Patient name: **Todays Date** __________

Primary care Doctor? _ **(fax)**

Do you have any allergies: No ***Yes.- Please list ALL ALLERGIES.***

Do you have OR had ANY medical conditions: **No** ***Yes(please list)***

Asthma	**Cancer**	**Heart disease/attack**	**Diabetes**	**Hypertension**
Depression	**Anxiety**	**Bipolar disorder**	**Epilepsy**	**Schizophrenia**
HIV or AIDS	**Hepatitis B**	**Hepatitis C**	**Stroke**	**Ulcers**
Bleeding disorder		**Lymphoma**	**Brain mass/swelling**	
Tuberculosis				

Other____

____

Race ___*American/Indian* ___*Alaska Native*___*Asian*___*Black/African American*___*Multiple Races*
___*Native Hawian* ___*Pacific Islander* ___*Unreported/ refused to report* ___*White/ Cacasian*
(Please Circle or X next to indicated Race and Ethnicity)

Ethnicity __*Hispanic/ Latino* ___*Non Hispanic/ Latino* ___*Unreported/ Refused to Report*

Do you Smoke or use tobacco products? **NO** ***Yes (please list)***__________________
Do you use any drugs prescribed or OTHERWISE? **NO** ***Yes(please list)***__________________
Do you Drink alcohol more than once a week? **NO** ***Yes(Please list)***__________________
Have you had any surgery? **NO** ***Yes(please list procedure with date)***______________________________

Any Neck or Back Surgery? (Complications)______________________________
What medication(s) are you taking? (please list all meds with dosages)

______________ ______________________ ______________

______________ ______________________ ______________

Do you have any family history of ILLNESS?

Mother______________________ **Father**______________________

Height______________ **Weight**______________

Name/Nombre: _______________ Todays date/Fecha:_____________

DOB/Fecha de Nacimiento: ___________Social Security/Seguro Social:

Driver License/Licencia para conducer:____

Address/Direccion:___________________________________

Home Phone/Telefono: ____________ Cell Phone/Telefono Cellular: ____________

Emergency Contact/Contacto Emergencia:

Phone/Telefono:

Employer/Emplendor: _________________________________

Work Phone/Telefono del Trabajo:______________________

Address/Direccion:____

Medical Doctor/Doctor General:______________________ Phone/Telefono_________________

Ref Dr. /Medico que lo Refiere:

Primary Insurance/Seguro Medico Primario:____

Policy Number/Poliza: _____________________ Group/Grupo:__________________________

Address/Direccion:____

Secondary insurance:____

Relationship to Policy Holder/Relacion Posedor de Poliza:______________________________

I, undersigned patient or person responsible for the patient, do hereby direct and authorize Dr. Behnam Myers to furnish my insurance company, attorney, personal physician, or any representative thereof, any and all information which may be pertinent regarding my medical condition and medical treatment rendered to me. I authorize my doctor to act as my agent to make claims, assist in obtaining payment from my insurance company (ies) and authorize payment directly to my physician or to the party who accepts assignment. I authorize that I am responsible for my billing, including co-payments and deductibles. I further understand and agree to pay all costs and reasonable agency fees if any charge for services rendered and placed with an attorney or collection agency in the event of non-coverage, I agree to assume responsibility for payment should my insurance decline payment. I hereby declare by my signature below that I have read and understand all of the provisions above.

Patient's signature/Firma: __________________________________ Date/Fecha: ___________

MEDICAL INFORMATION SCREENING FORM:

Patient Name: ______________________ **Today's Date:** ________________________

Orthopedic Complaints (Please Circle Appropriate Areas):

Neck	Shoulder	Hand	Ankle
Back	Elbow	Hip	Foot
Wrist	Knee	Other	

What is your present Orthopedic problem?

____

Describe the injury in detail:

____

____

Date of Injury? ______________________________

Please fill out the following regarding our current injury.

Were you taken to the Emergency Room? YES __________ NO__________

If **YES**, did you go by Ambulance? YES __________ NO__________

Were you admitted to the hospital? YES __________ NO__________

If **YES**, name of Hospital: ____

Did you have Surgery? YES __________ NO__________

If **YES**, date of Surgery: ____

Do you have any Pain, numbness or tingling sensation in your arms or legs?

YES __________ NO__________

If **YES**, where? ____

Do you have any weakness? YES __________ NO__________

If **YES**, where? ____

Have you ever injured yourself in the same location as your current injury, either before or after this current event? YES __________ NO__________

If the answer to the above question is yes, please indicate when and what treatment you had:

____

____

Have you seen any other physician for this condition? YES __________ NO__________

If **YES**, who? ____

Attending Therapy? YES __________ NO__________

Is Therapy helping your condition? YES __________ NO__________

Seen by Pain Management Physician YES __________ NO__________

Are you on any Pain Medications? YES __________ NO__________

If **YES**, then what? YES __________ NO__________

Is the Pain Medication helping? YES __________ NO__________

Have you used a brace or support for this problem? YES __________ NO__________

Have you (circle one) **IMPROVED** **WORSENED** **NO CHANGE**

When is it the worst? (morning, afternoon, evening?): ________________________

What type of PAIN? (Circle one) **SHARP** **ACHY** **DULL**

Is the Pain constant? YES ___________ NO___________

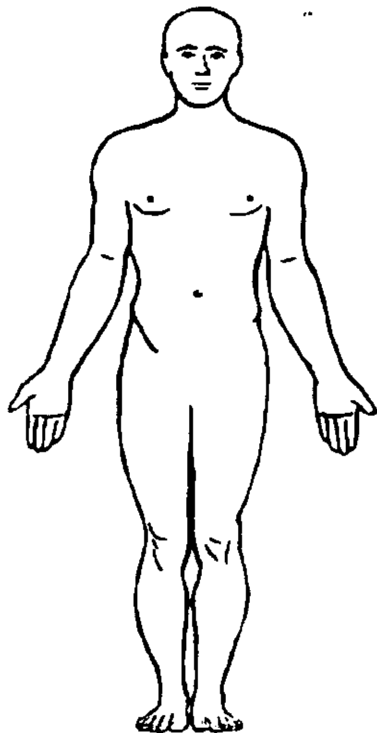
How often does the pain occur? (Circle one) **DAILY** **WEEKLY**

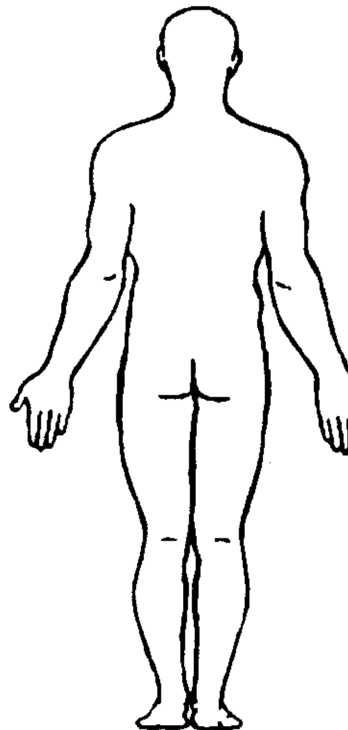
What makes it **BETTER**? ____

What makes it **WORSE**? ____

Please mark the location of your plan using the symbols below:

//// Ache **xxxx Pain** **oooo Tingling** **--------Numb**





Severity: Label your Pain (lower back, leg, arm, etc.) and Rate from 1 to 10, 10 being the worst

Problem Area 1: ______________________________ Pain Level: ________________________

Problem Area 2: ______________________________ Pain Level: ________________________

Problem Area 3: ______________________________ Pain Level: ________________________

Problem Area 4: ______________________________ Pain Level: ________________________

Patient Name: ______________________ MR# ________________

HEALTH CARE ARBITRATION AGREEMENT in an effort to counter the ever increasing cost of health care, we have agreed with an initiative by the American Medical Association to use Health Care Arbitration Agreements whenever possible. This is such an agreement.

ARTICLE 1: General Provisions The patient agrees that any controversy, including any malpractice claim, arising out of or in any way relating to the diagnosis, treatment, or care of the patient by the undersigned physician, including any partners, agents, or employees of the physician and Spine Solutions / Behnam Myers DO PA shall be submitted to binding arbitration.

The patient further agrees that any controversy arising out of or in any way relating to the **past** diagnosis, treatment, or care of the patient by a provider or medical services, or the provider's agents or employees shall likewise be submitted to binding arbitration.

INITIAL: _____

Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

ARTICLE 2: All Claims Must Be Arbitrated It is the intention of the parties that this agreement binds all parties whose claims may arise out of or relate to treatment or services provided by the provider of medical services, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's child or children.

ARTICLE 3: Procedures Within fifteen days after a party to this agreement has given written notice to the other of demand for arbitration of a dispute or controversy, the parties to the dispute or controversy shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator.

Expenses of the arbitration shall be shared equally by the parties to this agreement. Except as herein provided, the arbitration shall be conducted and governed by the provisions of the Florida Arbitration Code, Florida Statues s. 682.01 et. seq.

In the event that any party to this agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, the appointment of an arbitrator, and hearings to resolve the dispute, despite the refusal to participate or absence of the opposing party. Submission of any dispute under this agreement to arbitration may only be avoided by a valid court order, indicating that the dispute is beyond the scope of the arbitration agreement, or contains an illegal aspect precluding the resolution of the dispute by arbitration. Any party to this agreement who refuses to go forward with arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without participation of the party opposing arbitration or despite its absence at the arbitration hearing.

ARTICLE 4: Patients Right to Cancel Arbitration Agreement The patient has the right to rescind this agreement by written notice to the provider of medical services within three (3) days after the agreement has been signed and executed. The patient may rescind by merely writing "cancelled" on the face of one of his copies of this agreement, signing his name under such word, and mailing, by certified mail, return receipt requested, such copy to the provider of medical services with such three (3) day period.

ARTICLE 5: Arbitration as Exclusive Remedy With respect to any dispute or controversy that is made subject to arbitration under the terms of this agreement, no suit at law or in equity based on such dispute or controversy shall be instituted by either party, except to enforce the award of the arbitrators.

ARTICLE 6: Death of Party not to Affect Submission This submission shall not be withdrawn or affected by the death of either of the parties pending a final award, by the executor, administrator, or other representative of the party shall be deemed to be a party to this submission made, any rule of law or equity to the contrary notwithstanding. The parties agree that this agreement is to be binding on the parties' assigns, heirs executors, and administrators.

ARTICLE 7: Acknowledgements The patient, by signing this agreement, also acknowledges that he or she has been informed that:

(1) Medical or hospital care, diagnosis, or treatment will be provided whether or not the patient signs the agreement to arbitrate;

(2) The agreement may not be submitted to a patient for approval when the patient's condition prevents the patient from making a rational decision whether or not to agree;

(3) The decision whether or not to sign the agreement is solely a matter for the patient's determination without any influence by the physician or hospital;

(4) The patient must be furnished with one copy of this agreement.

ARTICLE 8: Awardable Damages The damages awardable at arbitration are limited to those available under Florida law. By signing this contract you are giving up your right to a jury or court trial.

Date: ____________

By ______________________
Patient

By ______________________
Parent or Guardian if patient is a Minor

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I have certain right to privacy regarding my protected Health Information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessment and physicians and certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to the address below to obtain a current copy of the Notice of Privacy Practices.

SPINE SOLUTIONS
3850 SHERIDAN STREET
HOLLYWOOD, FLORIDA 33021

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out my treatment payment of health care operations; I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to patient: ______________________________

Signature: ____________________ Date: ____________________

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 the health care provider's or health facility's right to expect certain behavior on the part of the patients.

1) A patient has the right to be treated with courtesy and respect with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
2) A patient has the right to prompt and reasonable response to questions and requests.
3) A patient has the right to know who is providing medical services and who is responsible for his or her care.
4) 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.
5) A patient has the right to know what rules and regulations apply to his or her conduct.
6) A patient has the right to be given, by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
7) A patient has the right to refuse any treatment, except as otherwise provided by the law.
8) 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.
9) 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.
10) A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charge for medical care.
11) 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.
12) A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or resource of payment.
13) A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
14) A patient has the right to know if medical treatment is for the purposes of experimental research, and to give his or her consent or refusal to participate in such experimental research.
15) A patient has the right to express grievances regarding any violation of his or her right, as stated in Florida law, through the grievance procedure of the health care provider or health care facility that served him or her and to the appropriate state licensing agency.
16) A patient is responsible to provide to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalization, medications, and other matter relation to his or her health.
17) A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
18) 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.
19) A patient is responsible for following the treatment plan recommended by the health care provider.
20) A patient is responsible 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.
21) A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
22) A patient is responsible for the following health care facility rules and regulations affecting patient care and conduct.

Patient Signature: ______________________________ Date: ____________________

Medical Records Release Form

Patient Name: ______________________ Date of Birth: ______________________

Requesting Office: **Spine Solutions**

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed.

I give permission for my medical information / medical notes to be disclosed to the following:

✓ Primary Care Physician ✓ Referring Physician ✓ Attorney Representing Me

✓ Auto Insurance ✓ Entity to whom I have been referred in regard to treatment

I give permission to release my protected health information to the following entity:

Spine Solutions

954-983-3888

Patient Signature: ______________________________ Date: __________________

Dr. Behnam Myers, D.O. MPH
Dr. Steven Lasser, M.D.
Dr. Howard Levene, M.D. PhD
Juan Alfonso II, MSN ARNP, FNP-BC
Tel: 954-983-3888 Fax: 954-983-3999

3850 Sheridan Street, Hollywood FL 33021 2499 Glades Rd Suite 113, Boca Raton FL 33431
6705 South Red Rd., Suite 418 Coral Gables, FL 33146

It has been brought to my attention by Dr. Myers and his staff that I understand if I should at any time experience symptoms included but not limited to:

Fever, weakness, increased pain, difficulty walking and/or using the bathroom or I have any other concerns or change in my health status I am to go to the nearest emergency room and contact my physician immediately.

______________________ ______________________

Patient Signature Date