



Ph: (844) 238-7900 | Fax: (800) 887-4726 | info@sunshinespine.net

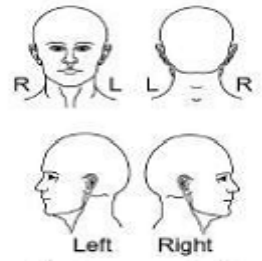
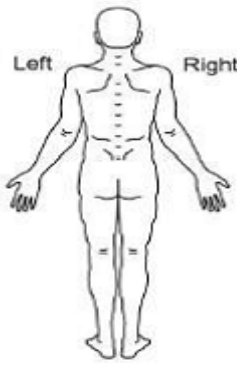
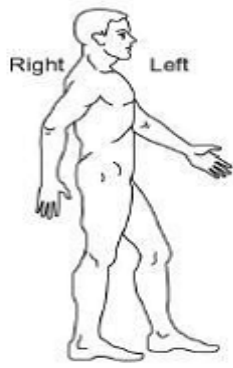
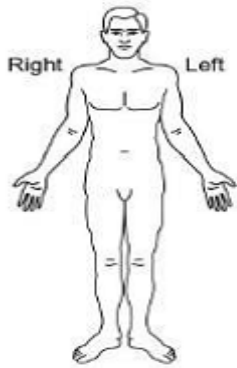
HISTORY AND PHYSICAL INTAKE FORM

Name: _____ DOB: _____ Age: _____ Height: _____ Weight: _____

Primary Care Physician: _____ Referring Physician: _____

Reason for visit/Area of pain (please specify body part): _____

Please **circle** the areas where you are experiencing pain & **rate** the area you are having pain from a 1 out of 10 (1 being minor and 10 being unimaginable): Pain score: _____



Pain score: _____

Current Medications:

Name of Medication	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies:

Yes No

No Known Drug Allergies	_____	_____
IV Dye	_____	_____
Iodine	_____	_____
Seafood/Shellfish	_____	_____
Latex	_____	_____
Adhesive Tape	_____	_____
NSAIDS	_____	_____
Penicillin	_____	_____

Pharmacy Name: _____ **Other:** _____

Pharmacy Address/Location: _____ **Pharmacy Phone #:** _____

Have you treated with a pain management physician within the last 12 months? Yes No

If yes, please provide Physician's Name: _____

Patient Name: _____

Past Medical History:	Yes	No		Yes	No		Yes	No
High blood pressure	___	___	Phlebitis/blood clots	___	___	Heart disease	___	___
Kidney problems/Stones	___	___	Stomach Ulcer disease	___	___	Bleeding disorder	___	___
Diabetes	___	___	Stroke	___	___	Emphysema/COPD	___	___
Cancer	___	___	Glaucoma	___	___	Depression	___	___
Fibromyalgia	___	___	HIV positive	___	___			

Other: _____

Surgical History: Check here if none ()

() Low back surgery (When) _____ Where _____ Surgeon _____
() Neck surgery (When) _____ Where _____ Surgeon _____
() Heart surgery (When) _____ Where _____ Surgeon _____
() Joint replacement (Which) _____ () OTHER SURGERY _____

Social History:

Right Handed () Left Handed ()

Smoker: () YES () NO # packs daily: _____ How many years: _____

Employment status: () None () Full Time () Part time

() Work with limitations (Since When Limited): _____ () Retired

If employed type of occupation: _____ () Sedentary () Light () Heavy duty

Family History:

Mother () Alive () Deceased Age: _____ Cause/medical conditions: _____

Father () Alive () Deceased Age: _____ Cause/medical conditions: _____

Family Medical Problems () Diabetes () Heart Disease () Cancer (type): _____ () Other: _____

Review of Systems: Possibly pregnant () Yes () No

Functional status evaluation, does your pain interfere with any of these?

() Eating () Bathing () Using the toilet () Dressing () Getting up out of bed/chair

() None **General:** () Numbness () Tingling Where? _____ Old/New: _____

() New incontinence () urine () stool () Coordination/Off balance

Patient Name: _____

- None **Constitutional:** Weight loss Tiredness
- None **HEENT:** Blurred vision Deafness Ringing Ears Dizziness Vertigo
- None **Heart:** Chest pain Pounding in chest
- None **Lungs:** Shortness of breath
- None **Abdomen:** Diarrhea Stomach bleeding
- None **Urinary:** Loss of urine Kidney disease
- None **Musculoskeletal:** Sprains Swelling Stiffness
- None **Skin/Breasts:** Rash
- None **Neurologic:** Balance problems Memory problems Falls
- None **Behavioral:** Depression Anxiety Sleep disturbance
- None **Endocrine:** Too cold Too hot
- None **Blood/Lymphatic:** Easy bruising Bleeding problems
- None **Immunologic:** Itching Frequent
colds/infections
- None **Menstrual:** Regular Irregular Post menopausal

I certify that the information given on the Initial Visit Intake is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this paperwork.

Date: _____

Patient/Family/Legal Guardian Signature

Physician Signature: _____ Date: _____

It is your responsibility as a patient of Sunshine Spine FL, LLC to provide us with your accurate insurance information at the time of service. If another party (auto, w/c, legal attorney) is responsible for paying for your treatment, you must give us that information. Otherwise, you will be financially responsible. (Please Note: we only have 30 days in which to file your claim and get reimbursed from auto insurance.)



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Patient Information	Patient Information Continued
Name (F, M, L):	Race: (please check one)
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic
Social Security #:	<input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Indian
Date of Birth:	<input type="checkbox"/> Other: _____
Home Address:	Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish
	<input type="checkbox"/> Other: _
City, State:	Ethnicity: <input type="checkbox"/> Latino or Hispanic
Zip Code:	<input type="checkbox"/> Not Latino or Hispanic
Home Phone:	<input type="checkbox"/> Declined to answer
Cell Phone:	Emergency Contact:
Email Address:	Emergency Contact Number:
Employer:	Referring Physician:
Mailing Address (If Different):	Primary Care Physician:
Marital Status	Health Insurance
Please Check One:	What is your Primary Health Insurance?
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow	
If Married Spouse Name:	Policy/ID #:
Spouses Phone #:	Group #:
Spouse Social Security #:	Policy Holders Name:
Date of Birth:	Date of Birth:
Employer	What is your Secondary Health Insurance?
Health Information	
Do you have an <u>OPEN CLAIM OR CASE</u> for an auto accident ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy/ID #:
Are you currently here as a result of an accident that happened on the job and is connected to a <u>WORKERS COMPENSATION</u> case? <input type="checkbox"/> Yes <input type="checkbox"/> No	Group #:
	Policy Holders Name:
	Date of Birth:

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CONSENT FOR TREATMENT

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment at **SUNSHINE SPINE FL, LLC**.

Patient/Legal Guardian Name & Signature: _____ **Date:** _____

CONSENT FOR DISCLOSURES

Please list the person, or persons you are authorizing Spine and Wellness to speak with on your behalf. This person or persons will be authorized to speak with members of our staff regarding, but not limited to, your health status, diagnosis, treatment options, balances inquiries, or to make scheduling changes.

Our commitment here at Sunshine Spine FL, LLC is to serve our patients in a professional, courteous, and caring manner. Therefore we ask that all members of your party conduct themselves in that same manner while in the office or on the phone. Any inappropriate behavior and/or rudeness to the staff for any reason, is not tolerated and are grounds for discharge

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

I DO NOT give authorization for medical information, lab work results and any other information regarding my appointments or treatment to be released to anyone.

I allow Phone Messages to be left on my Phone **Yes** **No** _____
(Your Initials) (Your Initials)

Patient/Legal Guardian Name & Signature: _____ **Date:** _____

PRIVACY NOTICE ACKNOWLEDGEMENT

During the course of your treatment it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- During your treatment, a referral to other services may be necessary.
- During health care operations, we may need a second opinion.
- During the payment process, we may need to release notes and other laboratory results.
- Release information to legal authorities or case workers.

I acknowledge that I have had the opportunity to review a copy of the **SUNSHINE SPINE FL, LLC NOTICE OF PRIVACY PRACTICES**. I understand that I am responsible for reading this notice and for notifying Sunshine Spine FL, LLC in writing of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand that the notice includes electronic access to my medication history. Sunshine Spine FL, LLC has the right to revise this notice at anytime and will post a copy of the current notice in the office in a visible location at all times. Sunshine Spine FL, LLC may also provide me with a copy of its most recent notice upon my request.

Patient/Legal Guardian Name & Signature: _____ **Date:** _____



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PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

AUTO INFORMATION

If you are requesting treatment for injuries sustained in an auto accident, and have an open auto claim or case, please complete this form. Individuals seeking PIP medical benefits **must receive initial services and care within 14 days** after the motor vehicle accident. Initial services and care are only reimbursable if lawfully provided, supervised, ordered, or prescribed by a licensed physician, licensed chiropractic physician, licensed dentist, or must be rendered in a hospital, a facility that owns or is owned by a hospital, or a licensed emergency transportation and treatment provider. **Follow up services and care requires a referral from such providers and must be consistent with the underlying medical diagnosis rendered when the individual received initial services and care.**

Name of Auto Insurance Carrier: _____ Auto Policy #: _____

Name of Insured: _____ Claim #: _____

Date of Accident: _____ **Date of First Treatment:** _____

Body Parts Injured: _____

Doctor/Facility Name: _____

Adjuster's Name: _____ Phone #/Ext: _____ Fax: _____

Auto Insurance Billing Address: _____

What State Did This Occur In? _____ Do you have an Open Legal Case?

Attorney Firm: _____

Attorney Name: _____ Phone #/Ext: _____ Fax: _____

Legal Case #: _____ Date Legal Case was Opened: _____

I _____, hereby authorize and direct _____ to send to Sunshine Spine FL, LLC. An accounting of payouts made under **all claims** submitted for payment under the above referenced policy relating to the auto accident occurring on the above referenced date **as those payouts occurred. have completed this form with accurate and truthful information about the above-mentioned incident.**

Patient/Legal Guardian Signature: _____ **Date:** _____



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FINANCIAL POLICY AND AGREEMENT

I understand that in consideration of the services provided to me, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered by Sunshine Spine FL, LLC. I am responsible for any applicable deductible, co-payments and coinsurance prior to the provision of services. Sunshine Spine FL, LLC may file ALL claims for payment with my insurance company as a courtesy to me. If the insurance company fails to pay in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts due. Payments may be made in the form of check, Visa, Mastercard, and Discover. Should my account be referred to a collection agency and/or attorney for collection, the undersigned agrees to pay all collection fees and/or attorney fees associated with the collection of this debt.

I hereby authorize and assign all payments, insurance or Medicare benefits for medical services and/or procedures rendered to me, directly to Sunshine Spine FL, LLC. I hereby authorize Sunshine Spine FL, LLC to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance company or Medicare.

If my insurance company requires me to obtain referrals/authorizations, it is my responsibility to obtain such and if not, then I will be responsible for any unpaid balance.

By signing this agreement, I acknowledge that I have carefully read, understood and agree to the above terms and conditions. I also understand that it is mandatory to tell Sunshine Spine FL, LLC if another party is responsible for paying for my treatment (i.e. Automobile Insurance, Workers' Compensation, slip and fall). Section 1128B of Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

MEDICAID & COMMERCIAL INSURANCE WAIVER

This notice is to inform all patients that we are **NOT MEDICAID PROVIDERS or PROVIDERS OF FEW OTHER COMMERCIAL INSURANCES**. If you decide to seek treatment at Sunshine Spine FL, LLC **you are required to sign this waiver in acknowledgment that you have received this waiver (even if you do not have Medicaid or other commercial insurance we are not in-network with)**, and that you will be responsible for any portion of your bill that is not covered by any other insurance.

Medical Records Fees:

If you are requesting a copy of your medical records, a signed authorization to release your records is required before we can process any requests. As a courtesy we will release a copy of your records to a physician of your choice with a signed release form and appropriate forwarding information for that physician free of charge. Any additional requests will be charged a fee (see below) and must be paid in full prior to pick up. Please note the final charge will include postage if you are requesting your records to be mailed. All records are processed out of our Baptist South location and must be picked up at that location. Fees for copies of medical records are as follows: **\$1.00 per page for the first 20 pages, \$0.25 per page thereafter.**

By signing this agreement, I acknowledge that I have carefully read, understand, and agree to the terms and conditions of the Consent for Treatment Agreement, the Privacy Notice Acknowledgment, the Consent for Disclosure, the Financial Policy and Agreement, the Medicaid Insurance Waiver, and the Fee Policy. I have completed these forms accurately and to the best of my knowledge and will be financially responsible if I have failed to provide Sunshine Spine FL, LLC with all of my applicable insurance information.

Patient/Legal Guardian Name (print): _____

Patient/Legal Guardian Signature: _____ **Date:** _____



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SUNSHINE SPINE FL, LLC

ASSIGNMENT OF RIGHTS & BENEFITS WITHIN THE MEANING OF SECTION 627-736, FLORIDA STATUTES; PROVIDER’S LIEN; AUTHORIZATION TO SCHEDULE PATIENT INTERVIEWS; PATIENT’S LETTER OF PROTECTION; SPECIAL POWER OF ATTORNEY

This agreement allows me, (hereafter Patient), to be treated Arkam Rehman, M.D/ Sunshine Spine FL, LLC. (Provider), without paying for my care and treatment in advance. I understand and acknowledge Provider’s waiver of its right to receive immediate payment is given in exchange for good and valuable consideration, including, but not limited to, a) my assignment of benefits of any available insurance benefits to Provider; b) a grant to provider of a lien against any eventual proceeds of my claim for damages for the injuries which Provider is treating me. This mutual consideration is considered good and sufficient by the parties.

By my signature below, for good and valuable consideration (including, but not limited to the extension of credit to me), I hereby assign, transfer and convey to Provider all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not to any automobile liability medical expense payment or other health benefits indemnification and/or agreement otherwise payable to me. This is a direct assignment of my rights and benefits due to me under any policy of insurance which would otherwise pay benefits directly to me. This payment should not exceed my indebtedness to Provider and I acknowledge that I will timely pay any indebtedness owed by me to Provider that is not otherwise satisfied by the above-mentioned assigned proceeds.

I further authorize Provider, their agents, counsel, or negotiate, collect and settle any claim with any insurance carrier or other third-party payor with regard to these services, which authorization shall include authority to (1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including without limitation any independent Medical Examination Reports, Records Review Reports, Explanation of Benefits, and Benefits Payment Sheets of Logs (P.I.P Payout Sheets), without regard as to whether such documentation has already been provided to me, 2) endorse in my name any check issued for payment where benefits were assigned; and 3) file suit to collect payment of insurance benefits. The insurer shall further be directed to furnish the Provider with an itemized specification of unpaid charges of each item the insurer reduces or denies (including bills applied to deductible of received after policy exhaustion) in accordance with F.S. 627-736(4)(b). this request includes a request for the name and address of the insurer’s designated recipient for demand letters and disputes of denials pursuant to F.S.627-736(11).

I hereby authorize provider, their agents, counsel or assigns to contact any insurer of other party in order to coordinate any recorded statements, sworn statements, examination under oath, independent Medical Examination, or similar investigative interviews. I further direct my insurer to coordinate the aforementioned examinations directly with Provider, their agents, counsel, or assigns.

I further direct my insurer to direct all payment for services rendered by Provider to the billing address of Provider identifies on the medical billing claim forms submitted by Provider and direct the insurer to set aside as disputed funds any amount reduced or denied by insurer and resolve said dispute before exhausting the remaining policy benefits.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each of the above provision:

DATED THIS _____ DAY OF _____, 20 _____

Patient/Family/Legal Guardian Name & Signature _____ Date: _____

Physician Signature: _____ Date: _____



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Patient Responsibility Form

Patient Name: _____ **Date of Accident:** _____

To the extent for the bill of services rendered by Arkam Rehman, MD [hereby known as “Medical Provider”] and their associates, I, the undersigned, hereby consent that this agreement constitutes an irrevocable lien against any recovery of proceeds paid by any insurance carrier from whatever source, including, but not limited to, PIP coverage, bodily injury coverage, health insurance coverage, uninsured/underinsured motorist coverage, medical payments coverage, general liability coverage, or any other coverage that may be available to pay me for my medical bills or my damages stemming from an accident occurring on the above-referenced date. Further, and to the extent of the bills incurred, the undersigned agrees that this agreement shall constitute an irrevocable lien against any recovery resulting from any settlement of any third-party or first-party or first-party claim for damages relating to the aforementioned accident, or any judgment or verdict obtained in the pursuit of my claim for damages stemming from said accident.

This lien is provided by the above-named patient to Medical Provider and their associates in consideration of Medical Provider’s agreement to refrain from any collection efforts against me, the patient, until my claim for damages stemming from the above-referenced accident is settled, resolved in litigation, or abandoned. The undersigned agrees that it has a duty to keep Medical Provider informed of the status of the patient’s claim for damages by immediately advising Medical Provider of any settlement reached, or any verdict or judgment rendered, whether favorable or not. The undersigned agrees that it has a duty to advise Medical Provider should the patient choose to abandon its claim for damages. The claimant further recognizes, that should his/her claim for damages result in no recovery, or in an amount insufficient to pay this provider’s medical bill in full, that it shall remain obligated to pay the outstanding balance owed to Medical Provider.

I hereby authorize any attorney I choose to represent me in my personal injury claim/case, to discuss my case, or provide Medical Provider with any and all information necessary to assist in the payment of medical bills incurred with Medical Provider. I further authorize and irrevocably instruct paid attorney(s) to withhold such sums from any insurance payments made, from any settlement reached, or any verdict or judgment paid, and to pay Medical Provider said funds in payment of my medical bill with Medical Provider, and to deposit any disputed amount in the registry of the Court of County, State. **The parties agree that Medical Provider and it’s associates is an interested party in the outcome for my claim of damages, and shall remain an interested party, until the balance owed by me, to Medical Provider is paid in full.** I acknowledge my understanding this lien shall remain in full force and effect, even if I should decide to substitute counsel or represent myself.

I hereby further give my authorization to Medical Provider to record a Uniform Commercial Code Form (UCC-1) to protect this medical lien and to send any unpaid sum to the Tortfeasor.

I HEREBY CERTIFY THAT I HAVE READ, FULLY UNDERSTAND AND AGREE WITH THE ABOVE.

Patient name: _____

Patient/Guardian Signature: _____

Date: _____



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Authorization for Disclosure of Health Information

Patient Name	
DOB	
Phone #	
Address:	

In order to process your request, we must have complete contact information for the doctor or facility you are requesting to obtain or release medical records. Incomplete requests will not be processed.

Release Records From (please print clearly)	Release Records To (please print clearly)
Doctor Name/Facility:	Doctor Name/Facility: Sunshine Spine FL, LLC
Phone #:	Phone #: (844) 238-7900
Fax # :	Fax # :
Address:	Address: 4788 Hodges Blvd, Ste 105 # 4, Jacksonville, FL, 32224

Records Requested (please check all that apply)

- All Medical Records
- Laboratory Reports
- Progress/Visit Notes
- Radiology/Diagnostic Reports
- Other: _____
- Cat Scan MRI X-Ray

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Sunshine Spine FL, LLC. I understand that the revocation will not apply to all circumstances especially in any legal situation where a subpoena is issued. If I fail to specify an expiration date, event or condition, this authorization will expire one year from today's date. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect the information being used or disclosed. If I have questions about disclosure of my health information, I can contact the Privacy Officer for Sunshine Spine FL, LLC.

Signature of Patient or Legal Representative:

Date:

Hodges Clinic: 4788 Hodges Blvd, Ste 105 # 4, Jacksonville, FL, 32224
Orange City Clinic: 1209 Saxon Blvd, Orange City, FL 32763

Orange Park Clinic: 1409 Kingsley Ave STE 2, Orange Park, FL 32073
Daytona Clinic: 1367 Beville Rd, Daytona Beach, FL 32119

Mailing Address: 3565 Westover Rd, Fleming Island, FL, 32003



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE <small>(Medicare #)</small>	MEDICAID <small>(Medicaid #)</small>	TRICARE <small>(ID#/DoD#)</small>	CHAMPVA <small>(Member ID#)</small>	GROUP HEALTH PLAN <small>(ID#)</small>	FECA BLK LUNG <small>(ID#)</small>	OTHER <small>(ID#)</small>	1a. INSURED'S I.D. NUMBER <small>(For Program in Item 1)</small>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)							4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		7. INSURED'S ADDRESS (No., Street)			
CITY		STATE	8. RESERVED FOR NUCC USE				CITY	STATE
ZIP CODE		TELEPHONE (Include Area Code) ()		ZIP CODE		TELEPHONE (Include Area Code) ()		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES NO		a. INSURED'S DATE OF BIRTH MM DD YY		SEX M F		
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? YES NO		PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)		
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES NO		c. INSURANCE PLAN NAME OR PROGRAM NAME				
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO <i>If yes, complete items 9, 9a and 9d.</i>			

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize a payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED	DATE	SIGNED
--------	------	--------

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL. MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES CODE YES NO ORIGINAL REF. NO.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____

A. _____	B. _____	C. _____	D. _____
F. _____	G. _____	H. _____	I. _____
J. _____	K. _____	L. _____	

22. RESUBMISSION _____

23. PRIOR AUTHORIZATION NUMBER _____

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. SERVICE	D. PROCEDURES, SERVICES, OR SUPPLIES	E. DIAGNOSIS	F. \$ CHARGES	G. DAYS OR UNITS	H. EPST Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From MM DD YY To MM DD YY	EMG	CPT/HCPCS	MODIFIER	POINTER					
1									
2									
3									
4									
5									
6									

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. BALANCE DUE \$
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ()
--	---	--------------------------------------

CARRIER

X

PHYSICIAN OR SUPPLIER INFORMATION

V



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Injection Consent

Patients Name: _____ **DOB** _____

Injection: _____

I have explained to the patient/family/guardian the nature of patient's condition, the nature to the procedure and the benefits to be reasonably expected. I have discussed the likelihood of major risks or complications of this procedure including (if applicable), but not limited to, brain and nerve damage, paralysis, infection, drug reactions, blood clots and death. I have also indicated that with any procedure there is no guarantee of relief and as always the possibility of an unexpected/ rare complication.

Allergies/Additional Comments (if any): _____

Risks explained including:

Common:

- Bleeding/Bruising
- Redness/Flushing (With Steroids)
- Allergic reaction
- Seizure
- Stroke

Rare:

- Nerve Damage
- Long term increase pain
- Infection
- Pneumothorax
- Blood vessel injection w/ risk of stroke

All questions were answered and the patient/family/guardian consent to the procedure.

All questions were answered and the patient/family/guardian consent to the procedure.

Physician Signature

Date

Patient/Family/Guardian Signature

Date

If patient's signature cannot be obtained indicate reason in comments section above.

Internal Use:

Medications Used	Lot #	Exp Dates
<input type="checkbox"/> Marcaine		
<input type="checkbox"/> Lidocaine		
<input type="checkbox"/> Carbocaine		
<input type="checkbox"/> Betamethasone		
<input type="checkbox"/> Depomedrol		
<input type="checkbox"/> Isovue		
<input type="checkbox"/> Dexamethasone		
<input type="checkbox"/> _____		



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Patient Name: _____

DOB: _____

PROVIDER ORDER

Procedure (CPT code)	Diagnosis Codes	Levels	Pain Score
Percutaneous Discectomy (62287)			
Other			

Provider Signature: _____

Date: _____

PRE-PROCEDURE INSTRUCTIONS

- IN ORDER FOR THE ABOVE PROCEDURES TO BE PERFORMED YOU ARE **REQUIRED** TO HAVE SOMEONE WITH YOU TO DRIVE YOU HOME.
- If you have an Iodine allergy, and medication has been prescribed to you please take as directed.
- Remember to eat and drink prior to the procedure as this helps in the recovery process.
- **Avoid Caffeine** and drink plenty of water.
- Medications to stop 7 days prior to the procedure include but are not limited to: Aspirin, Motrin, Ibuprofen, Excedrin, Aleve, Naprosyn, Indomethacin, Relafen, Diclofenac, Goody & BC Powders, Voltaren, Atherotec, Clinoril, Celebrex, Mobic, Meloxicam, Pradaxa, Coumadin, Plavix, Effient, Aggrenox, Pletal. All other arthritis medication in the ANTI-INFLAMMATORY FAMILY is also to be stopped.
- Take all your blood pressure, diabetes and other medications as prescribed prior to the procedure.
- You are **REQUIRED** to have a Pro Time & INR done the day before the procedure if on **COUMADIN** and the results **MUST** be brought in with you the day of the procedure.
- **The procedure cannot be performed** if you have an **ACTIVE INFECTION** such as a UTI, cough or cold, bronchitis, or tooth abscess. The procedure can **ONLY** be performed after you have finished all of your antibiotics, and have fully recovered from

If you have any questions / concerns please contact our office at (844) 238-7900

This procedure will be performed at the:

_____ **Orange Park Surgery Center**

Date of procedure: _____ **Time of procedure:** _____

Patient Signature: _____ **Date:** _____



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Post-Procedure Instructions

Your physician has given you an injection of medication to decrease pain in your area of discomfort. The duration of pain relief from this procedure varies in each patient. The local anesthetic medication if given, (____) will provide a temporary numbing effect lasting from 1 to 5 days. The steroid medication if given, (____) should begin to take effect 2-14 days after the injection and will continue to be effective for an extended period of time.

- **FOR FALL AND SAFETY CONCERNS WE RECOMMEND NO DRIVING AND TO REST FOR THE REMAINDER OF THE DAY**
- Tomorrow you may resume your regular activities including exercise
- Applying an ice pack to the injection site for 20-minute periods, and then removing for 1 hour and repeating can relieve and prevent some tenderness to the site
- Increase your fluid intake today, return to your normal diet as tolerated
- Avoid activities that require bending, lifting, twisting or prolonged sitting
- Sometimes your pain may remain or you may even feel slightly worse (this is not unusual)
- If you are taking pain medications please take them as directed
- Restart all your blood thinners / medications the night **AFTER** the procedure

It is **NOT** necessary to call Sunshine Spine FL, LLC for the following side effects.

These side effects are considered acceptable, usually temporary, and will most likely subside in a day or so.

- Dizziness, mild headaches
- Ache from needle insertion
- General redness or flushing of the face, that will usually resolve within 3-5 days

NOTIFY Sunshine Spine FL, LLC if the following symptoms occur:

- Weakness or numbness in legs or arms
- Drainage, redness, active bleeding or swelling at the injection site
- Prolonged dizziness - lasting more than one day
- Headache that increases when your head is upright and decreases when you lie flat
- Temperature above 100.5
- Uncontrolled loss of urine
- Inability to stand or walk from weakness or balance issues

If you are experiencing severe pain it may be necessary for you to go the nearest **Emergency Room**. Make them aware that you had a procedure done at our office.

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