

Greater Orlando Neurosurgery and Spine, P.A.

Max B. Medary, M.D.

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Dear _____,

This is confirmation that your appointment is scheduled on _____
at _____ with Dr. Max B. Medary. We have enclosed some basic instructions to
ensure a more productive appointment with our neurosurgeon.

Without the following, your appointment may be rescheduled.

- ✓ Please bring ALL MRI/CT/XRAY films, **NOT CD'S**, and reports associated with your condition. Should you have only been provided with CD's please call our office to make alternate arrangements. Please include any pertinent medical records.
- ✓ Please bring one form of picture ID, your insurance cards, and a copy of your insurance referral as required by most HMO's and POS plans.
- ✓ Please bring cash, check, credit card, or debit card as your source of payment. **All copays and deductibles are required to be paid at the time of service.**
- ✓ Enclosed with this letter is the information that is required by our office to be filled out. Please fill out as completely as possible, signing ALL pertinent areas. Incomplete or incorrect information may result in non-payment from your insurance carrier. Any balances remaining unpaid by your insurance company will be your responsibility.
- ✓ Enclosed you will find a section titled "Consent to the Use and Disclosure of Health Info". This basically explains your rights as a patient. By law, you must sign and return the first page only, after reading the entire document. **The additional 2 pages are for your personal records.**

Your cooperation in advance is greatly appreciated. Should you have any questions, please do not hesitate to call our office at (407) 355-0575.

Greater Orlando Neurosurgery & Spine Staff

Office Policy

The following guidelines have been established by our office to ensure proper communication of insurance and account requirements for our patients and staff.

- **All patient copays, deductibles, and/or coinsurance responsibilities are required to be paid at the time of service.** There are no exceptions. We will gladly accept cash, check, money order, credit cards or debit cards as acceptable forms of payment.
- We are happy to bill any secondary insurance as a courtesy for you. **However, if secondary insurance is not provided in advance of your appointment for verification, you will be responsible for payment as indicated by your primary insurance.** Your secondary insurance will still be filed as indicated and once your claim is processed, any monies due will be refunded accordingly.
- Insurance plans that are affiliated with Health Savings Accounts must be verified at the time of service for the Health Savings Account balance. If sufficient funds are not available or unable to be verified at the time of service, **payment in full will be required.** If your insurance should pay once billed, any monies due will be refunded accordingly.

I have read and understood the above listed office policies of Greater Orlando Neurosurgery and Spine, PA.

Patient Signature

Date

Greater Orlando Neurosurgery and Spine, P.A.

Patient Information

Please Print

Date _____

Patient's Last Name _____ First _____ M.I. _____

Patient's social security number _____ D.O.B. _____

Address _____ Apt. _____

City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

Do you have an alternate address? Yes No

If yes please print here: Address _____

City _____ State _____ Zip _____

Sex: Male Female Student: Full-time Part-time

Marital Status: Single Married Divorced Widowed Separated

Employed Status: Full time Part time Retired Other _____

Employer: _____ Occupation _____

Employer address: _____

Spouse/Parent Name: Last _____ First _____ M.I. _____

SSN: _____ D.O.B. _____

Employed by: _____ Phone # _____

Name of closest relative not living with you: _____

Relationship: _____ Phone # _____

Referring physician: _____

Address: _____ Phone # _____

PCP Name (if different than above) _____

Address: _____ Phone#: _____

Please have your insurance card and Driver's license ready for the receptionist. Payments for professional services are due when service is rendered.

Please fill out forms to follow.

Insurance Information
Please Print

Primary Ins. Co.: _____ Secondary Ins. Co. _____
Insured's Name _____ Insured's Name: _____
Relationship to patient: _____ Relationship to patient: _____

Accident Information

Is your injury/illness due to: A work related accident or condition?
 An automobile accident?
 A condition covered under Black Lung Program?
 An accident other than automobile accident?
 Was the accident the fault of another party?
 N/A (go to Insurance Assignment section)

What were the circumstances of the condition or injury? _____
Do you have notice of injury on file? Yes No

Place of Accident/Injury: _____ Date of Accident/Injury _____
Insurance Co. _____ Phone # _____
Address _____ City _____ State _____ Zip _____
Claim # _____ Policy# _____
Case Manager/Adjuster Name _____ Ext. _____

Are you eligible for coverage under the Veteran's Administration?
Are you eligible for coverage under the United Mine Workers of America?
Do you have coverage under an Employer Group Health Insurance?
Do you have coverage under your spouse's Employer Group Health Insurance?
Are you a dependent covered under a parent's/guardian's Employer Group Health Insurance?

Insurance Assignment

I hereby authorize my insurance benefits to be paid directly to Greater Orlando Neurosurgery and Spine, P.A. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

Patient's Signature _____ **Date** _____

Please sign forms attached
Release of Medical Records

I hereby authorize the release of medical, psychiatric, alcohol, HIV testing and/or drug abuse information for insurance carriers or for continuing patient care. Any of the classifications above may be crossed off if that information is not to be released.

Patient Signature _____ **Date** _____

Signature of Parent, Guardian, and/or responsible party Date

Consent for Evaluation or Treatment

The undersigned hereby consent to whatever evaluation or treatment the assigned physician may deem necessary to the patient name above.

Patient, Parent, Legal Guardian or Authorized Representative **Date**

For Medicare Patients only
Medicare B Signature Authorization-Lifetime

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician organization to submit a claim to Medicare for payment to me.

Patient's Name _____ Patient's **Signature** _____

Medicare B# _____ **Date** _____

Allergies

1. Medication Allergies: _____
2. Food Allergies: _____
3. Other Allergies: _____

Social History

1. Do you smoke: Yes No Quit Year: _____ How long? _____
What type do you smoke? _____
2. Do you chew tobacco: Yes No
3. Do you use snuff: Yes No
4. Do you drink alcohol? Never Occasionally Every day

Family History

Please answer the following questions as they apply to your biological family (blood relations).

1. Is your mother alive? **Yes** **No**
Is she in good health? Yes No What was the cause of her death?
If no, what medical problem does she have? _____
What other medical problems did she have? _____

2. Is your father alive? **Yes** **No**
Is he in good health? Yes No What was the cause of his death?
If, no what medical problems does he have? _____
What other medical problems did he have? _____

3. Do you have any siblings? No Yes
If yes, please list whether brother or sister, their current state of health and any health problems they may have.

4. Are there any other familial medical problems?

Review of Systems

Please check all the signs or symptoms that you may have had in the last 6 months.

- | | | |
|--|--|--|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Gastritis | <input type="checkbox"/> Urine Leakage | <input type="checkbox"/> Stool Leakage |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Headaches | <input type="checkbox"/> Black/Tarry Stools |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Chills | <input type="checkbox"/> Difficulty with Sleep |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Pain | <input type="checkbox"/> Problem with Appetite |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression | <input type="checkbox"/> Hopelessness |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Feeling Down or Blue |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Blood in Stool |
| <input type="checkbox"/> Extreme Fatigue | <input type="checkbox"/> Weakness | <input type="checkbox"/> Extreme Thirst |

Other Concerns:

Psychiatric History

1. Have you ever visited a psychiatrist, psychologist, counselor, or therapist?
 Yes No

2. Have you ever had a problem with addiction to any substances or drugs?
 Yes No

Social and Environmental History

1. Is anyone your household disabled? No Yes
If yes, please list the relationship to you and the type of disability.

2. Do you exercise Yes No
If Yes, please describe the type and how frequently.

3. Do you have any other issues regarding your medical history?

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR
TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS.

I _____ (print name) understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- q A basis for planning my care and treatment
- q A means of communication among the many health professionals who contribute to my care
- q A source of information for applying my diagnosis and surgical information to my bill
- q A mean by which a third-party can verify that services billed were actually provided
- q A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a *Notice of Information Practices*, which provides an in depth description of information uses and disclosures, and fully understand it. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the rights to change their notice and practices and prior to implementation will mail a copy of the revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and accept/decline the terms of this consent.

(Signature)

(Date)

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information is, often referred to by the health professionals who contribute to your care:

- ◆ Basis for planning your care and treatment
- ◆ Means of communication among the many health professionals who contribute to your care
- ◆ Legal document describing the care you received
- ◆ Means by which you or a third-party payer can verify that services billed were actually provided
- ◆ A tool in educating health professionals
- ◆ A source of information for public health officials charged with improving the health of the nation
- ◆ A source of data for facility planning and marketing
- ◆ A tool with which we can assess and continually use to improve the care we render and the outcomes we achieve
- ◆ Understanding what is in your record and how your health information is used helps you to:
 - ◆ Ensure its accuracy
 - ◆ Better understand who, what, when, where and why others may access your health information
 - ◆ Make more informed decisions when authorizing disclosure to other

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- ◆ Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- ◆ Obtain a paper copy of the notice of information practices upon request
- ◆ Inspect and copy your health information as provided in 12 CFR 164.524
- ◆ Amend your health record as provided in 45 CFR 164.524
- ◆ Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- ◆ Request communication of your health information by alternative means or at alternative locations
- ◆ Revoke your authorization to use or disclose health information except to the extent that action has already been taken

OUR RESPONSIBILITIES

This organization is required to:

- ◆ Maintain the privacy of your health information
- ◆ Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- ◆ Abide by the terms of this notice
- ◆ Notify you if we are unable to agree to a requested restriction
- ◆ Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practice and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us. We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you believe your privacy rights have been violated, you can file a complaint with the director of Health Information Management or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

We will use health information for treatment.

For example: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you are discharged from this hospital.

We will use your health information for payment

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations

For example: Members of the medical staff, the risk or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates:

There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department, and radiology, certain laboratory tests and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification:

We may use or disclose information to notify or assist in notifying a family member, personal representative or another person responsible for your care, your location and general condition.

Communication with family:

Health professionals, using their best judgement may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research:

We may disclose information to researchers once their research has been approved by an institutional review board which has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors:

We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement organizations:

Consistent with applicable law, we may disclose health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation:

We may disclose health information to the extent authorized by and necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health:

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional Institute:

Should you be an inmate of a correctional institution, we may disclose to that institution or agents thereof, health information necessary for your health and the health and safety of other individuals.

Law Enforcement:

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney. Provided that a work force member or business associate believes, in good faith, that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

AMENDMENT POLICY AND PROCEDURE POLICY

Patient's who believe information in their health record is incomplete or incorrect may request an amendment or correction to the information as outlined below.

PROCEDURE

The patient may point out the error, and ask that the author correct it. The patient can contact the office manager or other qualified employees in the practice. The entry author can correct the entry or add a progress note to clarify content. Or the office manager will assist the patient in completing the health record correction/amendment form.

Upon completion of the form, the office manager will give the last copy of the form to the patient, place the third copy in the patient's health record to the author. If the author chooses to add a comment to the amendment/correction form, the second copy of the form will be routed to the patient with the author's comments.

The original correction/amendment with the author's signature will replace the copy previously placed in the patient's record.

Copies of the correction/amendment form will be furnished to those individuals or organizations the patient deems necessary and documents on the correction/amendment form.

Copies of the correction/amendment form will also be furnished to the facility's business associates or others who have the information subject to the amendment and that may have relied or could rely on that information to the detriment of the patient.

Disclosures will be noted on the correction/amendment form with a short notation indicating to whom the correction/amendment was sent, the date, and staff member processing the disclosure.

When a correction/amendment form is used, there will be an entry at the site of the information that is being used, corrected or amend indicating, "See correction/amendment." The correction/amendment form will be attached to the incorrect or amended entry.

Whenever a copy of the corrected/amended entry is disclosed, a copy of the correction/amendment form will accompany the disclosed entry.