SOUTHERN LASER SPINE

Lawrence M. Alexander, M.D.

Today's Date: _____

Injury/Complaint: _____ Date of Injury/Onset: _____

Pharmacy Name: _____ Pharmacy Phone #: (____) _____

PATIENT INFORMATION

Patient name: Last_____ First _____ Middle _____

Sex: ☐ M ☐ F Date of Birth: _____ Age: _____ Social Security No.: _____

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

Home Phone: (_____) _____ Work Phone: (_____) _____ Mobile Phone: (____) _____

Email: _____ Preferred Contact:☐email ☐phone☐mail Occupation: _____

Emergency Contact: Name _____ Phone: _____ Relation: _____

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

COMPLETE THE SECTION BELOW THAT APPLIES TO YOU:

INSURANCE COVERAGE AND PAYMENT

Primary Insurance: _____ Insurance ID: _____

Subscriber's Last Name: _____ ___First _____ Middle _____

Social Security: _____ Date of Birth: _____

Plan Effective Date: _____ Subscriber's Employer: _____

Relation to Patient: _____

Secondary Insurance: _____ Insurance ID: _____

AUTO ACCIDENT OR SLIP/FALL INJURY

Name of Insurance Carrier: _____ Phone #: (_____) _____

Policy #: _____ Claim #: _____

Adjuster Name (if known): _____ Adjuster Phone: (____) _____

Name of Policy Holder (if you are not the primary policy holder): _____

Relationship to Patient: _____ Phone Number of Policy Holder: _____

Date of Injury or Crash: _____ Was Injury Reported to Insurance Carrier? ☐ Yes ☐ No

Attorney Name: _____ Phone #: (_____) _____

WORK COMP

Name of Insurance Carrier: _____ Phone #: (_____) _____

Adjuster Name (if known): _____ Adjuster Phone: (____) _____

Employer Name: _____ State _____

Date of Injury: _____ Was Injury Reported to Employer? ☐ Yes ☐ No

PATIENT SIGNATURE: _____ DATE: _____

PAST MEDICAL HISTORY (SELF): REVIEW OF SYMPTOMS
Circle yes or no.

Conditions			Physician Comments Only
Heart Disease / Heart Problems	**YES**	**No**	
Heart Attack/Chest Pain	**YES**	**No**	
High or Low Blood Pressure	**YES**	**No**	
High Cholesterol	**YES**	**No**	
Diabetes Type I or Type 2	**YES**	**No**	
Hypoglycemia	**YES**	**No**	
Stomach Ulcer	**YES**	**No**	
Acid Reflux or GERD	**YES**	**No**	
Hypothyroidism or Hyperthyroidism	**YES**	**No**	
Cancer – Past or present	**YES**	**No**	
Seizures/Epilepsy	**YES**	**No**	
Kidney or Bladder Problems	**YES**	**No**	
Asthma	**YES**	**No**	
Frequent Pneumonia/Bronchitis	**YES**	**No**	
COPD/ Emphysema	**YES**	**No**	
Tuberculosis	**YES**	**No**	
Sleep Apnea – use of CPAP	**YES**	**No**	
Eye Disease	**YES**	**No**	
Glaucoma	**YES**	**No**	
Sinus Problems	**YES**	**No**	
Ear Problems	**YES**	**No**	
Deaf/Hearing Deficit	**YES**	**No**	
Headaches/Migraine	**YES**	**No**	
Liver Disease	**YES**	**No**	
Hepatitis Type _____	**YES**	**No**	
HIV/AIDS	**YES**	**No**	
Arthritis	**YES**	**No**	
Osteoporosis/ Osteopenia	**YES**	**No**	
Blood Disorder	**YES**	**No**	Type:
Anxiety/ Depression	**YES**	**No**	
Swallowing Difficulty	**YES**	**No**	

List any other health conditions: _____

_____

_____

_____

Do you use tobacco? ☐ Yes ☐ No **If yes:** ☐ Cigars ☐ Cigarettes ☐ Pipe ☐ Chewing **Amount:** _____ per day

How long have you used tobacco? _____

Do you drink alcoholic beverages? ☐ No use ☐ Rare/seldom ☐ Social only ☐ Frequent (at least daily two weekly)

☐ I drink a glass a wine with food usually

Type: _____ Frequency: _____

Do you partake in any recreational drugs? ☐ Yes ☐ No (*this is confidential for medical use only)*

Type: _____ Last used: _____

Do you use medical marijuana? ☐ Yes ☐ No How Long been using? _____

Type: _____ Last used: _____

Does anyone in your immediate family suffer from any of the following? ☐ High Blood Pressure ☐ Diabetes

☐ Heart Disease ☐ Cancer ☐ Kidney Disease ☐ Arthritis ☐ Stroke ☐ Other _____

List any surgeries/hospitalizations you have had:

TYPE	DATE OR AT LEAST YEAR	PHYSICIAN OR FACILITY

Have you ever had any problems with anesthesia (being numbed or put to sleep)? _____ YES ____ NO

If yes, please list problems or explain: _____

_____

Please list all current medications or vitamins/supplements:

NAME	DOSAGE	HOW OFTEN TAKING

If more space is needed, please write on back or under additional notes

ARE YOU ALLERGIC TO ANY MEDICATION? _____ Yes _____ No If yes, list below:

Name of Medication	Type of Reaction

Right or Left Hand dominant? _____ Height? _____ Weight? _____

SOUTHERN LASER SPINE

Lawrence M. Alexander, M.D.

1216 SE 1st Avenue, Fort Lauderdale, FL 33312
TEL: 305-901-1268 • FAX: 305-901-1596

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize Southern Laser Spine and/or Dr. Lawrence Alexander to Obtain healthcare and/or medical information via mail, facsimile, verbal communication, written communication, or another appropriate source from:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

I. This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: **ALL RECORDS**

II. The purpose or need for the disclosure of information:
□ Continued medical care □ Legal Case □ Personal Use **X** Other, please explain: **DR REVIEW**

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION *_____
NO, DO NOT DISCLOSE THIS INFORMATION * _____

1. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
2. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
3. My purpose/use of the information is for _____ .
4. This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws prohibit a fee to be charged for transmitting of patient records to another physician for continuation of care.

_____ _____ _____
Signature of Individual **Date** **Relation to Patient**

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ASSIGNMENT OF BENEFITS & **LIMITED POWER OF ATTORNEY**

PATIENT: _____ Policy Holder: _____

CLAIM/GROUP #: _____

SS# / ID#: _____

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to: **Southern Laser Spine, 1216 SE 1st Avenue, Fort Lauderdale, FL 33312**

I irrevocably assign to you, my medical provider, to the extent of any services rendered to me by its physicians or staff, the proceeds of any settlement or judgment resulting from the exercise by myself of any rights of recovery I have against any person or organization legally responsible for the bodily injury for which I have been rendered treatment and/or the proceeds of my insurance policy under which such services are covered and against which I may make a claim for payment.

I irrevocably assign to you, my medical provider, all my right and benefits under my insurance contract and/or any employee welfare benefit plan for payment for services rendered to me, including but not limited all of my rights under "ERISA" applicable to the medical services at issue. I authorize you to file insurance claims on my behalf for services rendered to me and tis specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health insurance carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your medical bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and regarding my general health insurance coverage and I specifically authorize you to pursue any administrative appeals conducted pursuant to 'ERISA" or any other state or federal health care procedural laws.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize the attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from my insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance company to pay you directly any monies due to you for medical services rendered to me. **I authorize you and your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining (to include what is known as a PIP payment log as well if applicable).**

I further hereby agree and give authorization that you, my medical provider, be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor's bill. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case. I authorize the doctor to initiate a complaint to the Insurance Commissioner or insurer for any reason on my behalf. A photocopy of this Assignment shall be considered as effective and valid as is the original.

DATED THIS _____ DAY OF _____20_____.

_____ _____

SIGNATURE WITNESS

_____

SIGNATURE OF CLAIMANT, IF OTHER THAN POLICYHOLDER

HIPAA Notice of Privacy Practices
&
Consents for Purposes of Treatment, Payment, and Health Care Operations

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SOUTHERN LASER SPINE
1216 SE 1st Avenue
TEL: 305-901-1268 • FAX: 305-901-1596

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically. Any and all request must be in writing.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. All request must be in writing.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **October 14, 2016.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

CONSENT FOR PURPOSES OF TREATMENT PAYMENT AND HEALTH OPERATIONS

- I consent to the use or disclosure of my protected health information ("PHI") by Q Spine Institute for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Q Spine Institute.
- I understand that diagnosis and treatment of me by Q Spine Institute may be conditioned upon my consent as evidence by my signature on this document. I hereby grant consent to Q Spine Institute to evaluate, diagnose and treat me.
- I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Q Spine Institute is not required to agree to the restrictions that I may request. However, if agrees to a restriction that I request, the restriction is binding on Q Spine Institute.
- I have the right to revoke consent in writing, at any time, except to the extent that Q Spine Institute has taken action in reliance on this consent.

- My “protected health information” means health information, including my demographic information, collected from me, and created or received by my physician, another health care provider, a health plan, my employer, or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is reasonable basis to believe the information may identify me.

- My protected health information may be released to my immediate family members unless I request otherwise.

- I may be contacted at home or work. Messages be left on my answering machine or voice mail unless I state otherwise.

- The Q Spine Institute Notice of Privacy Practices has been provided to me on the above portion of this document.

- I acknowledge all the itemized uses, disclosures and rights listed above.

Signature below is acknowledging that you have received and given an opportunity to read and review this Notice of our Privacy Practices, and that you consent to treatment as discussed above, and that you consent to the bullet points listed just above:

Print Name: _____ Signature_____ Date_____

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NOTICE OF PAYMENT RESPONSIBILITY AND INSURANCE NETWORKS

To all our patients:

Dr. Lawrence Alexander and Southern Laser Spine specializes in minimally invasive surgery for the spine.

I understand that unless visit is a Post Op (operation) visit, or due to no fault, worker's compensation injury, Dr. Alexander does not participate or is not in network with any other insurance providers for Southern Laser Spine.

Southern Laser Spine is a non-participating facility with Medicare. We do not take Medicare and Medicare patients will be responsible for their office visit. However, your visit may be capped at limiting charges by Medicare for this region and locale as noted under Medicare fee schedules and limiting charges.

It is with this understanding, regardless of insurance, that I, the patient, acknowledge that I will be responsible for all charges related to my office visit.

With my signature below, I _____ take full responsibility to pay the balance owed to Southern Laser Spine and/or the offices of Lawrence M. Alexander, M.D.

_____ _____

Print Name Date

_____ _____

Signature Date