SPINE SPORTS & PAIN MEDICINE

1565 SAXON BOULEVARD
SUITE 204
DELTONA, FLORIDA 32725
PHONE: (386) 742-4343
FAX: (386) 742-1323

1979 LONGWOOD LAKE MARY RD
SUITE 1001
LONGWOOD, FLORIDA 32750
PHONE: (407) 878-5056
FAX: (407) 878-3929

NEW PATIENT PACKET

Thank you for choosing Spine Sports & Pain Medicine. Please complete the attached forms and return them together with **your prior medical records** to our office at least 1 week prior to your appointment. Please feel free to contact our office to confirm which prior medical records will be required prior to your initial appointment. You could either bring them to our office or fax them to our office at the following:

DELTONA
Spine Sports & Pain Medicine
1565 Saxon Blvd, Suite 204
Deltona, Florida 32725
Phone: 386-742-4343
Fax: 386-742-1323

LONGWOOD
Spine Sports & Pain Medicine
1979 Longwood Lake Mary Rd, Suite 1001
Longwood, FL 32750
Phone: 407-878-5056
Fax: 407-878-3929

PLEASE BE ADVISED THAT IF WE DO NOT RECEIVE THESE COMPLETED FORMS (unless other arrangements have been made) AND YOUR PRIOR MEDICAL RECORDS AT LEAST 24 HOURS BEFORE YOUR APPOINTMENT, WE **WILL NEED TO RESCHEDULE YOUR APPOINTMENT TO A LATER DATE.**

While completing the attached forms, please do not date any such form until you arrive in our office.

On the date of your appointment, please be sure to arrive **30 minutes prior to your appointment**. Also, please be sure to bring with you a valid photo identification and all of your insurance cards. For your convenience, you may also want to bring with you a completed medication list (with a list of all medications you are currently taking, the dosages of such medications and how you are taking such medications).

We do not accept any personal checks on your initial visit. Therefore, should you have any financial responsibility during you visit, please be sure to bring a debit card, credit card or cash. We accept all major debit and credit cards (except American Express).

Thank you and we look forward to meeting you.

The Physician and Staff at Spine Sports & Pain Medicine

SPINE SPORTS & PAIN MEDICINE

1565 SAXON BOULEVARD
SUITE 204
DELTONA, FLORIDA 32725
PHONE: (386) 742-4343
FAX: (386) 742-1323

1979 LONGWOOD LAKE MARY RD
SUITE 1001
LONGWOOD, FLORIDA 32750
PHONE: (407) 878-5056
FAX: (407) 878-3929

INITIAL HEALTH HISTORY

Name: ____ Date ____/____/______

Date of Birth: ____/_____/____

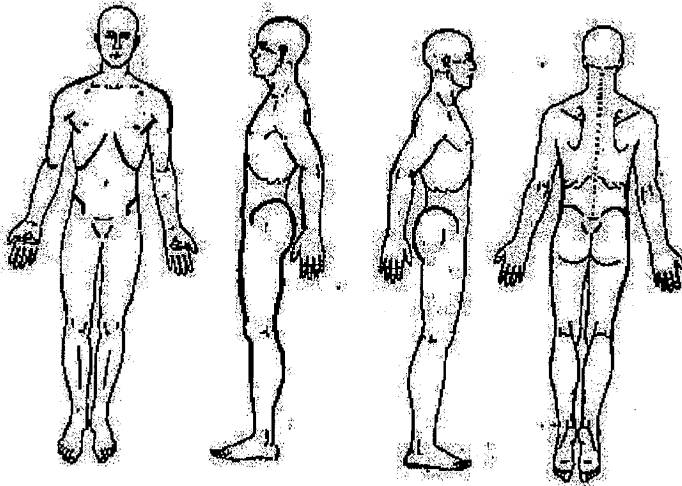
Please circle which applies: I am **LEFT / RIGHT** handed.

HISTORY OF PRESENT ILLNESS
Chief Complaint (Why are you here?):

____

____

PAIN LOCATION (please circle)



MEDICATIONS: What medications are you currently taking? What is the dosage of such medication? How are such medications prescribed? If you need more space, please provide a copy of your medication list.

____

____

____

Are you or might you be pregnant? ☐Yes ☐No

ALLERGIES: Check **ALL** that you are allergic to and side effect::

☐None ☐Demerol ____________ ☐Morphine ____________
☐Penicillin ____________ ☐Aspirin ____________
☐Sulfa ____________ ☐Codeine ____________
☐Other: ____

REVIEW OF SYSTEMS (Last six months) Please read carefully and circle where appropriate:

1. **General**

Recent weight change (up or down)   Chills   Fever

2. **HEENT**

Headache   Change in Vision   Ear Pain   Nose Bleed   Sinus Pain   Hoarseness

3. **Respiratory**

Shortness of breath   Wheezing   Asthma   Pneumonia

4. **Cardiovascular**

Shortness of breath with exercise   Shortness of breath on lying down   Hypertension
Chest Pain   Heart Palpitations

5. **Gastro Intestinal**

Vomiting blood   Heartburn   Blood in stool   Diarrhea   Constipation   Ulcer

6. **Urinary**

Kidney infection   Kidney stones   Difficulty urinating   Incontinence

7. **Skin**

Rash   Skin Cancer   Hives   Psoriasis

8. **Neurological**

Seizures   Frequent Falls   Dizziness   Weakness   Stroke   Head trauma   Tremors

9. **Psychiatric**

Depression   Anxiety   Psychiatric problems or hospitalization   Suicidal ideation   Homicidal ideation

10. **Musculoskeletal**

Arthritis   Joint Pain   Joint Stiffness   Joint Swelling   Rheumatism   Broken bones

11. **Hematology**

Anemia   Bleeding problems

PAST MEDICAL HISTORY:

☐High Blood Pressure ☐Heart Attack ☐Diabetes ☐Kidney Failure ☐Hepatitis ☐Cancer (Type) ☐High Cholesterol ☐Stroke ☐Thyroid ☐Other: ____________________

PAST SURGICAL HISTORY: Please include the year of such surgeries

☐Heart Bypass ____________ Date:____
☐Gallbladder ____________ Date:____
☐Neck Surgery (Type) ____________ Date:____
☐Back Surgery (Type) ____________ Date:____
☐Knee Surgery (Type) ____________ Date:____
☐Hip Surgery (Type) ____________ Date:____
☐Wrist Surgery (Type) ____________ Date:____
☐Shoulder Surgery (Type) ____________ Date:____
☐Ankle/Foot Surgery (Type) ____________ Date:____
☐Joint Replacement (Type) ____________ Date:____

☐Other:____________________

SOCIAL HISTORY:

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐ Other ________
Work Occupation: ____________ Employer Name:____________

Smoking History:

☐ current smoker   Pack(s) per day: ________   I have smoked for ____________ years
☐ former smoker   I have quit smoking ______ years ago
☐ never smoked

Alcoholic beverages? ☐Never   ☐Daily   ☐Social

FAMILY HISTORY (if relevant):

____
____
____

____
Patient's Signature

____
Date

SPINE SPORTS & PAIN MEDICINE

1565 SAXON BOULEVARD
SUITE 204
DELTONA, FLORIDA 32725
PHONE: (386) 742-4343
FAX: (386) 742-1323

1979 LONGWOOD LAKE MARY RD
SUITE 1001
LONGWOOD, FLORIDA 32750
PHONE: (407) 878-5056
FAX: (407) 878-3929

REGISTRATION

Date: ____________________ Home Phone: ____________________

Alternate Phone (Cell/Work): ____________________

Patient: ____

Last Name First Name Initial

Responsible Party (if a minor or health surrogate): ____________________

Street Address: ____

City: ____________ State: ________ Zip Code: ____________

Email Address: ____

Occupation ____________ Employer ____________

Birthdate: ___/___/______ Age: ______ Sex: ☐ M ☐ F

Social Security #: ____________

Marital Status (Circle One): Single Married Widowed Legally Separated Divorced

Preferred Language: ____________ Ethnicity: ____________

Race: ☐ American Indian ☐ Alaskan Native ☐ Asian ☐ Black or African American ☐ Black Hispanic or Latino ☐ White
☐ Native Hawaiian or other Pacific Islands ☐ White Hispanic or Latino

How did you learn of our practice? ____________________

Primary Physician: ____________________ Phone: ____________

MEDICAL INSURANCE:

Name of Primary Insurance ____________________

Name of Secondary Insurance (if any): ____________________

Responsible party under the medical insurance (primary insured)? ☐ Self ☐ Other If Other:

Name of Responsible Party: ____________ Relationship to Patient: ____________

Birthdate: ____________ Spouse's Social Security #: ____________

Please provide our office with a copy of your photo identification and all insurance cards (front and back)

Emergency Contact Information:

Name: ____________ Relationship: ____________ Phone Number: ____________

My Pharmacy is: ____________________ Telephone Number: ____________

SPINE SPORTS & PAIN MEDICINE

1565 SAXON BOULEVARD
SUITE 204
DELTONA, FLORIDA 32725
PHONE: (386) 742-4343
FAX: (386) 742-1323

1979 LONGWOOD LAKE MARY RD
SUITE 1001
LONGWOOD, FLORIDA 32750
PHONE: (407) 878-5056
FAX: (407) 878-3929

REGISTRATION (Page 2)

Name: ______________________________ DOB: ______________ Today's Date: _____________

ASSIGNMENT AND RELEASE

I, the undersigned have insurance coverage with ____

Name of Insurance Company

and assign directly to SSP Medicine, P.A. and/or SSP Medicine, Inc. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release any information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

____

Signature of Insured Date

MEDICARE AUTHORIZATION (Medicare only)

I request that payment of authorized Medicare benefits be made directly to me or on my behalf to SSP Medicine, P.A. and/or SSP Medicine, Inc. for any services furnished to me by that physician. I authorize any notes or medical information about me be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim if "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown in Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____

Beneficiary Signature Date

SPINE SPORTS & PAIN MEDICINE

1565 SAXON BOULEVARD
SUITE 204
DELTONA, FLORIDA 32725
PHONE: (386) 742-4343
FAX: (386) 742-1323

1979 LONGWOOD LAKE MARY RD
SUITE 1001
LONGWOOD, FLORIDA 32750
PHONE: (407) 878-5056
FAX: (407) 878-3929

PATIENT'S CONSENT

For Use and Disclosure of Protected Health Information to carry out Treatment, Payment, or Health Care Operations

____
Name of Patient

Dr. Alex Khromov and/or Dr. Kristeen Ortega
Name of Health Care Provider

I agree to allow the listed health care provider to use or disclose the protected health care information of the listed patient to carry out treatment, payment, or health care operations.

I have been informed of the existence of the Privacy Notice. The Notice is a more complete description of the uses and disclosures of protected health information that may be made, and of my rights with respect to protected health information.

- I understand that I have the right to review the Notice before signing this Consent.
- I understand that I have the right to request a copy of the Notice.
- I understand that the terms of the Notice may change, and that I have the right to request a revised copy of the Notice.

I understand that I have the right to request a restriction on how protected health information is used or disclosed to carry out treatment, payment, and health care operations. This request for restriction must be in writing. If the health care provider agrees to the restriction, the restriction is binding. However, the health care provider is not required to agree to a requested restriction.

I understand that I have the right to revoke this Consent at any time. This revocation must be in writing.

____
Signature of patient, legal guardian, or personal representative

____
Date

SPINE SPORTS & PAIN MEDICINE

1565 SAXON BOULEVARD
SUITE 204
DELTONA, FLORIDA 32725
PHONE: (386) 742-4343
FAX: (386) 742-1323

1979 LONGWOOD LAKE MARY RD
SUITE 1001
LONGWOOD, FLORIDA 32750
PHONE: (407) 878-5056
FAX: (407) 878-3929

PAIN MANAGEMENT GUIDELINES AND CONTRACT

Name ______________________________ Date of Birth ____________________________

I understand that compliance with the following guidelines is important to the continuation of pain treatment at Spine Sports & Pain Medicine. Breaking this pain contract will result in **discharge** from the practice.

1. I will take medications at the dose and frequency prescribed and will make my physician aware of any other medications that are to be taken.

2. I will comply with my scheduled appointments. I understand that if it becomes necessary to cancel or reschedule an appointment, I will give at least **24 hour** notice to Spine Sports & Pain Medicine at 386-742-4343 or 407-878-5056, as applicable. I also understand that if I do not keep an appointment and do not notify Spine Sports & Pain Medicine within 24 hours of such appointment, I will be responsible for a penalty of **$50.00**.

3. No pain medication will be refilled by phone. I understand that pain medication prescriptions will only be refilled at the scheduled clinic appointments.

4. I will NOT request controlled-substances or any other pain medicine from any physician other those at Spine Sports & Pain Medicine.

5. I do not have problems with substance abuse or dependence of any kind, and/or I have disclosed my prior history to Spine Sports & Pain Medicine.

6. I will consent to random urine and/or blood drug testing.

7. I certify that I am not pregnant and will take appropriate measures to prevent pregnancy during the course of treatment with opioids. In the case that pregnancy occurs I will notify my physician immediately.

8. I will protect my prescribed medications and/or prescriptions. NO lost or stolen medications or prescriptions will be replaced.

9. I will tell my physicians that I am receiving pain treatment and management from Dr. Alex Khromov and/or Dr. Kristeen Ortega at Spine Sports & Pain Medicine.

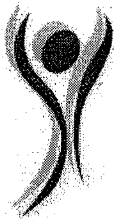
10. I agree to participate in psychiatric, psychological and/or substance abuse assessments/treatment, if deemed necessary by Spine Sports & Pain Medicine.

This agreement will be placed in my medical record. I understand that if I have any questions or concerns regarding my pain treatment that I will call my physician at (386)742-4343 and/or (407)878-5056, as applicable.

I have read and understand the above guidelines.

______________________________ ______________________________

Patient Signature Date Physician Date



SPINE SPORTS & PAIN MEDICINE

1565 SAXON BOULEVARD
SUITE 204
DELTONA, FLORIDA 32725
PHONE: (386) 742-4343
FAX: (386) 742-1323

1979 LONGWOOD LAKE MARY RD
SUITE 1001
LONGWOOD, FLORIDA 32750
PHONE: (407) 878-5056
FAX: (407) 878-3929

Financial and Payment Policy

In order for us to be able to continue to deliver high quality of care, it is necessary to describe our financial policies. PLEASE READ ALL OF THE FOLLOWING INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

All balances are due in full at the time all services are rendered. Typical charges may include any of the following: Evaluation/follow up charge (diagnosing and treating your problem), physical therapy charge, bracing charge, injections administration charge, medication charge for those medications used in injections, EMG/NCV administration charge and other procedures.

For those patients with health care insurance, the **balance** of the ***patient's responsibility*** is due and payable on the day of service. We will verify your insurance prior to, or on the day of your appointment and determine if your calendar year deductible has been met, in order to determine the patient's responsibility for services rendered. We will be happy to bill your insurance for their portion, but the patient responsibility portion is due and payable on the day of service.

Please present your insurance card(s) at each visit. It is your responsibility to provide us with the correct and up to date information so that we may submit charges to your insurance.

If you have a change of address, telephone number, employer, insurance companies (even if you have received a new card from the same insurance company), please notify the receptionist.

METHODS OF PAYMENT: We will collect your deductible, co-payment, coinsurance or charge for non-covered services at the time of your visit. If you have a balance after the insurance payment from a previous service, we will also collect (or send you an invoice for) that balance. Payment options include: *cash, check, credit card or debit card.*

INSURANCE FILING: If we are not a participating provider with your insurance, we will gladly file to your insurance, however, payment for services is due and payable at the time of your visit.

COLLECTIONS: If the balance of your account is not paid within 90 days, interest will apply unless further arrangements have been made. If your account is not paid in a timely manner, it may be referred to an outside collection agency. You will be responsible for any charges incurred by the collection agency.

PPO/HMO PATIENTS: If your plan requires an authorization to see a specialist, you will need to obtain that from your Primary Care Physician's office. It is not our responsibility to obtain retroactive referrals. If a referral is not obtained by the time of your visit, your appointment will need to be rescheduled. We will try our best to inform you if we are a participating provider with your insurance, however, it is your responsibility to verify if we are in/out of network.

Returned personal checks will be charged a **$30.00** finance charge.

Patient will receive a penalty fee of **$50.00** for any missed appointments that were not cancelled or rescheduled within **24 hours** prior to such appointment

If you have any questions regarding our financial policy, please do not hesitate to contact our Billing Department at (407) 295-9409 or speak to our receptionist.

I have read and agree to abide by the above financial policy.

______________________	______________	______________________
Signature of Patient/Guardian	Date	Print name of Patient/Guardian

SPINE SPORTS & PAIN MEDICINE

1565 SAXON BOULEVARD
SUITE 204
DELTONA, FLORIDA 32725
PHONE: (386) 742-4343
FAX: (386) 742-1323

1979 LONGWOOD LAKE MARY RD
SUITE 1001
LONGWOOD, FLORIDA 32750
PHONE: (407) 878-5056
FAX: (407) 878-3929

ELECTRONIC COMMUNICATION AUTHORIZATION

I, ______________________________ ("Patient"), DOB: _________________, hereby recognize that technology is ever-evolving and that electronic communications cannot be fully protected from unauthorized interception. Understanding the risks of electronic communication via e-mail or text messaging, I hereby indicate my preferences and consent for the following communications methods:

I hereby give my consent for appointment reminders, balance reminders and other communication via **e-mail** _____ yes _____ no using the following email address: ____________________________________.

I hereby give my consent for appointment reminders, balance reminders and other communication via **text message** _____ yes _____ no to the following cell phone number: ___________________________.

I understand that I have the right to revoke this authorization in writing at any time.

____
(Signature of Patient/Patient's Representative)

____
(Date)

____
(Print Name)

____
Relationship to Patient

PLEASE COMPLETE ONE FOR EACH PERSON WITH WHOM YOU WOULD LIKE US TO SHARE YOUR MEDICAL INFORMATION AND/OR YOUR TREATMENT PLANS, INCLUDING CAREGIVERS, SPOUSES AND EMERGENCY CONTACTS.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ______________________ ("Patient"), DOB: __________________, hereby authorize Spine Sports & Pain Medicine, Dr. Alex Khromov and/or Dr. Kristeen Ortega and its staff ("Provider) to use or disclosure Protected Health Information in the following manner:

__X__ Release to and discuss with

Name: ______________________________________
Relationship: _________________________________
Telephone Number: ____________________________

The following Protected Health Information: any and all medical information of any nature whatsoever which is maintained by you in your records, including notes, treatment plans and imaging reports and diagnosis and any other information with respect to the Patient.

The Protected Health Information is being used or disclosed for the following purpose (s): For **Dr. Khromov's and/or Dr. Kristeen Ortega's use in medical services**.

This authorization is in full force and effect for **so long as Patient remains a patient of SSP Medicine, Inc.** from the date hereof at which time, this authorization to used or disclose Protected Health Information expires.

I understand that I have the right to revoke this authorization in writing by sending notification to Provider.

I understand that when I revoke this authorization, it is not effective to the extent that Provider has already relied on the use or disclosure of the Protected Health Information.

I also understand Protected Health Information released prior to this authorization may be re-disclosed by party who received that information and may no longer be protected by federal or state law.

Provider will not condition my treatment or payment on whether I provide an authorization for the requested use or disclosure.

I understand I have the following rights:

__X__ to inspect or copy the Protected Health Information to be used or disclosed.
__X__ to refuse to sign this authorization

____ ________________________
(Signature of Patient/Patient's Representative) (Date)

________________________________ ________________________
(Print Name) Relationship to Patient

A Photocopy of This Release Shall be Deemed as Effective as the Original

PLEASE COMPLETE AND FORWARD TO YOUR CURRENT DOCTOR (ONE PER DOCTOR) SO THAT YOUR CURRENT DOCTOR COULD SEND US RECORDS PRIOR TO YOUR APPOINTMENT.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ______________________________ ("Patient"), DOB: ________________, hereby authorize Current Doctor: ____ ("Provider) to use or disclosure Protected Health Information in the following manner:

__X__ Release to

Spine Sports & Pain Medicine
1565 Saxon Blvd, Suite 204
Deltona, Florida 32725
Phone: 386-742-4343
Fax: 386-742-1323

Spine Sports & Pain Medicine
1979 Longwood Lake Mary Rd, Suite 1001
Longwood, FL 32750
Phone: 407-878-5056
Fax: 407-878-3929

The following Protected Health Information: the last three (3) medical notes, all radiology reports EMG/NCV reports and/or other imaging or studies regarding the referenced patient.

The Protected Health Information is being used or disclosed for the following purpose (s): For **Dr. Khromov's and/or Dr. Kristeen Ortega's use in medical services**.

This authorization is in full force and effect for **so long as Patient remains a patient of SSP Medicine, Inc.** from the date hereof at which time, this authorization to used or disclose Protected Health Information expires.

I understand that I have the right to revoke this authorization in writing by sending notification to Provider.

I understand that when I revoke this authorization, it is not effective to the extent that Provider has already relied on the use or disclosure of the Protected Health Information.

I also understand Protected Health Information released prior to this authorization may be re-disclosed by party who received that information and may no longer be protected by federal or state law.

Provider will not condition my treatment or payment on whether I provide an authorization for the requested use or disclosure.

I understand I have the following rights:

__X__ to inspect or copy the Protected Health Information to be used or disclosed.
__X__ to refuse to sign this authorization

______________________________ (Signature of Patient/Patient's Representative)

______________________________ (Date)

______________________________ (Print Name)

______________________________ Relationship to Patient

A Photocopy of This Release Shall be Deemed as Effective as the Original