Universal Spine & Joint Specialists

8318 North Habana Ave, Tampa FL 33614

Phone: 813-667-2460 Fax 813-667-2461

New Patient Packet

Dear Patient,

Welcome to Universal Spine and Joint Specialists. We look forward to meeting you and developing a professional relationship. We are dedicated to creating an individualized plan for each patient we treat. Our ultimate goal is restore vitality and reduce suffering.

Please take the time to review this packet and be as through as possible. We respect your time, completing this packet allows us to be as efficient and optimal as possible with your care.

We prescribe minimal to no opioids. We are an interventional and multi modal treatment clinic with minimal emphasis on pain medications.

Please make sure the following is complete before coming to our office:

- **If required, referral or pre authorization from the referring physicians office**
- **Medical records from your primary care doctor and/or referring physicians**
- **Obtain copies or records of any imaging (X-Ray, MRI, CT) or other diagnostic tests (EMG)**

Please bring the following on the day of your appointment:

- **This packet**
- **Insurance card- Must present on first visit if insurance is to be billed**
- **Government issued identification (Driver's License, Passport, State ID)**
- **Method of payment (Cash, Checks, Credit Card)**
- **If you do not speak English or Spanish please bring someone with you that can translate your language, this allows us to make sure we communicate effectively**

Your Appointment Date: _____ Time: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____

SOCIAL SECURITY NUMBER _____

DATE OF BIRTH: _____ FAMILY PHYSICIAN: _____

REFERRING PHYSICIAN: _____

ATTORNEY NAME IF INVOLVED IN A CASE: _____

EMAIL ADDRESS: _____

PHARMACY NAME: _____ **PHARMACY NUMBER:** _____

MEDICATIONS:

Please list all medications, doses, and frequency. Include any and all pain medications. List all medications even if over the counter and herbal supplements.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

PAST MEDICAL HISTORY:

□ Fibromyalgia □ Depression □ Anxiety □ Herniated Disc □ Radiculopathy □ Shingles

□ Insomnia □ Sleep Apnea □ Diabetes □ Osteoarthritis □ Rheumatoid Arthritis

□ Headaches / Migraines □ High Blood Pressure □ High Cholesterol □ Hypothyroidism

□ Heart Disease or Attack □ Asthma □ COPD □ Gout □ Stroke

□ Peripheral Vascular Disease □ Bleeding Disorder □ Kidney Disease □ Hepatitis

□ Cancer □ AIDS / HIV □ Prostate Disease / Enlargement □ Seizures □ Depression

□ Bipolar □ Schizophrenia □ Attention Deficit Disorder

□ _____ □ _____

ALLERGY:

Please list any allergy and the reaction. Include latex or iodine allergy as well

_____

_____

PAST SURGICAL HISTORY:

_____

_____

_____

PREVIOUS MOTOR VEHICLE ACCIDENTS OR FALLS THAT RESULTED IN ONGOING PAIN OR INJURY:

_____

_____

FAMILY HISTORY:

Please list any ailments or diseases in your immediate family (i.e. Mom - Diabetes), especially pain related conditions:

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY:

Occupation: _____

Do you smoke? □ YES □ NO How many pack / day _____ Years _____

Drink alcohol? □ YES □ NO If yes how much / how often _____

Do you use any other illegal drugs (Marijuana, Cocaine, etc.)? □ YES □ NO

Have you ever been or currently addicted to any medications / drugs □ YES □ NO

If YES which one _____

Marital status? □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED

Do you live alone? □ YES □ NO If no who do you live with _____

Have you ever seen or been treated by a psychologist or psychiatrist? □ YES □ NO

If YES, what was the diagnosis _____

PHQ2

During the last month have you often been bothered by:

Little or no interest in doing things	□ YES	□ NO
Feeling down, depressed, or hopeless	□ YES	□ NO

Review of symptoms

Are currently experiencing any of the following symptoms?

GENERAL:

Loss of appetite …… □ YES □ NO
Fever or chills ……..□ YES □ NO
Recent weight loss ……□ YES □ NO
Low energy/Fatigue ……..□ YES □ NO

ENDOCRINE:

Heat/Cold intolerance…… □ YES □ NO
Difficulty sleeping……... □ YES □ NO
Frequent urination…… □ YES □ NO
Increased thirst…….. □ YES □ NO

CARDIOVASCULAR:

Chest pain……□ YES □ NO
Leg Swelling……□ YES □ NO
Palpitations……,,,, YES □ NO
Orthopnea……..□ YES □ NO

RESPIRATORY:

Shortness of breath ……...□ YES □ NO
Wheezing……..……..□ YES □ NO
Chronic cough ……...□ YES □ NO

EYES:

Blurred vision……□ YES □ NO
Loss of vision……□ YES □ NO
Double vision……...□ YES □ NO
Eye Pain……...□ YES □ NO

KIDNEY/BLADDER/URINE:

Painful urination……□ YES □ NO
Incontinence……..□ YES □ NO
Blood in urine……..□ YES □ NO
No / Reduced urinary output…… □ YES □ NO

SKIN:

Rash……..□ YES □ NO
Frequent Rashes……..□ YES □ NO
Itching……□ YES □ NO

GASTROINTESTINAL:

Nausea or vomiting……..□ YES □ NO
Blood in stool……□ YES □ NO
Heartburn……..……..□ YES □ NO
Constipation……..……..□ YES □ NO

EARS/NOSE/THROAT:

Sore Throat……□ YES □ NO
Trouble swallowing……..□ YES □ NO
Hearing loss……□ YES □ NO
Ear pain…….……□ YES □ NO

NEUROLOGICAL

Tremor……..□ YES □ NO
Seizures……..…□ YES □ NO
Dizziness……..…..□ YES □ NO
Tingling /Numbness……...□ YES □ NO

PSYCHIATRIC:

Depression……...□ YES □ NO
Memory loss……..……□ YES □ NO
Suicidal Thoughts……..□ YES □ NO
Anxiety……□ YES □ NO

HEMATOLOGICAL/LYMPHATIC:

Easy bruising……□ YES □ NO
Easy bleeding……..……□ YES □ NO

PAIN QUESTIONAIRE:

Where is your pain? _____

When did it happen and did something cause it to happen? _____

_____

How long have you had this pain? _____

Where is the pain located? _____

Where does the pain travel to? _____

How many hours a night do you sleep? _____

Describe the pain and symptoms. (Circle all that apply)

Sharp Shooting Pins and Needles Aching Throbbing

Numbness Burning Other _____

What makes the pain worse? (Circle all that apply)

Climbing down stairs Climbing up stairs Walking Standing

Sitting Leaning Forward Leaning Backward Coughing

Laying on your back Reaching Raising Arms Turning Neck

Other _____

What makes the pain better? (Circle all that apply)

Sitting Bending Walking Lying down Leaning forward Leaning Back

Stretching Rest Heat Cold Bed Rest Medication

If medication which ones? _____

What treatments have you tried in the past? How long did you have these treatments? Did it help? (Indicate below)

Treatments	**Tried (mark x if yes)**	**How Many Weeks**	**Helped (yes or no)**
Physical Therapy	_____	_____	_____
Chiropractor	_____	_____	_____
Braces	_____	_____	_____
Pain Injection	_____	_____	_____
Ice/heat Pack	_____	_____	_____
Massage	_____	_____	_____
TENS/Electrical Stim	_____	_____	_____
Pain Medication (Narcotics)	_____	_____	_____
Medication (Non Narcotics)	_____	_____	_____
Surgery	_____	_____	_____

Other:

Circle what your average pain is

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

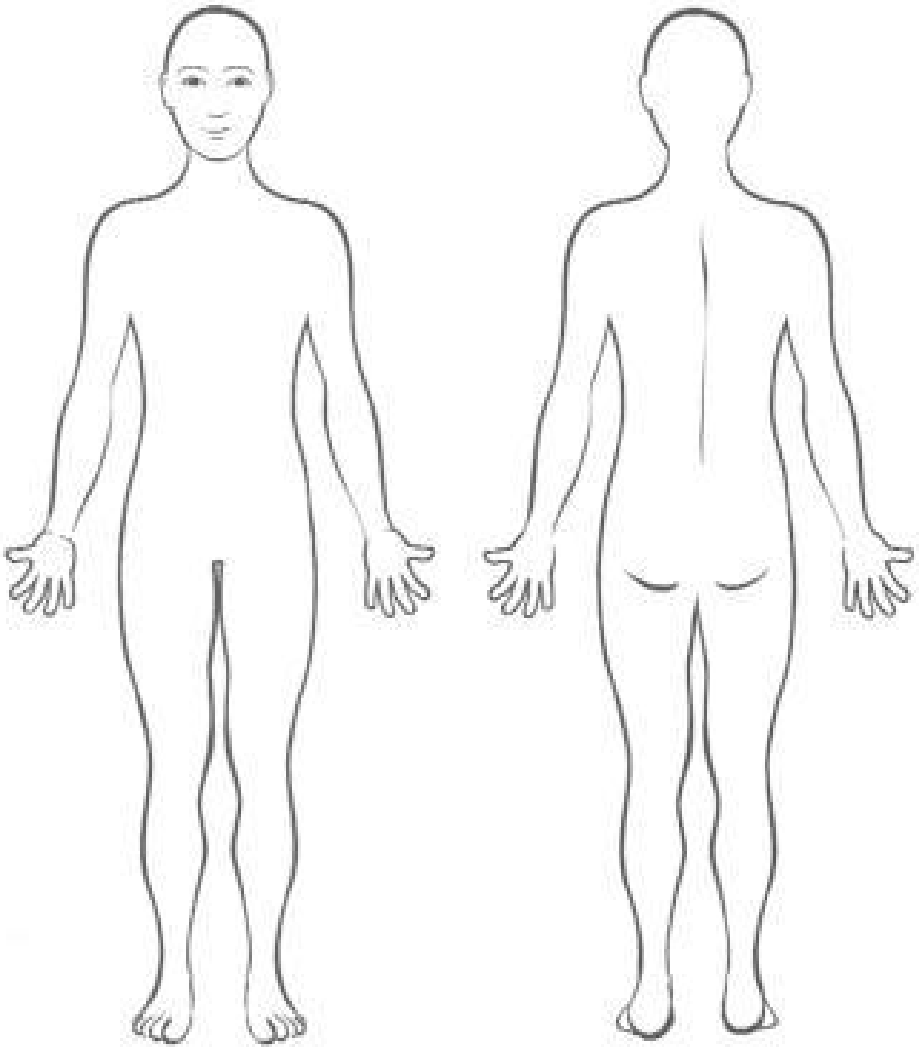
Circle when your pain is at its best

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Circle what your worst pain is

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Please mark where you have pain and where it travels



PAIN
XXXXXXXX

NUMBNESS
OOOOOOOOO

Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No shows", late shows and cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments, please call **813-667-2460**. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

No Show Policy:

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner which is 24 hours prior to your appointment. A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a no-show. Appointment will be a no show if the patient is 15 minutes late to their appointment.

The first time visit there is a no-show there will be no charge to the patient. The 2nd time will result in a fee of $50.00 billed to the patient's account. The 3rd time will result in a fee of $50.00 billed to the patient's account and may result in a discharge from the practice.

First time procedure no-show will be charged at $50.00 for all procedures except radiofrequency ablations. No-show to radiofrequency ablations will be a $100.00 charge as these procedures require additional costly equipment and time.

I have read, and understand this policy. I agree to comply and realize that if I do not I may be charged.

Signature: _____ Date:_____

We are humans and compassionate and understand things do occur out of our control. In rare circumstances we may make exceptions, but will require adequate documentation. This will be on a case by case basis and to sole discretion of the clinic as a courtesy.

Medical Release Form

Universal Joint and Spine Specialists

Jay Parekh D.O.

Board certified Interventional Pain Management

8318 North Habana Ave. Tampa FL 33614

Phone (813) 667-2460 Fax (813) 667-2461

Patient Name: _____

Date of Birth: ____/____/_____ SSN: _____

Address: _____

_____

Telephone Number: _____

I hereby authorize the below listed entity to release medical information to:

Universal Joint and Spine Specialists
Jay Parekh D.O.
8318 North Habana Ave. Tampa FL 33614
Phone (813) 667-2460 Fax (813) 667-2461

Medical Information Requested:

___X____ All medical records

_____ _____

Signature of Patient or Legal Guardian ***Date***

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under the federal and/state law and cannot be disclosed without written consent unless otherwise provided by the law. I further understand that the specific type of information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, auto immune deficiency syndrome (AIDS), AIDS related complex or HIV infection for any admissions. I understand that I have the right to revoke this consent any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.

Authorization of Use and Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____ SSN: _____

My Authorization

Universal Spine and Joint Specialists may use or disclose the following health care information:

__X___ ALL my health information maintained by you.

Other: _____

You may disclose this health information to:

Name (or title) and organization: _____
Relationship: (parent, child, sibling, legal guardian, etc,):_____

Name (or title) and organization: _____
Relationship: (parent, child, sibling, legal guardian, etc,): _____

II. My Rights

I understand I do not have to sign this authorization in order to receive treatment. However, I may be required to sign this authorization form: To receive health care when the purpose is to create health information for a third party. I may revoke this authorization at any time, in writing, sent to Universal Pain Specialists at the address provided below. If I do, it will not affect any actions already taken by Universal Pain Specialists based upon this authorization; uses and disclosures already made cannot be taken back. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once the office discloses health information, the person or organization that receives it may re- disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized signature Date

Patient is unable to sign because of (minor, disabled, etc.) _____

Our address to revoke

8318 North Habana, Tampa FL 33614

E-PRESCRIBING AND MEDICATION HISTORY CONSENT FORM

ePrecribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Universal Pain Specialists can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Universal Pain Specialists to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Name_____ DOB _____

Signature of Patient or Guardian _____

Relationship to patient _____

Date _____

Financial Policy

Because of our commitment to provide you with the highest standard of medical care, we want you to be aware of our policies concerning payment of your medical expenses.

At the initial visit and all visits, the patient is responsible for all co-payment/co-insurance amounts as assigned by the insurance carrier plus any applicable deductible amounts. **If our office cannot verify insurance benefits, payment is due in full when you check-in for your appointment.**

If your insurance carrier sends payment directly to you, then payment in full is due at each visit. If you are waiting for coverage to become effective or have no medical insurance coverage, payment in full will be expected the day you are seen. For your convenience, we accept VISA, MasterCard, cash, or check. We do not accept third party assignments nor do we recognize or enforce the terms of divorce decrees.

We require that an adult (parent or legal guardian) accompany a minor patient unless prior written authorization is given to our office. The adult accompanying the minor patient is required to pay in accordance with our policies.

Should an overpayment occur on the deductible or percentage amounts charged, we will apply a credit to your account. A refund is available upon request.

There is a $30.00 service fee on all returned checks in addition to the amount of the check. NSF (non- sufficient funds) checks must be redeemed with certified funds (cashier's check, credit card, money order, certified check, or cash) at or before the next office visit.

I have read and understood the foregoing Financial Policy and agree to abide by the terms of the policy.

_____	_____	_____
PRINT NAME	SIGNATURE	DATE

Universal Spine and Joint Specialists

Assignment of Benefits

I hereby authorize you, my insurance company and/or my attorney, to pay directly **Universal Spine and Joint Specialists**, such sums as be due and owing for service rendered, and to withhold such sums for any disability benefits, medical payments, no-fault benefits or any other insurance benefits obligated to reimburse or from any settlement, judgment, or verdict on my behalf. I hereby further give a lien to Universal Pain Specialists Inc. doing business as **Universal Spine and Joint Specialists** against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgement, or verdict which may be paid to me as a result of the injuries or illnesses for which I have been treated by **Universal Spine and Joint Specialists** as a result of the above stated loss date.

Pursuant to Florida statues 627.4137, I hereby assign the benefits of insurance and any and all causes of action available under my policy of automobile insurance to my physician and or **Universal Spine and Joint Specialists** in the event my insurance company, obligated to make payments to my physician and/or **Universal Spine and Joint Specialists** for services, refuses to make or reduce such insurance company for those benefits on my behalf. In order to maximize the benefits available under my policy coverage, I request that if the Company fails to pay my physician and/or **Universal Spine and Joint Specialists** the full amount of the bill (s) submitted, to avoid exhaustion of coverage while my physician and/or **Universal Pain Specialists** purses its right under this Assignment, I authorize and direct Insurance Company to set aside and place in escrow an amount equal to the full amount of any such denial or reduction, and to hold the amount in escrow until the dispute is result in the appropriate forum.

I understand that I remain personally responsible for the total amounts to my physician and/or **Universal Spine and Joint Specialists** for their services.

If health insurance is not provided on the first visit, then you have requested for us not to bill any health insurance and agree to be responsible for charges. In addition if health insurance is billed and claims are denied, you will be responsible for all outstanding charges.

I authorize my physician and/or **Universal Spine and Joint Specialists** to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment Lien and Authorization. I agree that the above mentioned physician and/or **Universal Spine and Joint Specialists** the given Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

I understand that if this account is assigned to an attorney for collection and/or suit, the physician and/ **Universal Spine and Joint Specialists** shall be entitled to reasonable attorney's fees and cost of collection. I also understand that if any bad check is written, I agree to pay for those added cost.

Dated this day_____of_____, 20___ .

_____.

Signature of Policyholder or Claimant