SPINE AND NERVE CENTER RIVERVIEW
EMPOWERING MOVEMENT, ENHANCING WELLNESS

Patient Information

Patient Name: _____ Date of Birth: _____
Last First M.I.

Mailing Address: _____
Street City State Zip Code

Permanent Address: _____
Street City State Zip Code

Daytime Phone: _____ Ext. _____ Evening Phone: _____

SSN: _____ Marital Status: | SINGLE | MARRIED | DIVORCED | WIDOWED |

Current Employer: _____ Occupation: _____
(If workers' comp, indicate employer where accident occurred)

Employer Address: _____
Street City State Zip Code

Date of Injury/Accident/Illness: _____

Closest friend or relative not living with you: _____

Address: _____
Street City State Zip Code

Daytime Phone: _____ Ext. _____ Evening Phone: _____

Insurance Information

Primary Insurance Company: _____ Insurance ID#: _____
Subscriber's Relationship to Patient: | SELF | SPOUSE | PARENT | OTHER |

Subscriber's Name: _____ Date of Birth: _____
Last First M.I.
Subscriber's Employer: _____ Telephone #: _____

Subscriber's SSN: _____

Secondary Insurance Company: _____ Insurance ID#: _____

Third Insurance, if applicable: _____ Insurance ID#: _____

Referral Information

☐ Referring Physician_____ ☐ Health Plan Provider List _____

☐ Other Source_____ (W/C Adjuster, Case Manager, Website, Friend etc.)

I, the undersigned, do hereby agree and give my consent for ***SPINE AND NERVE CENTER RIVERVIEW, LLC*** to furnish medical care and treatment to, _____ considered necessary and proper in diagnosing or treating my/his/her physical and mental condition.

Patient/Guardian/Responsible Party_____ Date _____

Chief Complaint & Pain History

Main reason for visit: ☐ Follow-Up

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How long have you been experiencing this pain?

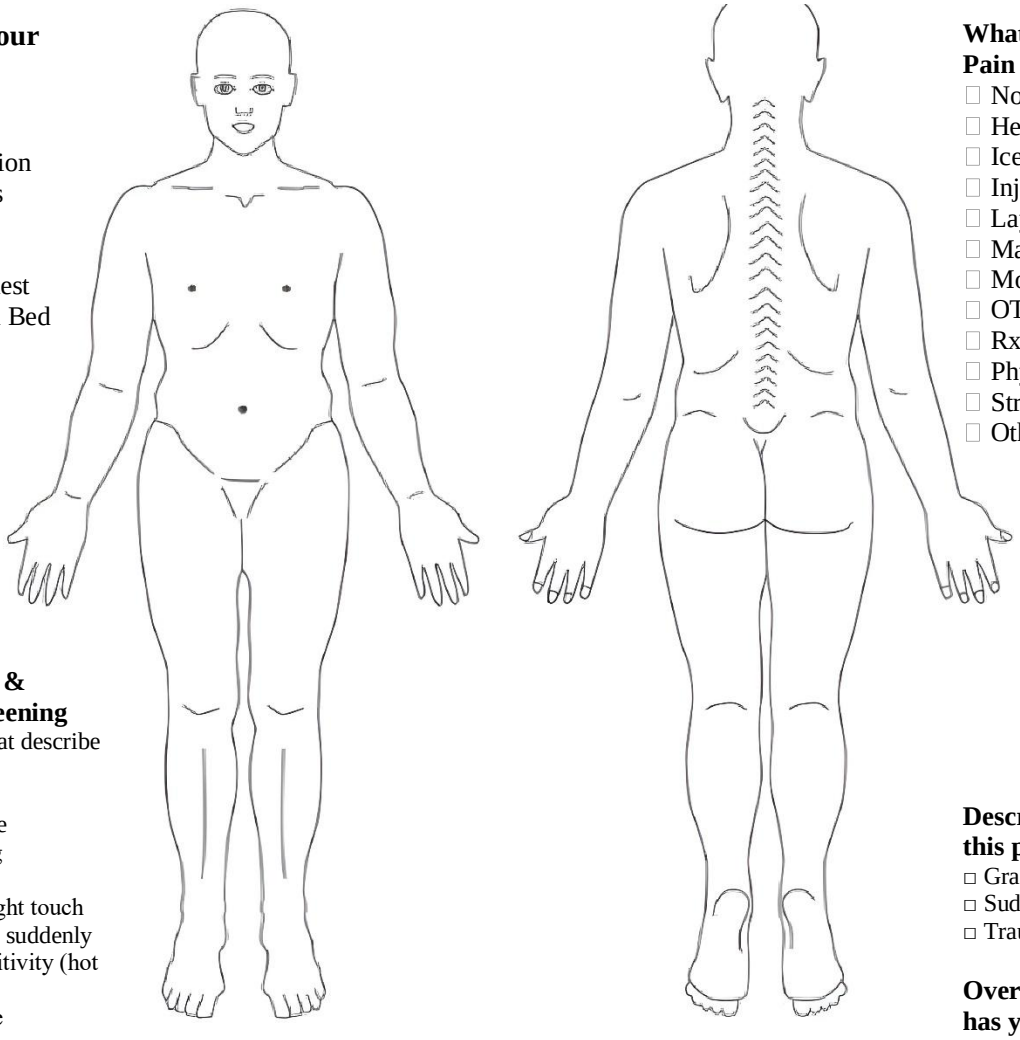
_____ days / months / years | Date of Onset: _____

Pain Location & Pattern

Instructions: Please mark the areas on the body where you feel pain on the diagrams below.

What Makes Your Pain Worse:
- ☐ Nothing
- ☐ Stairs
- ☐ Changing Position
- ☐ Daily Activities
- ☐ Jumping
- ☐ Lifting
- ☐ Laying down/Rest
- ☐ Rolling Over in Bed
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Weather
- ☐ Other:

_____
_____
_____
_____



What Makes Your Pain Better:
- ☐ Nothing
- ☐ Heat
- ☐ Ice
- ☐ Injections
- ☐ Laying Down/Rest
- ☐ Massages
- ☐ Movement
- ☐ OTC Medication
- ☐ Rx Medication
- ☐ Physical Therapy
- ☐ Stretching
- ☐ Other:

_____
_____
_____
_____

Pain Description & Neuropathic Screening
Check any words that describe your pain:
- □ Burning
- □ Electric shock-like
- □ Tingling/prickling
- □ Numbness
- □ Pain evoked by light touch
- □ Pain attacks come suddenly
- □ Temperature sensitivity (hot or cold)
- □ None of the above

- □ Aching
- □ Discomfort
- □ Dull
- □ Gnawing
- □ Piercing
- □ Sharp
- □ Shooting
- □ Stabbing
- □ Throbbing
- □ Tingling
- □ Other: _____

Pain Severity
On a scale from 0–10, where 0 = "no pain" and 10 = "pain as bad as you can imagine":

Average pain in the last week: ____

Worst pain in the last week: ____

Least pain in the last week: ____

Pain right now: ____

Describe the onset of this pain:
- □ Gradual
- □ Sudden
- □ Traumatic

Over the last month, has your pain:
- □ Worsened
- □ Improved
- □ Stayed the same

Is your pain:
- □ Continuous
- □ Fluctuating
- □ Intermittent (comes and goes)

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Diagnostics Tests & Imaging

Mark all of the following tests that you have had related to your current pain complaints:

☐MRI of the: _____ at: _____ Date: _____

☐X-Ray of the: _____ at: _____ Date: _____

☐CT Scan of the: _____ at: _____ Date: _____

☐EMG/NCV study of the: _____ at: _____ Date: _____

☐Other Diagnostic Testing: _____ at: _____ Date: _____

☐ I have not had ANY diagnostic tests for my current pain complaint

Please mark all of the following treatments you have had for pain relief:

	No Change	Worsened Pain	Improved Pain
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
TENS Unit	☐	☐	☐

Interventional Pain Treatment History

☐ None

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar
☐ Joint Injection – Joint(s) _____
☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar
☐ Nerve Blocks – Area/Nerve(s) - _____
☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar
☐ Spinal Cord Stimulator – Trial Only / Permanent Implant _____
☐ Trigger Point Injections – Where? _____
☐ Vertebroplasty/Kyphoplasty – Level(s) _____
☐ Other -

_____
_____

Which of these procedures listed above have helped with your pain? ☐ None

_____
_____

Please list the names of other Pain Physicians you have seen in the past: ☐ None

_____
_____

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist ☐ Neurosurgeon ☐ Psychiatrist/Psychologist ☐ Chiropractor ☐ Orthopedic Surgeon
☐ Rheumatologist ☐ Internist ☐ Physical Therapist ☐ Neurologist ☐ Other _____

Review of Systems

Mark the following symptoms that you currently suffer from:

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Constitutional:
☐Fevers
☐Chills
☐Sweats
☐Weakness
☐Fatigue
☐Decreased Activity
☐Malaise
☐Unexplained weight gain
☐Unexplained weight loss
☐Low sex drive
☐Difficulty sleeping

Eyes:
☐Blurriness
☐Double vision
☐Visual disturbance
☐Pain

Ears/Nose/Throat/Neck:
☐Hearing problems
☐Ear pain
☐Sinus problems
☐Sore throat
☐Nosebleeds

Respiratory:
☐Shortness of breath
☐Cough
☐Sputum production
☐Wheezing

Cardiovascular:
☐Chest pain
☐Palpitations
☐Swelling in feet
☐Shortness of breath
☐Bleeding disorder
☐Blood clots
☐Fainting

Gastrointestinal:
☐Nausea
☐Vomiting
☐Diarrhea
☐Constipation
☐Heartburn
☐Abdominal pain

Genitourinary/Nephrology:
☐Painful urination
☐Blood in urine
☐Change in urine stream
☐Unusual discharge
☐Flank pain
☐Urinary incontinence

Musculoskeletal:
☐Back pain
☐Neck pain
☐Joint pain
☐Muscle pain
☐Muscle cramping
☐Muscle spasms
☐Gait disturbances
☐Joint stiffness
☐Joint swelling
☐Trauma

Integumentary:
☐Rash
☐Itching
☐Lesions
☐Bruising

Neurological:
☐Abnormal balance
☐Confusion
☐Numbness
☐Tingling
☐Dizziness
☐Headaches
☐Loss of coordination
☐Memory loss
☐Seizures
☐Tinnitus
☐Tremors
☐Vertigo

Psychiatric:
☐Feeling anxious
☐Depressed mood
☐Suicidal thoughts
☐Hallucinations
☐Stress problems
☐Suicidal planning
☐Thoughts of harming others

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Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

Cancer/Oncology
☐ Cancer – Type _____

Cardiovascular/Hematologic
☐ Anemia
☐ Heart Attack
☐ Coronary Artery Disease
☐ High Blood Pressure
☐ Peripheral Vascular Disease
☐ Stoke/TIA
☐ Heart Valve Disorders
☐ Presence of stent/pacemaker/defibrillator

Gastrointestinal
☐ GERD (Acid Reflux)
☐ Gastrointestinal Bleeding
☐ Stomach Ulcers
☐ IBS/Crohns Disease

Urological
☐ Chronic Kidney Disease
☐ Kidney Stones
☐ Urinary Incontinence
☐ Dialysis

Neurological
☐ Multiple Sclerosis
☐ Peripheral Neuropathy
☐ Seizures
☐ Balance Disorder
☐ Head Injury
☐ Headaches
☐ Migraines

ENT
☐ Glaucoma
☐ Vertigo
☐ Hearing Problems
☐ Nosebleeds

Respiratory
☐ Asthma
☐ Bronchitis/Pneumonia
☐ Emphysema/COPD

Psychological
☐ Depression
☐ Anxiety
☐ Schizophrenia
☐ Bipolar Disorder
☐ ADD/ADHD
☐ PTSD

Musculoskeletal/Rheumatologic
☐ Bursitis
☐ Carpal Tunnel Syndrome
☐ Fibromyalgia
☐ Osteoarthritis
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Chronic Joint Pains

Endocrinology
☐ Diabetes – Type_____
☐ Hyperthyroidism
☐ Hypothyroidism

Other Diagnosed Conditions

_____

_____

_____

_____

_____

_____

_____

_____

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Surgical History:

Please list any surgical procedures you have had done in the past including date:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

☐ I have **NEVER** had any surgical procedures performed.

Family History:

Mark all appropriate diagnoses as they pertain to your parents and siblings:

☐Arthritis ☐Cancer ☐Diabetes ☐Headaches/Migraines ☐ Stroke

☐High Blood Pressure ☐Kidney Problems ☐Liver Problems ☐Osteoporosis

☐Rheumatoid arthritis ☐Seizures ☐Other Medical Problems: _____

☐ I have no significant family medical history

Social History:

Current/Former Occupation: _____

Who is in your current household? _____

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

Are you currently under worker's compensation? ☐ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

Alcohol Use: ☐ Social drinker ☐ Daily use of alcohol ☐ Never drinker
☐ Drinks per day? _____ ☐ How many years? _____ ☐ Quit Date: _____

Tobacco Use: ☐ Current user ☐ Former user ☐ Never used
☐ Packs per day? _____ ☐ How many years? _____ ☐ Quit Date: _____

Illegal Drug Use: ☐ Denies any illegal drug use ☐ Current user ☐ Former user
Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

Are you currently taking any blood thinners or anti-coagulants? ☐ YES ☐ No

If YES, which ones?

☐ aspirin ☐ heparin ☐ warfarin ☐ dabigatran (Pradaxa) ☐ apixaban (Eliquis)
☐ rivaroxaban (Xarelto) ☐ edoxaban (Savaysa) ☐ dipyridamole (Persantine)
☐ ticlopidine (Ticid) ☐ clopidogrel (Plavix) ☐ prasugrel (Effient)
☐ ticagrelor (Brilinta) ☐ cangrelor (Kenreal) ☐ vorapaxar (Zontivity)
☐ abciximab (ReoPro) ☐ eptifibatide (Integrilin)

Please list all medications you are currently taking <u>including vitamins.</u>
Attach additional sheet if required:

Medication Name	**Dose**	**Frequency**

Please list all past pain medications that you have been on at any point for any reason.

Medication Name	**Dose**	**Frequency**

Do you have any drug/medication allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

Medication Name	**Allergic Reaction**

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

SPINE AND NERVE CENTER RIVERVIEW

EMPOWERING MOVEMENT, ENHANCING WELLNESS

Authorization for Release of Medical Records to Spine and Nerve Center Riverview, LLC

Phone: (813) 741-1071 | Fax: (866) 709-3257

Date: _____

Last name	**First name**	**DOB**
Address		**MRN**

I authorize SPINE AND NERVE CENTER RIVERVIEW, LLC to obtain from any healthcare provider with whom I am currently a patient or have been a patient within the last two years, any information about my health and health care, including the diagnosis, treatment, or examination rendered to me during the period from two (2) years prior to the date of this authorization.

I expressly authorize and consent to the disclosure of my health information related to (check all that apply):

☐ Alcohol and substance use ☐ Mental health ☐ STIs including HIV/AIDS ☐ Genetic testing/counseling

CONFIDENTIALITY POLICY (PLEASE READ BEFORE SIGNING)

Medical records are maintained to serve the patient and the health care team in accordance with all applicable legal and regulatory requirements. The information contained in medical records is considered highly confidential. All patient care information shall be regarded as confidential and available only to authorized users. The phrase "medical records" includes any protected health information (PHI), which includes test results, any medical reports, the medical record itself, claim files, and any correspondence relating to the care of a patient. Any disclosure of my protected health information to a different name, class of person, address, or fax number will require a separate authorization.

I have the right to revoke this authorization in writing, except to the extent that action has already been taken in reliance on this authorization. For the revocation of this authorization to be effective, the above name(s) or class of person(s) must receive the revocation in writing.

This authorization shall expire one year from the date signed. After one year, a new authorization form is needed to continually disclose my PHI. I understand this authorization is voluntary and may refuse to sign it.

I fully understand and accept the terms of this authorization. A copy of this authorization is valid as an original.

Patient or authorized representative signature: _____ **Date:** _____

Patient or authorized representative name: _____

AUXILLARY SERVICES PATIENT CONSENT FORM

Spine and Nerve Center Riverview
Phone: +1 (813) 741-1071 | Fax: +1 (866) 740-3257

SPINE AND NERVE CENTER RIVERVIEW
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Spine and Nerve Center Riverview participates in the electronic exchange of health data through the Carequality framework, electronic prescription history query systems, and utilizes artificial intelligence (AI) technology to enhance patient care, operational efficiency, clinical decision-making, security monitoring, and quality assurance. This form outlines the nature, scope, risks, benefits, alternatives, and your rights regarding these services.

1. Electronic Prescription History Query:

Retrieval of your medication history from national prescription databases to ensure accuracy and prevent medication interactions or duplications.

2. Carequality Health Data Exchange:

Electronic exchange of health data for accurate medical histories, preventing redundant tests and procedures. Automatic enrollment unless an explicit written opt-out request is submitted.

3. Facility-wide Audio and Video Recording:

Recordings used exclusively for patient safety, quality assurance, security, and healthcare improvement. Recordings occur only in common and treatment areas, excluding private consultation spaces.

4. Use of AI Technology:

Enhances clinical decisions, administrative efficiency, and cybersecurity protection. AI does not replace professional medical judgment; clinical decisions remain the provider's responsibility.

RISKS, BENEFITS, AND ALTERNATIVES

Minimal risk of data breach despite stringent safeguards. Recordings and AI data handling comply with HIPAA and state privacy regulations. Improved care coordination, medication safety, operational efficiency, enhanced security, informed clinical decisions, and better patient outcomes. Opting out is permissible but may lead to delays in obtaining records or processing administrative tasks.

PATIENT RIGHTS & RESPONSIBILITIES:

All practices comply with HIPAA and applicable Florida state laws. You may opt out of Carequality exchange, prescription history queries, AI interactions, and request non-recorded consultations. Data and recordings are securely stored and managed in compliance with privacy regulations. Notify the clinic immediately of inaccuracies in your records or changes in your health history.

FINANCIAL AND LEGAL CONSIDERATIONS:

No additional costs are incurred for these services. Compliance with federal and Florida state laws is strictly maintained. Data usage is strictly controlled, requiring authorization for disclosures except where legally mandated.

ACKNOWLEDGMENT & CONSENT:

Consent may be revoked or modified in writing at any time. Revocations are not retroactive and apply only to future interactions. By signing below, I acknowledge that I have read, understood, and consent to participation in electronic prescription history queries, Carequality health data exchange, facility-wide audio/video recording, and the use of AI technology as described above.

Patient/Authorized Representative: _____ Date: _____

PATIENT'S BILL OF RIGHTS AND CERTIFICATION

As a patient at SNCR, you have the right to:

- Have your pain prevented or controlled adequately and maintain a pain plan with your doctor
- Know what medication, treatment, or anesthesia will be given, including risks, benefits, and side effects
- Know what alternative pain treatments may be available
- Sign a statement of informed consent before any treatment
- Be believed when you say you have pain
- Have your pain assessed using the 0 = no pain, 10 = worst pain scale
- Ask for changes in treatments if your pain persists
- Receive compassionate and sympathetic care WITHOUT PREJUDICE from your doctor
- Seek a second opinion or request a pain specialist
- Be given your medical records on request
- Include your family in decision-making

CERTIFICATION AND EXPECTATIONS

I certify that the information sheet that I have filled out is correct, specifically about my current physicians from whom I am obtaining medical care and my history of addiction (if any.). I am listing those physician names here:

1. _____
2. _____
3. _____

I, therefore, expect kind and humane care for my intractable pain syndrome from Spine and Nerve Center Riverview and their office staff. This contract will remain in effect until either party withdraws from it in writing or until I violate it. If the contract is violated, I will no longer be a patient of Spine and Nerve Center Riverview and would strongly consider treatment for chemical dependency if clinically indicated. Diversion of controlled substances and non-therapeutic use of medications is a great societal concern.

CONSENT TO CARE

I am presenting myself to Spine and Nerve Center Riverview for care. I hereby voluntarily consent and authorize such care, including diagnostic procedures, surgical and medical treatment by authorized agents and employees of this Medical Center and by its medical staff or their professional judgment as necessary and beneficial. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment of my condition.

Patient/Guardian Name (Print): _____

Signature: _____ **Date:** _____

BENEFIT ASSIGNMENT

I hereby assign all medical and/or surgical benefits to which I am entitled—including Medicare, Medicaid, private insurance, and other third-party payors—to Spine and Nerve Center Riverview, LLC. This assignment includes any major medical benefits that apply to treatment received. A photocopy of this assignment is to be considered as valid as the original.

RELEASE OF INFORMATION

I hereby authorize SNCR or any physician(s) who have attended to me to furnish my insurance company (or companies), Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), or other healthcare providers involved in my care with necessary medical information, as permitted by Florida Statutes §§ 456.057 and 395.3025.

I authorize the Practice to release any information, including my medical records, that may be necessary to secure payment for services rendered, in accordance with the Health Insurance Portability and Accountability Act (HIPAA), Florida Statutes § 456.057, and any other applicable federal or state laws.

SPECIFIC INFORMATION AUTHORIZATION

I understand and authorize the release of the following categories of protected health information **if I place a check mark next to each**:

- ☐ **Alcohol and/or Drug Abuse** (Diagnosis, evaluation, treatment)
- ☐ **HTLV-III or HIV Testing (AIDS)** (Results, diagnosis, treatment)
- ☐ **Psychiatric/Psychological Records** (Evaluation, treatment for mental, physical, or emotional illness)

COMMUNICATION CONSENT

I authorize SNCR personnel to communicate with me via mail, voicemail, email, or other methods I have provided in my patient registration.

NOTICE OF PRIVACY PRACTICES

The Practice will use and disclose your personal health information for treatment, payment, and regular healthcare operations. We have prepared a detailed **Notice of Privacy Practices** to help you better understand our policies regarding your personal health information and to comply with both federal and Florida law. The most current version of the Notice will be posted at our facilities, and copies will be available upon request.

WAIVER OF PATIENT AUTHORIZATIONS (OPTIONAL)

If you **do not** wish to have information released to an insurance carrier and prefer to pay in full at the time of service, you may do so. Under this waiver, you assume full responsibility for payment of charges and for submitting any claims to your insurer at your discretion.

☐ **I elect to waive insurance billing and will pay in full at time of service**

Patient/Guardian Name (Print): _____

Signature: _____ **Date:** _____

SPINE AND NERVE CENTER RIVERVIEW
EMPOWERING MOVEMENT, ENHANCING WELLNESS

FINANCIAL POLICY STATEMENT

1. **Insurance Billing:** As a courtesy, we will bill your insurance carrier directly for services provided. Florida law generally requires insurers to pay or deny claims within certain time limits; however, you are ultimately **responsible for the full balance of your account** at the time services are rendered, subject to any contractual obligations with your insurer.

2. **Estimated Share:** We require that you make arrangements for payment of your estimated share (e.g., copayment, coinsurance, deductible) on the date of service. If your insurance carrier does not remit payment within **60 days**, the remaining balance will be due in full from you.

3. **Insurance Information Accuracy:** Insurance benefits and eligibility are verified as a courtesy to you. We are **not responsible for any incorrect information** provided by your insurance company regarding copays, deductibles, or plan limitations. Your specific policy limitations, exclusions, and effective date(s) of coverage may affect your financial responsibility.

4. **Refunds or Denials:** If your insurance company requests a refund of payments already made (e.g., due to policy termination or retroactive denial of coverage), you will be responsible for the refunded amount. If you receive any payment directly from the insurer for services rendered by the Practice, you agree to promptly forward those funds to the Practice.

5. **Finance Charges:** The Practice reserves the right to assess a finance charge of **18% annually** on any outstanding balance not paid within a reasonable period, in accordance with Florida Statutes governing finance charges and usury limits.

6. **Worker's Compensation:** If you are being treated under a Worker's Compensation claim, these policies may not apply. However, should you claim Worker's Compensation benefits that are later denied, you will be responsible for the total amount of charges.

7. **Collection of Past Due Balances:** By signing below, you acknowledge and agree that if you fail to timely pay any amounts owed, you will be responsible for **all costs** associated with collecting outstanding balances, including attorney fees, court costs, and any collection agency fees, in accordance with Florida law.

8. **Additional Charges:**
    - **Returned Checks:** Fees for checks returned by the bank for non-sufficient funds, as permitted by Florida law
    - **Missed Appointments:** A fee may be charged for missed appointments or cancellations without at least 24 hours' notice
    - **Extended or After-Hours Phone Services:** Calls requiring diagnosis, treatment, or prescriptions outside normal office hours may incur charges
    - **Medical Records:** Fees as allowed by Florida Statutes §§ 395.301 and 456.057

9. **Good Faith Estimate:** Under Florida law, you have the right to request a good faith estimate of reasonably anticipated charges for non-emergency healthcare services. If you have questions or wish to receive an estimate, please contact our billing department.

I acknowledge that I have read, understand, and accept these terms. I understand my financial responsibility for the payment of my account.

Patient/Guardian Name (Print): _____

Signature: _____ **Date:** _____

SPINE AND NERVE CENTER RIVERVIEW
EMPOWERING MOVEMENT, ENHANCING WELLNESS

FLORIDA FRAUD STATUTE

Section 817.234, Florida Statutes, stipulates that any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, is guilty of a felony of the third degree.

AUTHORIZATION GIVEN TO:

- Any hospital, Physician, Law enforcement agencies, Pharmacy and Health care provider of any nature

FINAL ACKNOWLEDGMENT

By signing below, I acknowledge that:

1. I have read, understand, and agree to all terms in this packet
2. I have been informed of my rights under Florida law
3. Any procedures have been adequately explained to me by my attending physicians
4. I have received a copy of SNCR's Notice of Privacy Practices
5. I have all the information that I desire

Patient/Guardian Name (Print): _____

Signature: _____ **Date:** _____

If you have any questions about this form or your financial responsibility, please contact our office staff or billing department.

FOR OFFICE USE ONLY

Documents reviewed with patient by: _____ Date: _____

Documents scanned into EMR by: _____ Date: _____