

# SOUTH PALM ORTHOSPINE INSTITUTE

## PATIENT INFORMATION SHEET

DATE: \_\_\_\_\_

<b>Patient Information</b>		
PATIENT'S NAME: (Last)	First	M.Init.
<hr/>		
LOCAL ADDRESS...Street	Unit/Apt. #	
City	State	Zip Code
<hr/>		
HOME PHONE: (LOCAL #) ( )	CELL PHONE: ( )	
<hr/>		
SEX...	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
<hr/>		
DATE OF BIRTH:	AGE:	
<hr/>		
SOCIAL SECURITY #:		
<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW (ER)		
<hr/>		
PERMANENT ADDRESS: <i>(if different from local above)</i> Unit/Apt #		
City	State	Zip Code
<hr/>		
PHONE NUMBER: (Permanent Location) ( )		
<hr/>		
EMERGENCY CONTACT #: ( )		
<hr/>		
NAME:	RELATION:	
<hr/>		
FAMILY PHYSICIAN:	PHONE NUMBER: ( )	
<hr/>		
CARDIOLOGIST:	( )	
<hr/>		
REFERRED BY?		

<b>Race/Ethnicity</b>
Black or African American <input type="checkbox"/>
Asian <input type="checkbox"/>
American Indian or Alaskan Native <input type="checkbox"/>
White (this includes all Hispanic or Latino) <input type="checkbox"/>
Prefer not to participate <input type="checkbox"/>

Do you have an Advanced Directive (i.e., Living will, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Provide your E-mail address to allow you to access your medical records**

e-mail: \_\_\_\_\_

<b>Are you being represented by an Attorney? Yes _____ NO _____</b>		
<hr/>		
FIRM & ATTORNEY'S NAME:		
<hr/>		
ATTORNEY'S Address...Street	Suite/Unit	
City	State	Zip Code
<hr/>		
ATTORNEY'S PHONE:	FILE/CASE #	
( )		

<b>Complete if <u>AUTO OR WORK</u> Injury</b>	
THE <u>STATE</u> IN WHICH ACCIDENT OCCURRED:	
DATE OF INJURY:	<input type="checkbox"/> <b>AUTO ACCIDENT</b> <input type="checkbox"/> <b>AT WORK</b> <input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER <input type="checkbox"/> PEDESTRIAN
WILL YOU BE CLAIMING THIS INJURY UNDER YOUR EMPLOYER'S WORKERS COMPENSATION INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

DESCRIBE HOW THE INJURY OCCURRED...
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<b>Authorization for Treatment:</b>
I hereby give my permission to <b><u>South Palm OrthoSpine Institute</u></b> to evaluate and treat as deemed medically necessary.
<b>SIGNED:</b> _____

**PATIENT'S NAME:** \_\_\_\_\_

**What is the main reason for your visit today? (Please check all that apply.)**

- Back pain       Leg pain (LT / RT)       Neck pain       Arm / Shoulder pain (LT / RT)  
 OTHER :(describe): \_\_\_\_\_

**Date of onset:** \_\_\_\_\_  No  Yes

**Did your current spine problem result from any of the following? (Please check all that apply.)**

- No Apparent Cause       Car Accident (date: \_\_\_\_\_)       Work Injury (date: \_\_\_\_\_)  
 Sports Injury (date: \_\_\_\_\_)       Other (Please Specify) \_\_\_\_\_

**Current Employment status:**  Retired  Disabled  Homemaker  Employed: Occupation: \_\_\_\_\_

**Current Work status:**  Full-Time  Job Task: \_\_\_\_\_  Part-Time  with-out limitations  
 with limitations (list limitations: \_\_\_\_\_ duration: \_\_\_\_\_)

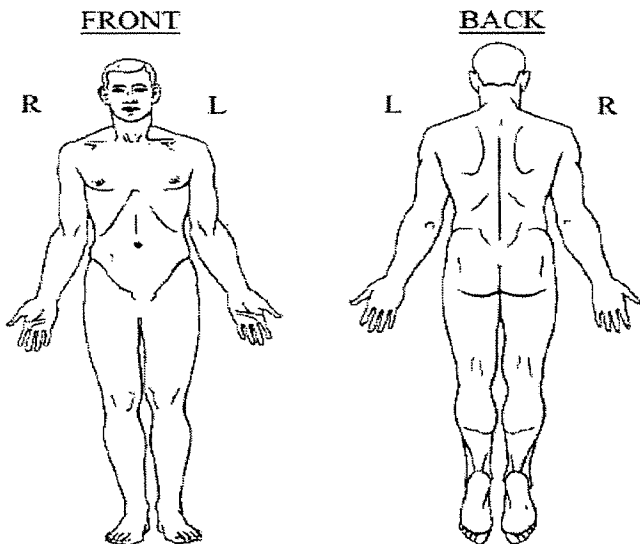
**Describe your current pain. Check all that apply:**  **NO PAIN**

- Electric shocks     Tingling       Cramping     Throbbing     Pins / needles     Numbness  
 Aching             Pulling       Dull         Burning  
 Shooting         Sharp/stabbing     Sore         Other:(describe): \_\_\_\_\_

**Is your pain:**  ALL THE TIME (constant)  HAS FLARE UPS (intermittent)

**Use of assisted device:**  NONE       CANE       WALKER       WHEELCHAIR

**WHAT MAKES IT WORSE:**  WALKING     SITTING     STANDING     ADL'S (Activities of daily living)  
 DRIVING     RESTING     SLEEPING     OTHER: \_\_\_\_\_



Which sensations you are feeling?

**Please use the scale below to indicate**  
Mark these drawings according to where you hurt.

- /// Stabbing  
XXX Burning  
+++ Aching  
=== Numbness  
000 Pins & Needles

**From 0 to 10, what is your currently pain range?**  
**(0 = no pain, 10 = unbearable):** \_\_\_\_\_

**Have you had any imaging studies in the past year?**  
**(MRI/CT/X-rays) Yes / No**



PATIENT'S NAME: \_\_\_\_\_

## Current Medical History

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_  RIGHT HANDED  LEFT HANDED

ALLERGIES TO MEDICATION (List): \_\_\_\_\_  NONE KNOWN

### NOT APPLICABLE

   DIABETIC (  INSULIN  TYPE II)    BLOOD THINNERS    MORPHINE PUMP  
   HEART (  PACEMAKER,  DEFIBRILLATOR,  STENTS)  
HISTORY OF CANCER? YES    NO    TYPE: \_\_\_\_\_

PAST SURGICAL HISTORY: All Types...  NONE

<u>TYPE</u>	<u>APPROX DATE</u>	<u>DOCTOR</u>	<u>FACILITY PERFORMED</u>

### FAMILY HISTORY: Please list age, general health, deceased or living...

AGE: \_\_\_\_\_  
HEALTH: \_\_\_\_\_  
CAUSE OF DEATH (IF APPLICABLE): \_\_\_\_\_

Mother      Father      Sister(s)      brother(s)

CHILDHOOD ILLNESSES....  NONE (List unusual illnesses such as rheumatic fever, polio, heart murmur, etc.)

ALCOHOL USAGE:  NONE  Occasional  Moderate  Excess

SMOKING:  NEVER  NO - Not now...Quit \_\_\_\_\_ years ago, Smoked \_\_\_\_\_ packs/day for \_\_\_\_\_ years.  
 YES - If yes, number of Packs/day \_\_\_\_\_ and, number of years \_\_\_\_\_?

OTHER INFORMATION PERTINENT TO YOUR CARE?  NONE (IF YES, PLEASE LIST)

PATIENT NAME: \_\_\_\_\_

**PAST MEDICAL HISTORY:** Have you / or are you being treated for the following:

- 1. ENDOCRINE: Include dates**  
 Diabetes  
 Thyroid disorders  
 Night sweats  
 Recent change in weight or appetite

- 2. SKIN AND HEMATOLOGIC: Include dates**  
 Frequent infections  
 Varicosities  
 Coagulation disorders  
 Anemia

- 3. CNS: Include dates**  
 Unusual headaches/ Migraines  
 Loss of consciousness  
 Epilepsy  
 Head trauma  
 Seizure disorders  
 Stroke  
 Loss of memory  
 Vertigo  
 Syncope  
 Paralysis  
 Numbness/tingling in extremities

- 4. EYES: Include dates**  
 Glaucoma  
 Cataracts

- 5. EARS: Include dates**  
 Buzzing or ringing in ears (tinnitus)  
 Earache  
 Discharge from ears

- 6. NOSE AND MOUTH: Include dates**  
 Difficulty Speaking  
 Sinus problems  
 Unusual bleeding

- 7. BREASTS: Include dates**  
 Masses  
 Cystic Condition  
 Past biopsy or surgery

- 8. RESPIRATORY: Include dates**  
 Asthma  
 Bronchitis  
 Emphysema  
 Pneumonia  
 Tuberculosis

- 9. CARDIOVASCULAR: Include dates**  
 Angina chest pain  
 Heart Attack  
 Murmurs  
 Hypertension  
 Stroke  
 Palpitations  
 Peripheral edema  
 Claudication  
 Poor circulation  
 Congestive heart failure  
 Phlebitis  
 Cramping of legs when walking

- 10. GASTROINTESTINAL: Include dates**  
 Constipation  
 Enteritis  
 Vomiting blood  
 GI Bleed  
 Bright red blood per rectum  
 Jaundice  
 Hepatitis  
 Diverticulitis  
 Gallbladder disease  
 Peptic or duodenal ulcer disease.

- 11. UROLOGY: Include dates**  
 Pain on urination  
 Frequency  
 Urgency  
 Decreased stream  
 Kidney stones  
 Incontinence  
 Bladder infections  
 Blood in urine  
 Syphilis  
 Gonorrhea

**IF CONDITION NOT MENTIONED, PLEASE SPECIFY BELOW:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# South Palm OrthoSpine Institute

## Patient Consent for Use and Disclosure of Protected Health Information

I \_\_\_\_\_ hereby give my consent for **South Palm OrthoSpine Institute** to use and disclose **protected health information** (PHI) about me to carry out **treatment, payment and health care operations** (TPO). (The Notice of Privacy Practices provided by **South Palm OrthoSpine Institute** describes such uses and disclosures more completely.)

I have the right to review the **Notice of Privacy Practices (HIPAA)** prior to signing this consent. **South Palm OrthoSpine Institute** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Stewart G. Eidelson, M.D., 15300 Jog Road, #108, Delray Beach, FL 33446**.

With this consent, **South Palm OrthoSpine Institute** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **South Palm OrthoSpine Institute** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **South Palm OrthoSpine Institute** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **South Palm OrthoSpine Institute** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

**I have been duly informed that the possibilities for release would include spinal outcome research, educational forums and publicity featuring Dr. Eidelson and South Palm OrthoSpine Institute.**

**I understand that my "Protected Health Information" including demographic information such as address, social security, insurance or any personal medical history whatsoever will not be violated. I affirm that I am more than twenty-one (21) years of age.**

By signing this form, I am consenting to allow **South Palm OrthoSpine Institute** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **South Palm OrthoSpine Institute** may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date

Authorized release of my medical record to :

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

# SOUTH PALM ORTHOSPINE INSTITUTE

**Stewart G. Eidelson, M.D.**

Dear Valued Patients:

You would be surprised to know how many people do not know what kind of benefits they have with their Insurance Companies.

We will bill your insurance company, **if we are current provides in your plan**. However if for any reason we are unable to be reimbursed from your insurance company, all monies owed will become your responsibility.

Any patient that is seen or treated in our office, without prior authorization from their **HMO group**, is responsible for full payment at the time of the visit.

If you need to use a specific lab or x-ray facility, you must notify a nurse before the service is rendered.

We will attempt to get the most benefit from your Insurance Company; however, we will need your assistance. Please supply us with your most recent information and make us aware should changes arise in your policy. Prior to your next appointment, please contact your Insurance Company to be sure that we are on your Plan and that your coverage is current. **THIS IS YOUR RESPONSIBILITY, NOT OURS!!!!!!** Any service that is rendered by this office, that is not a covered benefit of your insurance policy, is your responsibility to pay.

Please be aware that all co-payments and deductibles are due at the time of service.

By signing below, you are stating that you understand this important component of our Office Policy.

As always, thank you for choosing South Palm OrthoSpine Institute.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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Signature

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Date



PATIENT NAME:

### ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. 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 arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

**Article 2: All Claims Must be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

**Article 4: General Provision:** All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. \_\_\_\_\_ Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

PATIENT SIGNATURE **X** (Date)  
(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** (Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE