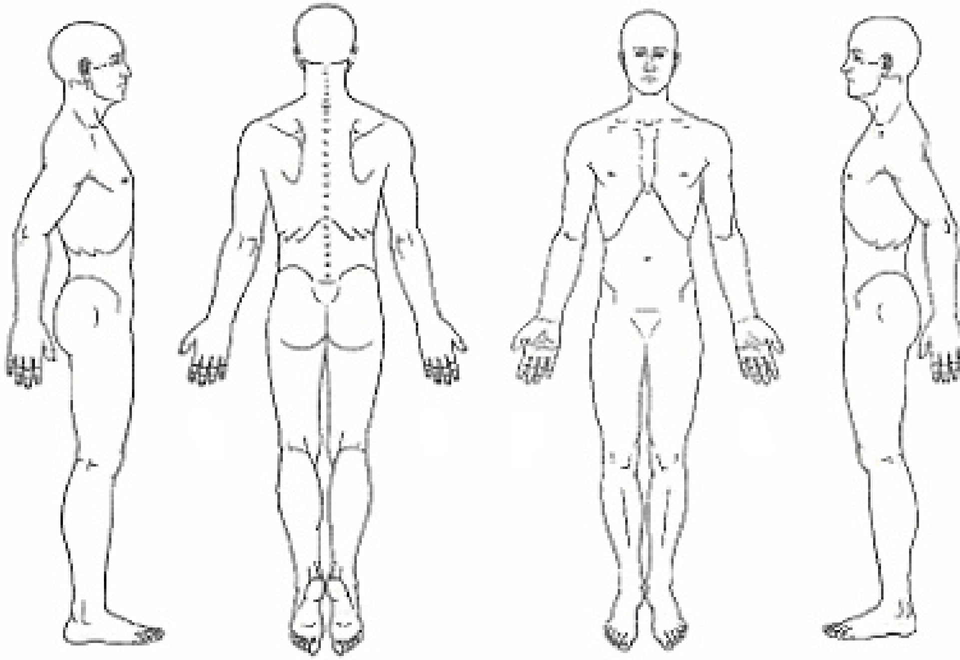
MR # ___________________

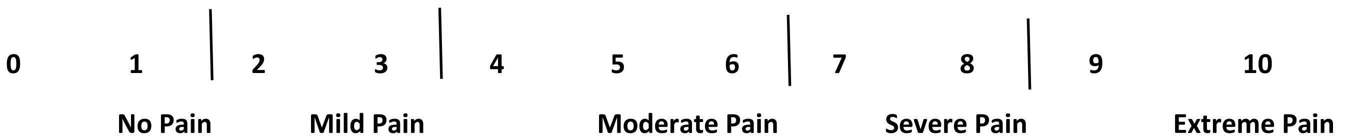
PAIN DIAGRAM

Please indicate where your pain is on your body.

Draw XXXX for areas of pain

Draw OOOO for areas of numbness and/or tingling





On a scale of 1 to 10, please indicate what you would consider your daily pain level to be ________________________

On a scale of 1 to 10, please indicate what you would consider your highest pain level has reached _______________

Signature: X____

Medical Assistant: ____