8318 North Habana Ave, Tampa, FL 33614

26854 Ridgebrook Dr, Wesley Chapel, FL 33544

620 Mid-Florida Dr, Lakeland, FL 33813

1162 Bell Shoals Rd, Brandon, FL 33511

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 to restore vitality and reduce suffering.

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

We prescribe minimal to no opioids. We are a surgical, 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 can communicate effectively**

Your Appointment Date: _____________   Time: ___________

NAME: ____

ADDRESS: ____

CITY: ____ STATE: ________________ ZIP: ______________

HOME PHONE: ________________________ CELL: _________________________

SOCIAL SECURITY NUMBER ____

DATE OF BIRTH: ________________________ FAMILY PHYSICIAN: _________________________

EMAIL ADDRESS: ____

PRIMARY TREATING PHYSICIAN / CHIROPRACTOR: ____________________________________

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 Shingles

Insomnia Sleep Apnea Diabetes 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

Bipolar Schizophrenia Attention Deficit Disorder

______________________ ___________________________

ALLERGY:

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

____

____

PAST SURGICAL HISTORY:

____

____

____

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 YESÊwhich one ____

Marital status? ÁSINGLE ÁMARRIED ÁDIVORCED ÁWIDOWED

Do you live alone? YES NO If noÊwho do you live with _______________

Review of symptoms

Are currently experiencing any of the following symptoms?

GENERAL:

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

ENDOCRINE:

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

CARDIOVASCULAR:

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

RESPIRATORY:

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

EYES:

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

KIDNEY/BLADDER/URINE:

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

SKIN:

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

GASTROINTESTINAL:

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

EARS/NOSE/THROAT:

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

NEUROLOGICAL

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

PSYCHIATRIC:

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

HEMATOLOGICAL/LYMPHATIC:

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

CHIEF COMPLAINT 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 without waking up? _________________________________

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 Heat Cold 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	______________	______________	______________
Injections	______________	______________	______________
Ice/heat Pack	______________	______________	______________
Massage	______________	______________	______________
TENS/Electrical Stim	______________	______________	______________
Medication (Non Narcotics)	______________	______________	______________
Surgery	______________	______________	______________

Other:

Medical Release Form

Universal Spine and Joint Specialists

Board Certified Doctors

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

Patient Name: ____

Date of Birth: _____/_____/_______ SSN: ______________________________

Address:____

____

Telephone Number: ________________________________

I hereby authorize the entity ________________________________

To release medical information to:

Universal Spine and Joint Specialists
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.

Universal Spine and Joint Specialists

Patient Record Access Request Form

1. **Patient Information. I am a patient and my information is provided below:**

   Patient Name: ____
   Date of Birth: __________________________

   Patient Email Address: ____ Last 4 of SSN: __________

2. **What Records are Requested.** I am requesting a copy of the following records:

   _X___ Entire Record;

3. **Where Should the Records be Sent.** I am requesting my records be sent to: (Please include any doctors, healthcare facilities, family members, attorneys or anyone else you are okay with us releasing records to)

   Name of Recipient: ______________________________________

   Name of Recipient: ______________________________________

   Name of Recipient: ______________________________________

   Name of Recipient: ______________________________________

   Name of Recipient: ______________________________________

4. **Record Release.** Records maybe released by fax, email, physically in person, or by certified mail

You may revoke this request, at any time, in writing. The revocation will only be effective on the date received by us in writing and will not affect any records we sent on your behalf prior to that date.

Signature: ____________________________________ Print Name: ______________________________________

Relationship to Patient (if not patient): ____________________________________ Date: ________________

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 Spine and Joint 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 Spine and Joint 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 ____

Universal Spine and Joint Specialists

Dear New Patient:

Our medical practice is not in network with any private health insurance companies and does not accept Medicare or other governmental health insurance plans or benefits.

We have an alternative payment arrangement that will allow you to defer payments on your medical charges and make it easier for you to handle and prepare for this unexpected financial situation.

We are more than willing to answer any and all questions you may have before you sign this document. You also have the opportunity to have this document reviewed by an attorney of your choosing prior to signing same.

By signing below, you are affirming that you understand that the practice does not accept health insurance or Medicare benefits and that all of your questions on this issue have been answered satisfactorily by the medical practice.

I____________________ hereby acknowledge that this medical practice does not accept any health insurance or Medicare benefits, I wish to be seen and treated by this medical practice and I understand that I am personally responsible for any medical bills incurred for my treatment.

____
Patient Signature

____
Date

DEFERRED PAYMENT AGREEMENT (DPA):

1. Universal Spine and Joint Specialists hereby agrees to provide medically necessary care and treatment to the above patient based upon the terms and conditions of this agreement.

2. I understand that Universal Spine and Joint Specialists is not in network with any private health insurances and does not participate with Medicare. As a result, I agree to be seen and treated under this payment arrangement with the Practice.

3. Universal Spine and Joint Specialists agrees to provide the medically necessary medical care and treatment and to bill me at their usual and customary rate.

4. Based upon this agreement Universal Spine and Joint Specialists will defer collection of these medical bills as set out below.

5. I understand and agree that I am personally responsible for any and all medical charges billed by Universal Spine and Joint Specialists for my treatment and that if at any time, I default on this obligation, I am subject to a collection action and/or civil litigation instituted by Universal Spine and Joint Specialists to recover the above medical debt. My obligations under this Agreement stand alone and are not subject to any other contingency or occurrence.

6. I understand that I have the right to request, in writing (the form will be provided by the practice upon request), an estimate of medical charges to be incurred prior to undergoing any treatment or procedure at Universal Spine and Joint Specialists

7. If I have retained an attorney, I request and direct the Practice to follow my direction that any and all cost estimates for medical care and treatment and/or the actual medical billings for services provided be sent directly to his/her office.

8. Universal Spine and Joint Specialists agrees to defer the collection on any billings provided to me for 24 months from the date of my first medical treatment without interest.

   If my medical debt remains due and owing at the conclusion of that time period, I agree to pay 5% Annual Percentage Rate (hereinafter referred to as "APR") on the incurred medical debt for the third year the debt is due and owing.

   I further agree to pay an additional 5% APR for each additional year the debt remains outstanding up to five years from the date of my first treatment at the Practice or a maximum of 15% interest APR. The above interest shall be compounded annually.

At the conclusion of the five-year period, unless I have negotiated a payment agreement with Universal Spine and Joint Specialists, collection proceedings and/or civil litigation shall begin for the recovery of the entirety of the medical debt and associated interest that remains outstanding.

9. I, the Patient, enter into this Agreement freely and voluntarily. I have had an opportunity to ask any and all questions of the Practice and I have been provided with satisfactory responses to those questions.
10. Additionally, I have had an opportunity to have this Agreement reviewed by an attorney of my choice prior to signing it.

Patient/Legal Guardian (if patient is a minor):

____
Signature

Date: __________________