North Florida Medical Center
Bringing the Care, Back to Healthcare
O: 904.500.NFMC
F: 904.264.2330
www.nfmcjax.com
frontdesk@nfmcjax.com

Personal Information

Full Name: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Occupation: _____

Sex: M__ F__ Marital Status: S __ M __ D __ W __ Age: _____ DOB: _____ SS#: _____

How Did You Hear About Our Clinic? _____

Name Of Person Responsible For Account: _____ Method Of Payment: _____

Emergency Contact Name: _____ Phone Number: _____

Present Complaint

Briefly Describe Symptoms: _____

_____

Other Doctors Seen For This Condition: _____ Treatment Rendered: _____

Are You Taking Any Medication: Y __ N __ What Kind: _____

Previous Surgeries: _____

List Physicians Seen Within Last Year: For What Condition(s):

_____ _____

_____ _____

Women Only: Are You Pregnant? Y __ N __ Date Of Last Menstrual Period: __/__/__

Insurance Information

Relationship To Insured: Self__ Spouse__ Child__ Other__

Insured's Full Name:	Insured's DOB: ____/____/____
Address:	City: State: Zip:
Home Phone:	SS#:
Attorney Name:	Phone Number:
Insurance Company:	Phone Number:
Group #:	Insured's ID #:
Employed By:	Phone Number:
Address:	City: State: Zip:
Additional Insurance Company:	Phone Number:
Insured's SS#:	Policy #:

Assignment of Benefits

Financial Responsibility

I understand that insurance billing is service provided as a courtesy and that I am at all times financially responsible to Back & Neck Institute and/or North Florida Medical Center and/or its affiliate entities for any charges not covered by health care benefits. It is my responsibility to notify Back & Neck Institute and/or North Florida Medical Center of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Back & Neck Institute and/or North Florida Medical Center and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Back & Neck Institute and/or North Florida Medical Center for all covered medical services and supplies provided to me during courses of treatment and care provided by Back & Neck Institute and/or North Florida Medical Center and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Back & Neck Institute and/or North Florida Medical Center, and will constitute a continuing authorization, maintained on file with Back & Neck Institute and/or North Florida Medical Center, which will authorize and allow for direct payment to Back & Neck Institute and/or North Florida Medical Center of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Back & Neck Institute and/or North Florida Medical Center.

Authorization to Release Information

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Back & Neck Institute and/or North Florida Medical Center. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by Back & Neck Institute and/or North Florida Medical Center.

Patient/Insured Name (print): _____

Date of Birth: ____/____/____

SS#: ____-___-____

Patient Signature: _____ Date: ____/____/____

Witness Signature: _____ Date: ____/____/____

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Notice of Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review carefully.

At Back & Neck Institute, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Each time you visit Back & Neck Institute, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- 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 data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work 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, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Back & Neck Institute, the information belongs to you. You have the right to:

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

Our Responsibilities

- Maintain the privacy of your health information,
- Provide you with this 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, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices 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, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information as we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or To Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Tanya Alcantara, at (904) 269-3664. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with your regional Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Examples of Disclosures for Treatment, Payment and Health Operations

For Example: Information obtained by a nurse, physician, or other member of your health care 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 health care team. Members of your health care 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 health care provider with copies of various reports that should assist him or her in treating you once you're 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: We will share your relevant health information with other providers involved in your care, to assist in the coordination of your care. This may include specialists, hospitals, clinics, and other individuals or organizations prior to or after us who have provided you with health care.

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.

Directory: Unless you notify us that you object, we will use your name, location in the hospital, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

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 judgment, 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 when their research has been approved by an institutional review board that has reviewed the research proposal and establish protocols to ensure the privacy of your health information.

Funeral Director: 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 to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact your to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you.

Fund-Raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA 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 to the extent 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.

Law Enforcement: We may disclose health information for enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in food 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.

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Acknowledgment Form

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of Back & Neck Institute and North Florida Medical Center's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulation pertaining to medical assignment of benefits apply.

Patient Signature: _____ Date: ____/____/____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Date: ____/____/____

If the patient refuses to sign, indicate your attempt to obtain a signature below:

( ) Patient refused to sign this Acknowledgment.

Date: ____/____/____

Time: ___:___ AM/PM

Employee Name: _____

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To: _____

_____

Phone: _____ Fax: _____

I, _____, give full authorization to release my _____ to the physicians of Back & Neck Institute and/or North Florida Medical Center for purposes of diagnosing my condition. If you have any questions, please feel free to contact me at the number listed below.

Thank you,

_____ _____
Patient Signature Date

_____ _____
Phone Number Date of Birth

_____
Contact Person

This consent is valid for sixty days from the date of signature.

MEDICAL HISTORY

(PLEASE CHECK ALL THAT APPLY)

Cardiovascular	Respiratory	Gastrointestinal	Endocrine	Hematologic
☐ Chest Pain	☐ Asthma	☐ Acid Reflux/GERD	☐ Obesity	☐ Bleeding Disorder
☐ Heart Attack	☐ Emphysema	☐ Ulcers	☐ Hypothyroid	☐ Anomia
☐ Heart Disease	☐ Chronic Bronchitis	☐ Polyps	☐ Hyperthyroid	☐ Easy Bruising
☐ Heart Rhythm Disturbances	☐ Frequent Pneumonia	☐ Hepatitis A, B, C	☐ Diabetes	☐ Anticoagulation
☐ Arterial Insufficiency	☐ Frequent Colds/Sore Throat	☐ Pancreatitis	☐ Insulin	(blood thinners)
☐ Venous Insufficiency	☐ Positive TB Test	☐ Bowel Problems	☐ Other	☐ Blood Clots
☐ High Blood Pressure	☐ Abnormal Chest x-ray	☐ Colitis		
☐ Low Blood Pressure	☐ Other	☐ Hiatal Hernia		
☐ Embolism		☐ Gallbladder Problems		
☐ Other		☐ Irritable Bowel Syndrome		
		☐ Crohn's Disease		
		☐ Special Diet		
		☐ Liver Disease		

Neurological	Psychological	Genitourinary	Musculoskeletal
☐ Memory Problems	☐ Nervous Breakdown	☐ Sexual Dysfunction	☐ Fibromyalgia
☐ Seizures	☐ Depression	☐ Sexually Transmitted Disease	☐ Rheumatoid Arthritis
☐ Stroke	☐ Anxiety	☐ Prostate Disease	☐ Osteoporosis
☐ Movement Disorders	☐ Panic Disorder	☐ Kidney Problems	☐ Back Problems
☐ Muscular Dystrophy	☐ Psychosis	☐ Chronic Infection	☐ Neck Problems
☐ Neuropathy	☐ Alcohol or Drug Abuse	☐ Bladder Problems	
☐ Migraine	☐ Other		
☐ Epilepsy			
☐ Headaches			

Cancer	Miscellaneous	General	Allergic/Immunological
☐ Site	☐ Glaucoma	☐ Medical Equipment	☐ Autoimmune Disorder
☐ Diagnosis Date	☐ Cataracts	☐ Cane	☐ Lupus, Sjogren's
☐ Chemotherapy	☐ Visual Problems	☐ Walker	☐ Raynaud's Syndrome
☐ Radiation	☐ Hearing Loss	☐ Wheelchair	☐ Immune Deficiency
☐ Other	☐ Chronic Skin Disorder	☐ Hospital Bed	☐ HIV
	☐ Pregnancy	☐ Oxygen at ___ liters	
	☐ Date of Last Period		

SURGICAL HISTORY

(Please list all surgeries)

Patient Name:	DOB:	MR:

MEDICATIONS

List all medications that you are taking NOW. (Include over the counter, herbal, vitamins, & other supplemental medications)

Medications	Dose (mg)	How often? (# of time/day)	What is this medication for?	Date started	Prescribing Doctor

Do you take any blood thinning medication? What? _____

(This is not an all-inclusive list but ex. of some anticoagulants are: Coumadim, Plavix, Ticlid, Aggranox, Pradaxa)

List all other pain medications that you have tried in the past & why you stopped;

_____

_____

ALLERGIES

Please list any known drug, food, or environmental allergies and indicate what the adverse effect/reaction is:

_____

_____

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

Patient Name:	DOB:	MR: