



## New Patient Medical History Form

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Occupation: \_\_\_\_\_

Reason for your visit: \_\_\_\_\_

### Symptoms:

When did symptoms begin: \_\_\_\_\_

Do you have an open claim, including but not limited to auto, slip and fall, premises liability, personal injury, medical malpractice or any other claim? \_\_\_\_ Yes \_\_\_\_ No

Is this related to an auto accident? \_\_\_\_ Yes \_\_\_\_ No OR Workers' Compensation? \_\_\_\_ Yes \_\_\_\_ No

When does the pain/problem occur (i.e.: morning/night) \_\_\_\_\_

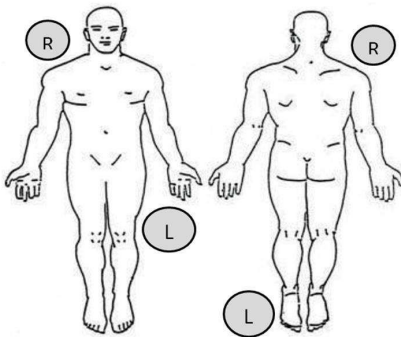
What aggravates the symptoms: \_\_\_\_\_

What reduced the symptoms: \_\_\_\_\_

### Please check if you have other symptoms:

| Symptom                                        | Occurrence                                                              | Location |
|------------------------------------------------|-------------------------------------------------------------------------|----------|
| <input type="checkbox"/> Numbness              | <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent |          |
| <input type="checkbox"/> Pins/Needles/Tingling | <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent |          |
| <input type="checkbox"/> Sharp Pain            | <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent |          |
| <input type="checkbox"/> Dull/Achy Pain        | <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent |          |

### Shade the areas you have pain



| Types of Therapy                          | Effect on your Symptoms                                                                           | Month/Year |
|-------------------------------------------|---------------------------------------------------------------------------------------------------|------------|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change |            |
| <input type="checkbox"/> Nerve Blocks     | <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change |            |
| <input type="checkbox"/> Medication Use   | <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change |            |
| <input type="checkbox"/> Chiropractor     | <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change |            |
| <input type="checkbox"/> Other            | <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change |            |

**Rate Your Pain:** Pain Scale 0 = No Pain 10 = Severe Today: \_\_\_\_ Last Week: \_\_\_\_

Patient Name: \_\_\_\_\_

**Current Medications:** List all medications you are taking, including over the counter and vitamins.

☐ No medications

| Name | Dose/Mg | Frequency |
|------|---------|-----------|
|      |         |           |
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**Allergies:** List all known allergies to medications, food and latex.

☐ No known drug allergies

| Name | Reaction |
|------|----------|
|      |          |
|      |          |
|      |          |
|      |          |
|      |          |
|      |          |
|      |          |

**Medical History:** List all medical problems for which you are currently being treated for

☐ No Medical History

| Medical Problem | Medical Problem |
|-----------------|-----------------|
|                 |                 |
|                 |                 |
|                 |                 |
|                 |                 |
|                 |                 |
|                 |                 |

Patient Name: \_\_\_\_\_

**Surgical History:** List all surgical procedures and year.

☐ No Surgeries

| Year | Procedure |
|------|-----------|
|      |           |
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|      |           |
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|      |           |

**Family History:**

Is there a family history of: PLEASE CIRCLE YES OR NO

|           |                         |           |                   |
|-----------|-------------------------|-----------|-------------------|
| YES or NO | CANCER                  | YES or NO | STROKE            |
| YES or NO | HYPERTENSION            | YES or NO | ALZHEIMER'S       |
| YES or NO | HYPERLIPIDEMIA          | YES or NO | DEPRESSION        |
| YES or NO | DIABETES                | YES or NO | OSTEOPOROSIS      |
| YES or NO | CORONARY ARTERY DISEASE | YES or NO | DOMESTIC VIOLENCE |

**Social History: Circle Yes or No**

Alcohol Use: Yes or No ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

Tobacco Use: Yes or No \_\_\_\_\_ Packs per day for \_\_\_\_\_ # of years. Quit smoking \_\_\_\_\_ years ago.

Street Drug Use: Yes or No Type: \_\_\_\_\_ Frequency: \_\_\_\_\_ Date of last use: \_\_\_\_\_

Caffeine Use: Yes or No Soda/Coffee/Tea \_\_\_\_\_ Cups daily

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

**Vaccinations: Circle Yes or No**

Pneumonia: Yes or No

Colonoscopy: Yes or No

Influenza: Yes or No

Room Number: \_\_\_\_\_



## *Review of Systems*

*Please circle if you have had any of the below symptoms within the **last 2 weeks***

|                            |                                                                                                                                                                                                                                                 |
|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b><i>Neurological</i></b> | Memory Loss • Dizziness • Fainting • Head Injury • Loss of Consciousness •<br>Arm Numbness • Leg Numbness • Paralysis • Speech Disorder • Stroke • Arm<br>Tingling • Leg Tingling • Tremors • Unsteady Gait • Leg Pain •<br>Arm Pain • Weakness |
|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Patient Print: \_\_\_\_\_ Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Imaging Provided: MRI \_\_\_\_\_ CD ☐ Rpt ☐ None ☐  
 CT \_\_\_\_\_ CD ☐ Rpt ☐ None ☐  
 X-Ray \_\_\_\_\_ CD ☐ Rpt ☐ None ☐



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**Patient Information:**

Patient Name: \_\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: M/F (Circle one) Married/Single/Divorced  
Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
Address: \_\_\_\_\_  
(Street) (City/State/Zip)  
Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
E-mail Address \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_  
Primary Care Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Primary Care Address: \_\_\_\_\_  
(Street) (City/State/Zip)  
Referring Physician: \_\_\_\_\_  
How did you hear about our practice? \_\_\_\_\_

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**Person Responsible for this account (if different from the above):**

Patient Name: \_\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: M/F (Circle one) Married/Single/Divorced  
Address: \_\_\_\_\_  
(Street) (City/State/Zip)  
Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

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**First Insurance Information:**

Plan Name: \_\_\_\_\_ I.D. Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_ Policy Holder SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Policy Holder's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: M/F

**Second Insurance Information:**

Plan Name: \_\_\_\_\_ I.D. Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_ Policy Holder SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Policy Holder's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: M/F

**Third Insurance Information:**

Plan Name: \_\_\_\_\_ I.D. Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_ Policy Holder SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Policy Holder's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: M/F

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**Pharmacy Information:**

Pharmacy Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Pharmacy Address: \_\_\_\_\_  
Consent to access your pharmacy for a medication list:  
(circle one) YES or NO Patient Initials: \_\_\_\_\_ Date: \_\_\_\_\_

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**IF THIS IS WORKERS COMPENSATION OR PERSONAL INJURY PLEASE NOTIFY  
THE FRONT DESK.**



John Soliman, D.O. Board Certified Neurosurgeon  
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Mark Michael, D.O. Orthopedic Spine Surgeon  
Suzanne Newby, PA-C • Courtney Rigby, APRN  
3519 Palm Harbor Blvd, Palm Harbor, FL 34683  
17849 Hunting Bow Circle, Suite 101, Lutz, FL 33558  
Phone: (813) 336-4461 Fax: (813) 336-4466

## **2026 FINANCIAL POLICY**

We are committed to providing you with the highest quality of care and believe it is important for you to clearly understand your financial commitment to Brain and Spine Neuroscience Institute so that we may focus on what is most important; your quality of care. To do this, you must agree to the following:

- That you, the patient or legal guardian of the patient are personally responsible for all services rendered to you by our offices. Any insurance policies are contracts between you and your insurance company. We may only call or electronically verify the insurance coverage. We accept that the information we are provided is an accurate representation of your coverage at that time. We request that you personally confirm with your insurer all your benefits, limitations, and policy guidelines.
- That you are considered a SELF PAY patient until YOU produce a copy of your insurance card and this office can verify your insurance coverage. If no insurance card is provided at the time of service, payment is forthwith due.
- That your co-payment, co-insurance, and deductibles will be paid in full at the time of service and you will not be billed for them at some future date. Our contracts with the insurance companies mandate our adherence to these policies.
- That a pre-authorization for service and provision of a qualified referring provider is your responsibility. If you are seen and your insurance company denies payment based on a pre-authorization or a lack of a qualified referring provider, the visit will become the patient's responsibility and therefore: you will be responsible for the full amount of the visit.
- That if your insurance company has not paid a claim within 45 days of submission, you are responsible for taking an active part in the recovery of that claim. After 90 days, you will be responsible for payment in full for any outstanding balance. That all patient accounts over 180 days past due without payment arrangements made may be turned over to our collection agency. You may be liable for all legal and collection fees.
- That patient will be charged a \$25.00 returned check fee, in addition to existing outstanding balance, should check be returned.
- That any patient who requires FMLA or Disability forms to be filled out, is aware the cost is \$25.00 per person per FMLA packet. It will take up to 10 business days for our providers to complete the paperwork. If you need expedited paperwork, (i.e., less than 10 business days) the cost is an additional \$25.00 per person per FMLA packet. All fees must be paid in advance.
- Copies of Medical Records are \$1.00/page for the first 25 pages, and \$0.25/page for every page thereafter.
- That our providers try to accommodate every patient, when you do not show up for an appointment or cancel without notice you take away from patient care. You will be charged \$50.00 per Office visit if you do not show up or do not give 24-hour notice. You will be charged \$150.00 per EMG/NCV visit if you do not show up or do not give 48- hour notice. You will be charged \$200.00 per Injection visit if you do not show up or do not give 48- hour notice. You will be charged \$250.00 per Kyphoplasty visit if you do not show up or do not give 48- hour notice. Any incurred No Show Fee must be paid prior to next scheduled appointment. No show fee can be paid upon check-in.
- That this office will not rely on the reports of other health care professionals in diagnosing or treatment; and that your insurance will be billed for this office conducting diagnosis. You may have a co-payment or co-insurance that is your responsibility and you may receive a bill for additional cost beyond what you have already paid.
- I understand there are financial obligations, along with surgical co-pay, our payment and cancellation policies prior to undergoing surgery with Brain and Spine Neuroscience Institute.
- **Patients are responsible to bring their imaging CD's to every appointment and take them back after each visit. BSNI will only hold CD's for 30 days, after that they will be discarded.**

I, \_\_\_\_\_, have read, understand, and agree to the above noted policies.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_



## **Surgical Copay and Cancellation Agreement**

It is very important to us that all our patients fully understand their financial obligations, along with our payment and cancellation policies prior to undergoing surgery with Brain and Spine Neuroscience Institute.

When you schedule surgery, we must reserve time in the operating room at the chosen facility. At these facilities, our physicians have secured operating room time, involving surgical nurses, technicians, and anesthesiologists to be available. Both facilities hold our physicians accountable if this time is not used. Furthermore, we must turn down every other patient who wants surgery on the day and the time we have reserved on your behalf.

The foregoing policy also holds for procedures done in our office: Based on both the financial and time commitments our physicians must make, we ask that you be definite about your desire for surgery, and certain you have the funds available before scheduling your surgery. The Surgical Deposit Agreement is outlined below. When you feel you understand the contents of this form, and agree to the terms, please sign, and date on the line indicated below.

### **I understand that:**

- Prior to scheduling surgery and reserving time in the operating room my health benefits will be verified. If I have a patient responsibility, that will be collected up front prior to scheduling. Once the surgical copay is collected, surgery will be scheduled.
- Cancellation fees are not covered by the insurance company, and I will be responsible for the charge.

### **Cancellation and Rescheduling Policy:**

- Cancellation at least 4 weeks prior to surgery date - Full Refund of copay.
- Cancellation less than 4 weeks prior to surgery date- Full Refund of copay and \$750.00 cancellation fee.
- All fees must be paid prior to confirming any new surgical date.
- Cancellation 2 days or less prior to surgery - Full refund of surgical copay and \$1,500 cancellation fee.
- Rescheduling your surgery more than once - Rescheduling Fee of \$300.

*There will be no funds held back in the event of rescheduling or cancellation by us, or in the event of a documentable medical reason with a treating doctor's statement. Any other reason will be at the operating physician's discretion.*

**I UNDERSTAND AND AGREE TO THE ABOVE TERMS Please sign and return. Thank you.**

PATIENT SIGNATURE: \_\_\_\_\_

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



## **NOTICE OF PRIVACY PRACTICES**

**Effective Date: January 1, 2026**

**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.**

Your health information is private, and no one without a legitimate need to know may have access to it. Brain and Spine Neuroscience Institute (“Practice”) is required by law to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. We safeguard information about your health and person. We collect information from you and store it in an electronic medical record. Charts are stored in a secure area and are available only to designated staff for designated reasons. In the unlikely event that your health information becomes unsecured, Practice will provide you with prompt notification.

Practice will not use or disclose your health information except as described in this Notice of Privacy Practices (“Notice”). This Notice applies to all of the medical records generated during your treatment at Practice.

### **EXAMPLES OF USE AND DISCLOSURES OF YOUR INFORMATION**

The following categories describe the ways that Practice may use and disclose your health information:

**Treatment:** Practice will use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your medical record information to your physician, consulting physician(s), nurses and other healthcare providers who have a legitimate need for such information in the care and continued treatment of the patient. For example, a healthcare provider treating you for an injury can ask another healthcare provider about your overall health condition.

**Payment:** Practice may release medical information about you for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. The information may be released to an insurance company, third-party payor or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record that are necessary for payment of your account. For example, we may give information about you to your health insurance plan so it will pay for your services.

**Routine Healthcare Operations:** Practice may use and disclose your medical information during routine health care operations to run our practice, improve your care, and contact you when necessary. For example, we can use your health information to manage your treatment and services.

**Business Associates:** Practice may use and disclose certain health information about you to its business associates. A business associate is an individual or entity under contract with Practice to perform or assist Practice in a function or activity that necessitates the use or disclosure of medical information. Examples of business associates include but are not limited to, a copy service used by the Clinic to copy medical records, consultants, independent contractors, accountants, lawyers, medical transcriptionists and third-party billing companies. Practice requires the business associate to protect the confidentiality of your medical information. In addition, Practice requires any subcontractor of Practice’s business associate to protect the confidentiality of your medical information.

**Regulatory Agencies:** Practice may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, billing practices may be audited by the State Auditor and records are subject to review by the Secretary of Health and Human Services and his/her authorized representatives.

**Workers’ Compensation:** Practice may release medical information about you for workers’ compensation or similar programs that provide benefits for work-related injuries or illnesses.

**Law Enforcement:** Practice may disclose your medical information for law enforcement purposes or with a law enforcement official.



**Military Veterans:** Practice may disclose your medical information as required by military command authorities if you are a member of the armed forces.

**Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement officer, Practice may release your medical information to the correctional institution or law enforcement official.

**Organ and Tissue Donation Requests:** Medical information can be shared with organ procurement organizations.

**Medical Examiner or Funeral Director:** Medical information can be shared with a coroner, medical examiner, or funeral director when an individual dies.

**Lawsuits and Legal Actions:** Practice may disclose your medical information in response to a court or administrative order, or in response to a subpoena.

**Required by Law:** Practice will disclose medical information about you when required to do so by law.

**Other Purposes:** We will not use or disclose your medical information for any purpose not listed without your specific written authorization. For example, we will not disclose your information for marketing purposes, sell your information, or share your psychotherapy notes (except in limited circumstances allowed by law) unless we receive a specific authorization from you. Any specific written authorization you provide may be revoked at any time by notifying us in writing. We will never share any substance abuse treatment records without your written authorization.

## **PATIENT INFORMATION RIGHTS**

Although all records concerning your treatment obtained at Practice are the property of Practice, you have the following rights concerning your medical information:

**Right to Confidential Communications:** You have the right to receive confidential communications of your medical information by alternative means or at alternative locations. For example, you may request that Practice contact you only at work or by mail.

**Right to Inspect and Copy:** You have the right to inspect and copy your medical information. We require your request to be in writing

**Right to Amend:** You have the right to amend your medical information. Any request for amendment should be submitted to Practice in writing, stating a reason in support of the amendment.

**Right to an Accounting:** You have the right to obtain an accounting of the disclosures of your medical information made during the preceding six (6) year period.

**Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of your medical information. Practice is not required to honor your request except where: (i) the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law, and (ii) the medical information pertains solely to a healthcare item or service for which you, or person other than the health plan on your behalf, has paid Practice in full.

**Right to Receive a Paper Copy:** You have the right to receive a paper copy of this Notice.

**Right to Receive Electronic Copies:** You have the right to receive electronic copies of your medical information.

**Right to Choose Someone to Act For You:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

**Right to Revoke Authorization:** You have the right to revoke your authorization to use or disclose your medical information, except to the extent that action has already been taken in reliance on your authorization. A request to exercise any of these rights must be submitted, in writing, to Practice at Brain and Spine Neuroscience Institute, 3519 Palm Harbor Blvd, Suite B, Palm Harbor, FL 34683, or by contacting Practice at 813-336-4461.

**FOR MORE INFORMATION OR TO REPORT A PROBLEM**

If you have questions and would like additional information, you may contact our office at 813-336-4461. If you believe your privacy rights have been violated, you may file a complaint (1) with us by contacting our Privacy Officer, at [info@brainandspineni.com](mailto:info@brainandspineni.com) or 813.336.4461 and (2) with the U.S. Department of Health and Human Services.

We will not retaliate against you for filing a complaint.

**CHANGES TO THIS NOTICE**

Practice can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

X \_\_\_\_\_ Date: \_\_\_\_\_  
Patient Name



## HIPAA PRIVACY POLICY PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers that are involved in my treatment)
- Obtaining payments from third-party payers (i.e. my insurance company)
- Conduct normal healthcare operations such as quality assessments and physician certifications.

**Patient initial** \_\_\_\_\_

You have informed me of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact the organization at any time to the address above to obtain a current copy of the Notice of Privacy Practices.

**Patient initial** \_\_\_\_\_

I understand that I have the right to request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**Patient initial** \_\_\_\_\_

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Witness: \_\_\_\_\_

### **Disclosure to Family Members and/or Friends**

**DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? Yes or NO (circle one)**

I give permission for my Protected Health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

**Patient initial** \_\_\_\_\_

| Name | Relationship | Contact Number |
|------|--------------|----------------|
|      |              |                |
|      |              |                |
|      |              |                |



## **Consent to Use AI Scribe during Medical Encounters**

Dear Patient,

We are committed to providing the best possible care for you, and as part of this commitment, we are continually looking for ways to enhance our services.

We would like to inform you about a new technology that we are using called AI Scribe. AI Scribe is an artificial intelligence (AI) tool that assists us during patient encounters by generating clinical notes based on our conversations. This tool allows us to focus more on you, the patient, and less on computer documentation.

### **What is AI Scribe?**

AI Scribe is a tool that listens, transcribes and records to the conversation between you and your provider during a medical consultation and generates a written summary or "note" based on that conversation. This note is then reviewed and approved by your provider.

### **How will this affect you?**

The AI tool does not interact with you directly. It merely listens to the conversation and creates a summary. This can allow the provider to focus more on the visit and less on taking notes.

### **Data Privacy and Confidentiality**

We want to assure you that your privacy is our utmost priority. The AI tool adheres strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secured and protected. Only the healthcare professionals involved in your care will have access to these notes.

### **Your Consent**

I agree to the use of AI Scribe during my consultations by signing and dating the form below. If you have any questions or concerns, please feel free to discuss them with us.

I, \_\_\_\_\_, consent to the use of AI Scribe during my medical encounters/appointments.

Signature: \_\_\_\_\_  
Patient Name

Date: \_\_\_\_\_



## Consent for Treatment and Payment Agreement

I \_\_\_\_\_ (name of patient), agree and consent to receive a neurosurgical evaluation and medical treatment provided by practitioners at the Brain and Spine Neuroscience Institute. Treatment includes but is not limited to the administration and performance of all treatments, surgical interventions, procedures, the administration of any needed anesthetics, the use of prescribed medications, the performance of such procedures as may be deemed as necessary or advisable in the treatment of the patient such as diagnostic procedures, the taking and utilization of cultures and of other medically necessary laboratory tests, all of which in the judgement of the attending physician or the assigned designee may be considered medically necessary or advisable.

**Patient initial** \_\_\_\_\_

Payment includes but is not limited to the authorization of payment directly to Brain and Spine Neuroscience Institute, LLC of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to the third- party entities or authorized persons to whom describes is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury/personal injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be absorbed electronically and made available through computer networks.

**Patient initial** \_\_\_\_\_

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### FOR MEDICARE PATIENTS ONLY MEDICARE PART B SIGNATURE AUTHORIZATION – LIFETIME

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organizations furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

**Patient initial** \_\_\_\_\_

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**IF THE PATIENT IS UNDER THE AGE OF EIGHTEEN OR UNABLE TO CONSENT TO TREATMENT,** I attest that I have legal custody of the above- named individual and am authorized to initiate and consent for treatment on the behalf of this individual.

Patient Name: \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

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*A Non-Disparagement or Protection of Reputation clause restricts individuals from taking any action that negatively impacts an organization, its reputation, products, services, management or employees.*

**Patient initial** \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## REQUEST FOR MEDICAL RECORDS RELEASE

|                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                     |                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| Patient Name:                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                     | DOB:                                                                                                                                    |
| Information Requested and Needed From (Requestee):<br>Name:<br>Address:<br>Phone:<br>Fax:                                                                                                                                                                                 |                                                                                                                                                                                                                                                                     | Recipient of Records (Requestor):                                                                                                       |
| <b>INFORMATION TO BE DISCLOSED:</b>                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                     |                                                                                                                                         |
| <b>Description:</b>                                                                                                                                                                                                                                                       | <b>Description:</b>                                                                                                                                                                                                                                                 | <b>Super Confidential Records:</b><br>Signature required by patient                                                                     |
| <input type="checkbox"/> Entire medical record (all info)<br><input type="checkbox"/> Physician Dictated Notes<br><input type="checkbox"/> Office Notes & Reports<br><input type="checkbox"/> Clinician office chart notes<br><input type="checkbox"/> Billing Statements | <input type="checkbox"/> Most recent one-year history<br><input type="checkbox"/> Records for continuity of care<br><input type="checkbox"/> Hospital Reports<br><input type="checkbox"/> Diagnostic Imaging reports<br><input type="checkbox"/> Laboratory Reports | _____ Alcohol and drug therapy notes<br>_____ Communicable Disease (HIV, TB)<br>_____ Psychotherapy Notes<br>_____ Other<br>_____ Other |
| <b>Purpose of Disclosure:</b>                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                     |                                                                                                                                         |
| <input type="checkbox"/> Ongoing medical care <input type="checkbox"/> Ongoing medical care <input type="checkbox"/> Other: _____<br><input type="checkbox"/> Patient's Request <input type="checkbox"/> Insurance                                                        |                                                                                                                                                                                                                                                                     |                                                                                                                                         |

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. Under Florida Law, fees for copying cannot exceed \$1.00 per page for the first 25 pages, and \$0.25 for each copy thereafter.

I understand that this consent shall be valid for a period of one year from the date of authorization and may be revoked at any time upon written notice to the Brain and Spine Neuroscience Institute, 3519 Palm Harbor Blvd, Suite B, Palm Harbor, FL 34683, Attn: Office Manager, except to the extent that the information has already been released in reliance upon this authorization.

I hereby hold harmless and release Brain and Spine Neuroscience Institute from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization. I understand that the confidentiality of this information may be protected by Federal Regulations (42CFR, Part II), prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated. I also understand that my refusal to sign this authorization will have no effect on the medical treatment I receive from Brain and Spine Neuroscience Institute.

|                                              |      |
|----------------------------------------------|------|
| Printed Name of Patient                      | Date |
| Signature of Patient or Legal Representative | Date |
| Witness Signature                            | Date |



**IF YOU ARE NOT BEING SEEN FOR AN AUTOMOBILE ACCIDENT,  
PERSONAL INJURY, PREMISES LIABILITY OR WORKERS  
COMPENSATION OR ANY OTHER CLAIM, PLEASE ACKNOWLEDGE  
THE BELOW.**

**My visit today is NOT for an automobile accident or workman's compensation and I have no open claims, including but not limited to auto, slip and fall, premises liability, personal injury, medical malpractice or any other claim. I want everything to be billed to my health insurance on file.**

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
Date

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**AUTO/ PERSONAL INJURY/ PREMISES LIABILITY/ATTORNEY/ WORKERS  
COMPENSATION/MEDICAL MALPRACTICE INFORMATION**

**Patient Information:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

(Circle one) Married/Single/Divorced Sex: M/F Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Address: \_\_\_\_\_ E-mail: \_\_\_\_\_  
(Street) (City/State/Zip)

Home Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Employer Address: \_\_\_\_\_  
(Street) (City/State/Zip)

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**Auto Information:** Insurance Company: \_\_\_\_\_ Policy Number \_\_\_\_\_

Claim Number: \_\_\_\_\_ Adjustor Name: \_\_\_\_\_ Adjustor Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

**Attorney Information:** Law Firm Name: \_\_\_\_\_ Attorney Name: \_\_\_\_\_

Paralegal Name: \_\_\_\_\_ Firm Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

**Workers Comp Information:** Insurance Company: \_\_\_\_\_ Policy Number \_\_\_\_\_

Claim Number: \_\_\_\_\_ Adjustor Name: \_\_\_\_\_ Adjustor Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Case Manager Name: \_\_\_\_\_ Case Manager Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

CONTINUE- PAGE 1 OF 2

### **IF YOU ARE BEING SEEN FOR AN AUTOMOBILE ACCIDENT**

**Florida** is a "No-Fault" car insurance state; therefore; it follows a "no-fault" practice when it comes to the payment of auto insurance claims after a car accident. In a "no-fault" state drivers are required to carry auto insurance that pays personal injury protection (PIP) benefits. Due to PIP laws BRAIN AND SPINE NEUROSCIENCE INSTITUTE will file your claim for the dates of service to the auto insurance you provide. If no auto insurance is provided you will be responsible for the full amount of your bill. If you would like your claim filed in another way you must notify BRAIN AND SPINE NEUROSCIENCE INSTITUTE in writing below. Select **ONLY ONE**:

- ☐ I DO NOT have auto insurance and I will be fully responsible for any charges incurred during treatment at BRAIN AND SPINE NEUROSCIENCE INSTITUTE
- ☐ I HAVE auto insurance as listed above and I DO NOT have an attorney. Once auto benefits are exhausted, I will be fully responsible for any charges incurred during treatment at BRAIN AND SPINE NEUROSCIENCE INSTITUTE
- ☐ I HAVE an attorney. I want all medical claims sent to them and NOT to any insurance.
- ☐ Please bill my auto until my auto benefits are exhausted and then bill my attorney

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### **IF YOU ARE BEING SEEN FOR WORKERS COMPENSATION**

**Workers compensation** is a form of insurance providing wage replacement and medical benefits to employees injured in the course of employment in exchange for mandatory relinquishment of the employee's rights to sue their employer for the tort of negligence. Cited: <http://www.myfloridacfo.com/division/wc/pdf/WC-System-Guide.pdf>

- ☐ I am being seen for an employment related injury and would like all medical claims filed to my workers compensation insurance

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PATIENT SIGNATURE

---

DATE

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WITNESS SIGNATURE

---

DATE