IntegraMed
ORTHOPEDICS AND SPINE

PATIENT REGISTRATION FORM

Patient Name: _____ Date:_____

Address:_____

Home Phone:_____Cell:_____Work:_____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female ☐ Other

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partner

Social Security:_____Email:_____

Race: _____ Ethnicity:_____Employer: _____

Pharmacy:_____ Pharmacy phone: _____

This visit is a result of: ☐ Health ☐ Work Injury ☐ Auto Accident ☐ Slip and Fall ☐ Other _____

Date of Injury/Accident: _____

Primary Insurance:_____Member ID:_____

Claim #_____ Group # _____

Insured's Name:_____Insured's Date of Birth:_____

Attorney (if applicable): _____ Phone:_____

Emergency Contact: _____Phone:_____

Relationship to Emergency Contact:_____

Primary Care Physician:_____Phone:_____

Referring Physician:_____Phone:_____

By my signature below, I affirm the information is accurate to the best of my knowledge.

Signature :_____Date:_____

IntegraMed
ORTHOPEDICS AND SPINE

Patient Name: _____

Date: _____

Could you please complete this Questionnaire? It is designed to give us information about your health that will allow us to better understand and assist you.

CURRENT HISTORY

What is the main reason for your visit today? (Check all that apply)

☐ Back Pain ☐ Leg Pain ☐ Neck Pain ☐ Arm Pain

☐ Other _____

How long has this been a problem?

☐ Less than 2 Months ☐ 2-6 months ☐ 6-12 months ☐ Greater than 1 year

☐ Further Comments: _____

Current problem is the result of a(n) (Check all that apply):

☐ Injured at work ☐ Auto Accident ☐ Sports ☐ No apparent cause

☐ Other _____

Is there any litigation pending? ☐ Lawsuit ☐ Workers Comp ☐ Disability Claim ☐ Social Security Claim

What treatments have you had for this problem? (Check all that apply):

☐ Nothing ☐ Chiropractic Care ☐ Acupuncture ☐ Injections

☐ Physical Therapy (Please check all that apply)

☐ *Stretching* ☐ *Strengthening* ☐ *Traction* ☐ *Iontophoresis/Topical Steroid* ☐ *TENS*

☐ *Massage* ☐ *Ultrasound* ☐ *Heat/Ice* ☐ *Therapeutic Ball*

☐ Medications

☐ *Muscle Relaxants* ☐ *Pain Medications* ☐ *Anti-Inflammatory (Prescription)*

☐ *Anti-inflammatory Over the Counter (Aspirin, Tylenol, Advil, Aleve, etc)*

☐ Other _____

Have you had any test for this problem? YES ☐ NO ☐

☐ X-Ray ☐ MRI ☐ Discography ☐ CT ☐ EMG

☐ CT/Myelogram ☐ Bone Scan ☐ Other (Please Specify): _____

_____

Have you been treated by any other Care Giver for this condition? YES ☐ NO ☐

If yes, please list: _____

_____

Current problem began: (Check all that apply)

☐ Suddenly ☐ Gradually ☐ Lifting ☐ Twisting Fall

☐ Bending ☐ Pulling ☐ Other_____

What makes the pain worse?

☐ During Exercise ☐ After Exercise ☐ Prolonged Sitting ☐ Prolonged Standing ☐ Walking

☐ Bending Forward ☐ Bending Backward ☐ Pushing ☐ Pulling ☐ Squatting

☐ Night Pain ☐ Other:

What reduces your pain?

☐ Nothing ☐ Lyingdown ☐ Sitting ☐ Standing ☐ Walking

☐ Medication ☐ Shifting/Changing positions

☐ Other_____

Medications and Dosage

	Medication	Strength	# of pills per day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

PAST MEDICAL HISTORY

CARDIOVASCULAR
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ Arrhythmia
- ❑ Pacemaker
- ❑ Heart Failure
- ❑ Heart Surgery
- ❑ Heart Murmur

RESPIRATORY
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema /Cardiopulmonary disorder
- ❑ Sleep Apnea

MUSCULOSKELETAL
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Gout
- ❑ Lupus
- ❑ Osteoporosis
- ❑ Other

HEPATIC
- ❑ Hepatitis ❑ A ❑ B ❑ C

NEUROLOGIC
- ❑ Stroke
- ❑ TIA

ENDOCRINE
- ❑ Diabetes
- ❑ Thyroid Disease
  - ❑ Hyper ❑ Hypo
- ❑ Adrenal Abnormality

CANCER
- ❑ List Type _____

GASTROINTESTINAL
- ❑ Ulcers
- ❑ Acid Reflux

Other _____

Medication Allergies **Are you Allergic to Latex:** YES ☐ NO ☐

_____

_____

_____

Spine Surgical History:

Date	Surgery	Complication
_____	_____	_____
_____	_____	_____

Other Surgical History:

Date	Surgery	Complication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

Do you have a family history of:

Arthritis	YES ☐	NO ☐	Blood clots/excessive-bleeding	YES ☐	NO ☐
Hypertension	YES ☐	NO ☐	Diabetes	YES ☐	NO ☐
Cancer	YES ☐	NO ☐	Adverse Reaction to Anesthesia	YES ☐	NO ☐
Mental Health Disorders	YES ☐	NO ☐	Cardiac Disorders	YES ☐	NO ☐

Other_____

SOCIAL HISTORY

Age: _____

Occupation: _____

Are you?	☐ Single	☐ Married	☐ Divorced	☐ Widowed	
Are you working?	☐ Full Time	☐ Part Time	☐ Disabled	☐ Retired	☐ Not working
Do you exercise?	☐ Daily	☐ Weekly	☐ Monthly	☐ Rarely	☐ Never

Type of exercise/activity? _____

Do you have children?	☐ Yes	☐ No			
Do you live alone?	☐ Yes	☐ No			
Do you have lots of stairs?	☐ Yes	☐ No			
Do you smoke?	☐ Yes	☐ No			
Use other nicotine products?	☐ Yes	☐ No			
Which product do you use?	☐ Chew	☐ Gum	☐ Patch	☐ Cigars	☐ Other _____
Have you Quit smoking?	☐ Yes	☐ No	☐ How long ago? _____		
Drink alcohol?	☐ Daily	☐ 1-2 x/week	☐ 1-2 x/month	☐ 1-2 x/year	☐ Never

REVIEW OF SYSTEMS

PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH:

Height: _____ Weight:_____

CONSTITUTIONAL:	Yes	No
Weight Loss	☐	☐
Fatigue	☐	☐
Fever	☐	☐
EYES:		
Glasses/Contacts	☐	☐
Eye Pain	☐	☐
Double Vision	☐	☐
Cataracts	☐	☐
EAR,NOSE,THROAT:		
Difficulty Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐
Sinus Trouble	☐	☐
Nasal Stuffiness	☐	☐
Frequent Sore Throat	☐	☐
CARDIOVASCULAR:		
Murmur	☐	☐
Chest Pain	☐	☐
Palpitations	☐	☐
Dizziness	☐	☐
Fainting Spells	☐	☐
Shortness of Breath	☐	☐
Difficulty lying Flat	☐	☐
Swelling Ankles	☐	☐
ENDOCRINE:		
Loss of Hair	☐	☐
Heat/Cold Intolerance	☐	☐

RESPIRATORY	Yes	No
Cough	☐	☐
Coughing Blood	☐	☐
Wheezing	☐	☐
Chills	☐	☐
GASTROINTESTINAL:		
Heartburn/Reflux	☐	☐
Nausea/Vomiting	☐	☐
Constipation	☐	☐
Change in BMs	☐	☐
Diarrhea	☐	☐
Jaundice	☐	☐
Abdominal Pain	☐	☐
Black or Bloody BM	☐	☐
GENITOURINARY:		
Burning/Frequency	☐	☐
Nighttime	☐	☐
Blood in Urine	☐	☐
Erectile Dysfunction	☐	☐
Abnormal Discharge	☐	☐
Bladder Leakage	☐	☐
ALLERGIC/IMMUNOLOGIC:		
Hives/Eczema	☐	☐
Hay Fever	☐	☐
PSYCHIATRIC:		
Anxiety/Depression	☐	☐
Mood Swings	☐	☐
Difficult Sleeping	☐	☐

HEMATOLOGY/LYMPH	Yes	No
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Enlarged Glands	☐	☐
MUSCULOSKELETAL:		
Joint Pain/Swelling	☐	☐
Stiffness	☐	☐
Muscle Pain	☐	☐
Back Pain	☐	☐
SKIN:		
Rash/Sores	☐	☐
Lesions	☐	☐
Itching/Burning	☐	☐
NEUROLOGICAL:		
Loss of Strength	☐	☐
Numbness	☐	☐
Headaches	☐	☐
Tremors	☐	☐
Memory Loss	☐	☐

FEMALES ONLY:

Date Last Mammogram_____

Normal_____Abnormal_____

Date last PAP_____

Normal_____Abnormal_____

Age Onset Periods_____

Age Onset Menopause_____

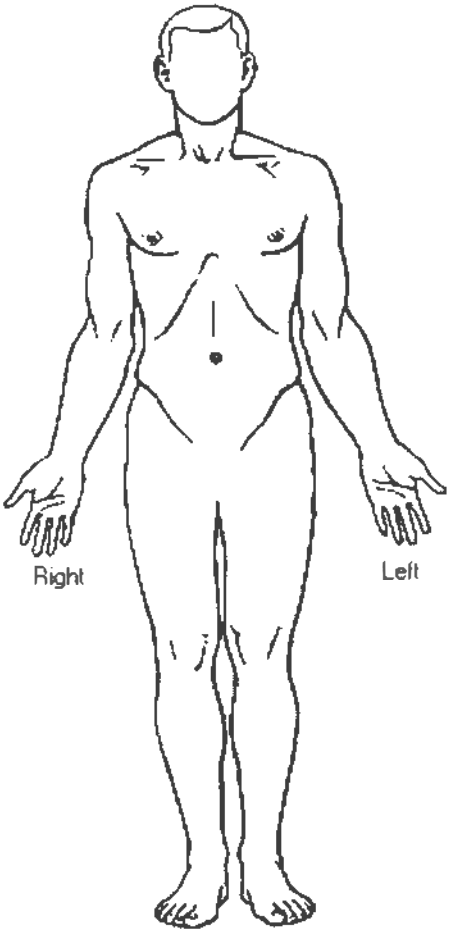
Periods Regular? Yes_____No____

Number Pregnancies_____

Spine New Patient Questionnaire

WHERE IS YOUR PAIN NOW?

Front

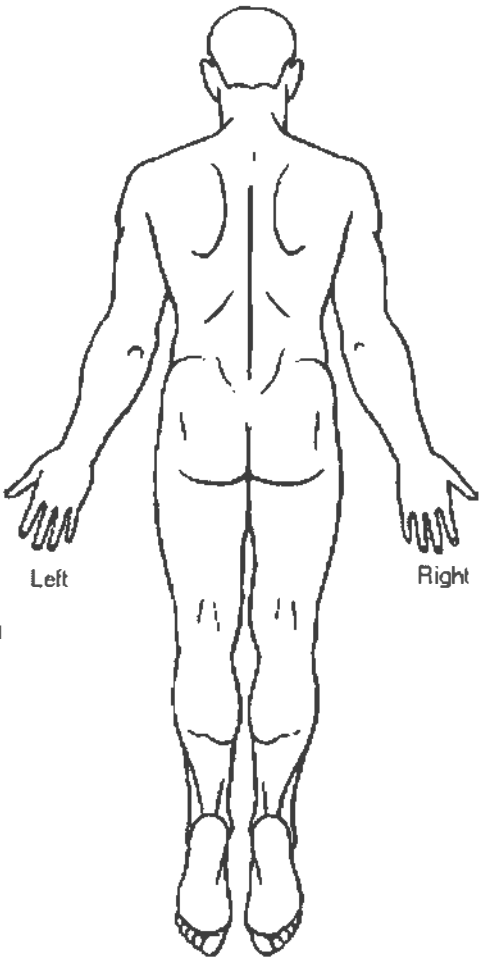


Leg Pain		%
Arm Pain		%
Neck Pain		%
Back Pain		%
Total	100	

Please indicate in the above table the percentage of pain that you currently feel in your legs, arms, and back.

The total for your entire body should add up to 100%

Back



Use the body diagrams to show where you feel the following sensations

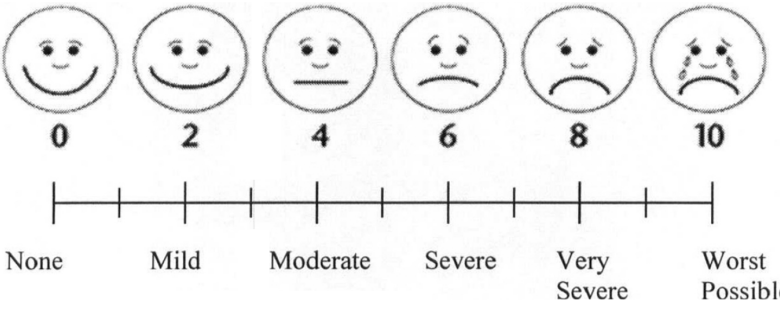
Ache	Numbness	Burning	Stabbing
AAA	OOO	XXX	///
AAA	OOO	XXX	///
AAA	OOO	XXX	///

Pins And Needles

– – –
– – –
– – –

Grade your overall Pain

Please place an X *on the hash mark* that most accurately describes your overall degree of pain



IntegraMed
ORTHOPEDICS AND SPINE

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: ___/___/____

By signing this form, I authorize the use and disclosure of my protected health information by IntegraMed Spine, as specified below:

Description of protected health information that IntegraMed Orthopedics and Spine may disclose:
❑ All healthcare information that may be maintained by IntegraMed Orthopedics and Spine including, *History & Physical Exam, Office notes, Emergency room report, Laboratory report, Radiology Report, Consultations, Prescriptions, HIV, Treatment for alcohol and/or drug abuse, Mental Health, Genetic Testing , and/or information related to my injury/illness and/or settlement*
IntegraMed Orthopedics and Spine may disclose the protected health information to:
Name: _____ (Organization/Person) Address: _____ _____ ❑ At my request ❑ For health care treatment purposes ❑ For payment/insurance ❑ For employment purposes ❑ Other _____

I understand that, by federal law, IntegraMed Spine may not use or disclose protected health information without authorization. By signing this Authorization, I am giving permission for the uses and disclosures of the described protected health information. I hereby release IntegraMed Orthopedics and Spine and its employees from any liability that may arise from the release of information as I have directed.

I understand that I have the right to revoke this Authorization at any time, if I do so in writing by contacting IntegraMed Orthopedics and Spine. I understand that I am not required to sign this Authorization as a condition of treatment, payment, enrollment or eligibility for benefits.

At IntegraMed Orthopedics and Spine we regard all medical and personal information as completely confidential. A copy of our "Notice of Privacy Practices" is available upon request.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____/_____/_____

Signature of Patient or Patient's Authorized Representative

Date

IntegraMed
ORTHOPEDICS AND SPINE

Authorization to Release Information to Family Members

Many of our patients allow family members, such as their spouse, significant other, parents, or children to call and request results oftest results, procedures, and financial information. Under the regulations of H.I.P.A.A., we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members, you must sign this form.

__ I do not authorize the office of IntegraMed Orthopedics and Spine to release my records or discuss any information with anyone but myself.

__ I authorize the office of IntegraMed Orthopedics and Spine to release my records and any information to the following individuals,

1._____Relationship to patient:_____

2._____Relationship to patient:_____

3._____Relationship to patient:_____

4._____Relationship to patient:_____

_____

Signature of Patient/Guardian Date

IntegraMed
ORTHOPEDICS AND SPINE

ASSIGNMENT OF BENEFITS POLICY RIGHTS

I hereby, being the patient, assigns the rights under the benefits of insurance to lntegraMed Orthopedics and Spine, for services rendered. The undersigned agrees to pay applicable deductible or copay not covered by insurance coverage. I have read the information herein and it is true to the best of my knowledge and belief.

This assignment includes, but not limited to, all rights to collect benefits directly from patient's Insurance company for services that the patient has received and all rights to proceed against patient's insurance company including legal suit if for any reason patient's insurance company fails to make payments of the benefits to which patient is due. This assignment also includes any right to recover attorney's fees and cost for such action brought by the provider as patient's assignee.

I agree that lntegraMed Orthopedics and Spine may select any attorney he/she wishes and understand and agrees that the attorney selected by lntegraMed Orthopedics and Spine may be different than the attorney handling my personal injury/bodily injury claim or case.

As part of this assignment of benefits, which becomes binding upon my insurance carrier upon its receipt of said assignment, I hereby instruct my insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness, customary and/or necessity, that the amounts of the benefits claimed by IntegraMed Spine is to be held in abeyance and not disputed until the resolution of any legal proceedings brought by said provider. As part of this assignment of benefits, the patient further instructs his/her insurance carrier to notify the provider immediately of any dispute as to payments so that they may exercise his/her legal rights.

Signature of Patient/Guardian

Date

IntegraMed
ORTHOPEDICS AND SPINE

4631 N. Congress Ave., Ste 205 ● West Palm Beach, FL 33407

(561) 725-0540 Fax (561) 249-2731

Financial and Office Policies

Thank you for choosing IntegraMed Orthopedics and Spine as your healthcare provider. We are committed to your successful treatment and optimal experience in our office. Please familiarize yourself with our policies and procedures to ensure the highest quality of care.

FINANCIAL POLICY

Insurance

Please understand that your insurance policy is a contract between you and your insurance company. Please ensure that we have updated information about your insurance at all time. We bill your insurance as a courtesy to you when provided with current information and an assignment of benefits, but the patient will be responsible for verifying their coverage and participating facilities, obtaining authorizations/referrals and ultimately paying the bill if the insurance company denies payment for services provided.

If your insurance requires a co-pay, it must be paid the day of your appointment or the appointment will be rescheduled. If your deductible hasn't been met, you will be required to make a payment the day services are provided. If your insurance cannot verify your coverage or you do not have insurance, you will be expected to pay in full the day the services are provided.

Patient Balances: All balances after insurance has processed will be due in full within 30 days. Any patient that has been placed on collections must pay any prior balance owed to the practice and the collection agency fee and/or attorney fees before the practice can schedule any future appointments. Patients sent to collections might have their debt reported to credit score agencies. **If your account is turned over to our collection agency, you will be responsible to pay the collection fee which is 21% of total patient responsible balance.**

Surgery Deposit: Patients who are scheduled for an elective surgery will be asked to make a deposit of 75% of the patient responsibility prior to scheduling the procedure. This allows us to reserve the operating time. Payment arrangements must be discussed with the billing office prior to surgery. Payments are not to exceed 3 installments after deposit.

HMO Plans: If you are required to have a PCP, please obtain a referral to see our providers. You are responsible for getting proper referral/authorization in advance of your appointment.

PPO Plans: If we are in your network, we have agreed to accept the discounted rate from your plan, however all co-insurance, co-payments and deductible are your responsibility.

Medicare: After your insurance or secondary insurance has cleared we will send you a statement for the co-payment you are responsible for. Having more than one insurer does not necessarily mean that your services are covered 100%. As a courtesy we will bill your secondary insurance carrier, if they do not pay after 60 days you will be responsible for balance.

Out of network PPO plans: We will bill your insurance carrier as a courtesy. In the event charges are applied to your responsibility by your insurance carrier, we will expect payment at the time of service.

Payment Plans: Patients who have financial hardship to fulfill their financial obligation and whose balance is over $500.00, might be eligible for a payment plan. Payment plans will not exceed 3 payments.

OFFICE POLICIES

Returned Checks: All returned checks are subject to a processing fee of $25.00 per transaction. This fee along with the original amount of the check will be due within 10 business days of the official notification given from IntegraMed Orthopedics and Spine. A returned check, against a closed account or an account with non-sufficient funds (NSF), is in violation of civil law and, in certain situations (checks written over $100), criminal law.

Patient Forms: Disability paper work will be filled out as a courtesy for patients during the post op period and whose balance has been paid. We also provide this service for patients for a fee of $25.00 or more depending on complexity, to the patient.

Missed/Canceled Appointments: A $50.00 charge may apply to missed appointments and appointments cancelled without 24 hours of notice. Appointment reminders are done as a courtesy and do not constitute a timely phone call or failure to appear.

I read and understand all of the financial and office policies. I agree to comply with these policies:

_____

Printed Name **Signature** **Date**