Vero Neurospine

1040 37th Place, Suite 101, Vero Beach, FL 32960, (772)205-3345 (phone), (772)205-3346 (fax)

REGISTRATION FORM

(Please Print)

Today's date:				PCP:		
PATIENT INFORMATION						
Patient's last name: First: Middle			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:		Home phone no.: ( )		
P.O. box:	City:		State:	ZIP Code:		
Occupation:	Employer:			Employer phone no.: ( )		
Did a physician refer you to us? Name: _____ How did you hear about us: (please check one box): ❑ Family ❑ Friend ❑ Close to home/work ❑ Website ❑ Other _____						

INSURANCE INFORMATION					
(Please give your insurance card and driver's license to the receptionist.)					
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ( )	
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:		Employer phone no.: ( )	
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance ❑ Medicare ❑ BCBS ❑ Cigna ❑ Aetna ❑ _____ ❑ ❑ ❑ ❑ ❑ Other					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Vero Neurospine** or insurance company to release any information required to process my claims. *Patient/Guardian signature*		*Date*	

Patient Name:_____ D.O.B._____

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COMMUNICATION OF MEDICAL INFORMATION

NAME: _____ DATE OF BIRTH_____

RELEASE OF MEDICAL INFORMATION

BY SIGNING BELOW, I AUTHORIZE VERO NEUROSPINE TO DISCLOSE MY RELEVANT MEDICAL AND BILLING INFORMATION TO:

NAME	RELATIONSHIP	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT SIGNATURE _____ DATE _____

We ask that if you have any changes in this request, that you please inform the receptionist.

REQUEST FOR ELECTRONIC COMMUNICATIONS

I request that the following communications from the practice be delivered to me by the electronic means selected. I understand that this form of communication may not be secure, creating a risk of improper disclosure to unauthorized individuals.

TYPE OF COMMUNICATION:

_____Appointment reminders _____Surgical scheduling _____Other_____

METHOD

_____Email Preferred Email Address: _____

_____Text Number: _____

_____Phone Number: _____

My signature below is an agreement that I am willing to accept that risk that personal health information could be received by unauthorized individuals through requested electronic means of communication and will not hold Vero Neurospine responsible should such incident occur.

PATIENT SIGNATURE _____ DATE _____

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HEALTH INFORMATION

DATE: _____

PATIENT NAME: _____DATE OF BIRTH_____

ALLERGIES: _____

PHARMACY: _____PHARMACY PHONE: _____

PHARMACY ADDRESS: _____

What is the reason for your visit today: _____

Past Medical History (Include all medical problems and/or surgeries)

_____
_____
_____
_____
_____

Medication and Dosages (include over the counter and those that you take occasionally as needed)

_____
_____
_____
_____
_____

Social History
Tobacco Use: Current smoker: _____, PPD_____, How many years; _____
Former smoker: _____, PPD_____ How many years: _____ When did you quit_____
Alcohol Use: _____, Type of beverage: _____: Frequency: _____ Average per day: ____

Pets in the home: _____ How many: _____ Type: _____

Family History (Parents and siblings – Please indicate ages, whether living or deceased and any significant health problems.)

_____
_____
_____
_____

Please list other physicians you are currently seeing and why (e.g. Cardiologist, Neurologist)
Name: _____ Specialty: _____ Reason: _____
Name: _____ Specialty: _____ Reason: _____
Name: _____ Specialty: _____ Reason: _____

PATIENT SIGNATURE_____ DATE: _____

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REVIEW OF SYSTEMS

PATIENT NAME: _____ DATE: _____

GENITOURINARY	**YES**	**NO**			**YES**	**NO**
Incontinence				Freq. Urination		
Blood in Urine				Painful Urination		
MUSCULOSKELETAL	**YES**	**NO**			**YES**	**NO**
Joint Disease				Osteoporosis		
Back Pain				Neck Pain		
Osteoarthritis				Muscle Weakness		
SKIN	**YES**	**NO**			**YES**	**NO**
Skin Cancer				Skin Rashes		
Changes in moles				Change in Skin		
NEUROLOGIC	**YES**	**NO**			**YES**	**NO**
Seizures				Weakness		
Numbness				Migraines		
CVA/TIA				Lightheaded		
HEMATOLOGIC	**YES**	**NO**			**YES**	**NO**
Anemia				Bruise easily		
Fever/Chills				Excess Bleeding		
WOMEN ONLY	**YES**	**NO**			**YES**	**NO**
Hysterectomy				Nipple Discharge		
Breast Lumps				Irregular Menses		
MEN ONLY	**YES**	**NO**			**YES**	**NO**
Prostate trouble				Dribbling urine		
Slow urination				Nighttime urination		
Burning urination						
ALLERGERY/IMMUNOLOGY	**YES**	**NO**			**YES**	**NO**
Allergies				Catch cold easily		
Hay Fever				Enlarged Nodes		
HIV/AIDS						
OTHER						

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DESCRIPTION OF YOUR PAIN

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

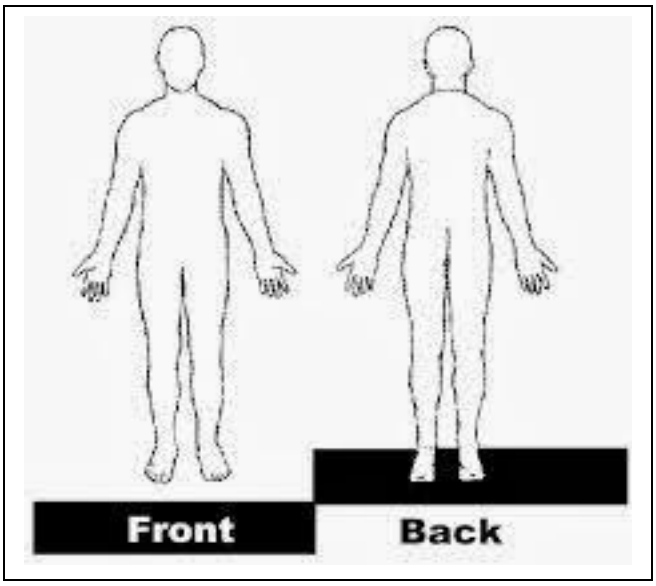
Please mark which of these words describes your pain.

Throbbing	
Shooting	
Stabbing	
Sharp	
Cramping/ Gnawing	
Hot- Burning	
Aching	
Heavy	
Tender	
Splitting	
Tiring – Exhausting	
Sickening	
Fearful	
Punishing- Cruel	

Please put a mark in the box to show how bad your usual pain has been recently.

NO PAIN	1	2	3	4	5	6	7	8	9	10	WORST PAIN

Please mark areas of pain on the figures below.



VERO NEUROSPINE
NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and are dedicated to maintaining confidentiality.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- Required by Law: We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used or disclosed require an authorization from you: use or disclosure for marketing and disclosures or uses that constitute a sale of protected health information. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. Other uses and disclosures not described in this notice will be made only with your written authorization, which you may revoke going forward in writing.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records. Your request must be in writing. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you, or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.
- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item or for health operations, if you have paid for the item or service in full out of pocket, and if the restriction is not otherwise forbidden

by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.

- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing and may be revoked in writing and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper. The copy may be provided electronically with your permission.

If you have any questions about our privacy practices, please contact our Privacy Officer at the phone number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer
Vero Neurospine
(772) 205-3345
Phone number: _____

Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective

DECEMBER 5, 2017.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand Vero Neurospine's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change it's Notice of Privacy Practices from time to time and that I may contact this office at any time to obtain a current copy of the Notice of Privacy Practices. I understand that if requested, a complete copy of Notice of Privacy Practices will be provided.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

PRACTICE USE ONLY
I attempted to obtain the patient's signature in acknowledgement of the Notice of Private Practices Acknowledgment but was unable to do so as documented below:

Date: _____Initials: _____ Reason: _____

FINANCIAL POLICIES

Thank you for choosing Vero Neurospine for your neurosurgical care. We appreciate that you have entrusted us with your healthcare needs. We are committed to providing you the best patient care.

Healthcare benefits and coverage options have become increasingly complex, so we have developed this financial policy to help you understand your responsibilities as a patient. We will do our best to assist you with understanding your proposed treatment and in answering questions related to submitting your insurance claim for reimbursement.

Your health insurance policy is a contract between you and your health insurance company. Please note that it is your responsibility to know if your insurance requires referrals, pre-certifications, pre-authorizations, limits on outpatient charges, and any requirements for specific physicians, labs and /or hospitals to use. You should be knowledgeable of any deductibles, co-payments, and/or co-insurance or other out - of - pocket expenses for your care.

If you are uncertain about your current health insurance policy benefits you should contact your plan administrator to learn the details about your benefits.

INSURANCE COVERAGE
Please provide us with your current insurance plan information at the time of *each* visit and notify us of any changes. We will request a copy of your insurance card to copy or scan and keep on file for our records. Please be aware of and provide required referrals or authorizations prior to your appointment. If this information is not available, you will be responsible for the cost of the care.

Our doctor belongs to different insurance plans. At times, our doctor is "out of network", in this case you will be billed for the services provided. Full payment will be required at the time of service for routine visits. After your appointment, we will submit a claim to your insurance for services performed. Depending on your plan, payment may be sent directly to you. If you receive this payment, please forward it to *Vero Neurospine*.

ADDRESS CHANGE
It is important that *Vero Neurospine* has your current address information on file (that is consistent with your insurance contract). Please advise us if there is any change to your address, telephone or other contact information.

COPAYMENTS/CO-INSURANCES/DEDUCTIBLES
You are expected to pay your co-payment and any co-insurance and/or deductible amounts, if known, at the time of service.

PAYMENT
Payment is due at the time services are provided or upon receipt of a statement from our billing office. We accept payment in the form of cash, check, money order or credit card (American Express, MasterCard, Visa). Returned checks are subject to a fee of $25. We do not accept traveler's checks.

NON-MEDICAL FEES

Additional fees may apply to the following: Returned checks, Copying of medical records, Completion of disability or other forms.

FAILURE TO PAY
If you do not pay your bill, your account may be sent to an outside collection agency. If your account is sent to a collection agency, you will need to contact them directly to settle your balances.

POLICY AND FEE CHANGES
These policy and fees are subject to change. We will keep you informed of any modifications. We realize that medical care is an unexpected expense. If you have any concerns about your ability to pay, you can contact us for help in managing your account. If you have questions about these policies, please contact our billing office at (772) 205-3345.

REFUNDS
A refund is issued when an overpayment has been identified. If you feel a refund is due, please contact our billing office at (772) 205-3345.

MISSED APPOINTMENTS
As a courtesy to other patients and our physician, please provide 24- hour advance notice if you are unable to keep your appointment.

ACKNOWLEDGEMENT AND AGREEMENT
I HAVE RECEIVED, READ, AND UNDERSTAND THE VERO NEUROSPINE FINANCIAL POLICIES. I AGREE TO THE FINANCIAL POLICIES.

_____ _____
PATIENT NAME DATE

_____
SIGNATURE

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DISCLOSURE OF FINANCIAL INTEREST
Pursuant to F.S. §§ 456.02 & 456.053

Florida law requires physicians and other health care providers to make certain disclosures to a patient when they refer a patient to another health care provider or facility in which the physician has a significant financial interest.

Dr. Michael Munz has a financial interest in Grove Place Surgery Center.

This interest means that Dr. Munz can better control the surgical environment, equipment, and staff and offer greater convenience for you as the patient. However, you do have a right to select another surgical center, including but not limited to the three options listed below.

(1) Indian River Medical Center
1000 36th Street, Vero Beach, FL 32960
(772)567-4311

(2) Advanced Center for Surgery
1355 37th Street, Ste 304
Vero Beach, FL 32960

(3) Sebastian River Medical Center
13695 US Highway A
Sebastian, FL 32968

PATIENT ACKNOWLEDGMENT

I, or my legal representative, hereby acknowledge receipt, on the date indicated and prior to the described referral, of a copy of the foregoing Disclosure of Financial Interest.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date