Patient Questionnaire and HIPAA Acknowledgement

Patient Name: _____ Date: _____

Home Tel. (___)_____ Work Tel. (___)_____ Cell Tel. (___)_____

May we contact you at home? **Yes / No** May we contact you at work? **Yes / No**
May we contact you on your cell phone? **Yes / No**

If there is a phone message system may we leave a message for you at any of the contact numbers you have provided? **Yes / No**

Comment:_____

Can a message be left with our company name and what the call is in reference to? **Yes / No**

Is there anyone we can leave a message with? **Yes / No** (If yes, please list first and last names as well as contact numbers)

_____ _____

_____ _____

_____ _____

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm or change appointments only. **Yes / No** (If yes, please list first and last names as well as contact number)

_____ _____

_____ _____
Patient Signature Date

Is there anyone you would like to designate as your personal representative that we may discuss your procedure, course of treatment and status. **Yes/No** (if yes, please list first and last name as well as contact numbers)

_____ _____

_____ _____
Patient Signature Date

_____ has provided me with a copy of my rights as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction.

_____ _____
Patient Signature Date

_____
Witness

Name:_____ **Age:** _____ **DOB:** ____/____/____ **Today's Date:** ____/____/____

PrimaryMD:_____ **Referring MD:** _____

Please list your symptoms / reason for visit

1._____

2._____

3._____

Pain level (on average)

0 1 2 3 4 5 6 7 8 9 10

Pain level (most severe)

0 1 2 3 4 5 6 7 8 9 10

How long have your symptoms been functionally limiting? (Please circle)

week(s) | month(s) | year(s)

Are your symptoms injury related? Yes | No

Date:_____

Past Medical history

1.

2.

3.

Past Surgical history

1.

2.

3.

4.

5.

Allergies (Circle) Tape || Iodine || Latex || Contrast Dye

Medication Allergies (list):

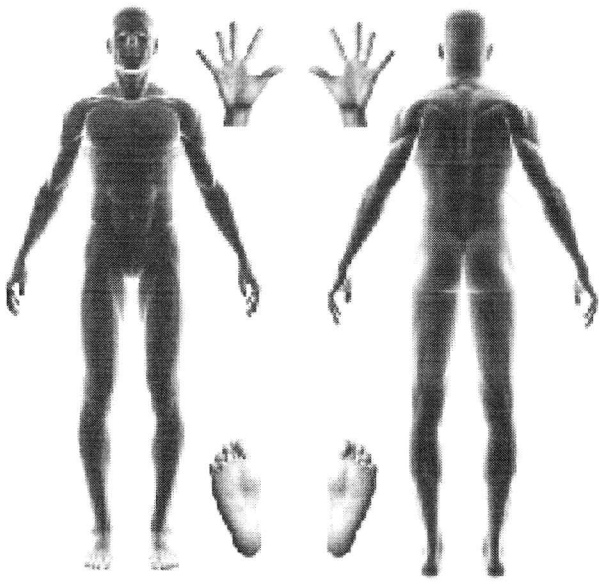
Are you currently **pregnant**? Yes || No

Do you have a **bleeding disorder**? Yes || No

Explain: _____

Are you on a **blood thinning medication**? Yes || No

PATIENT INITIALS _____



Please locate where your pain is on the diagram

Have you performed physical therapy, chiropractic care, or had acupuncture in the last 12 months	Please list the dates: ie. from Jan. 2018 to March 2018 _____ _____
Past Therapies tried (Circle)	Massage TENS Unit Psychology Physical therapy Acupuncture Chiropractor
Have you had a diagnostic studies in the past two years?	MRI CT EMG/NCS (Needle testing of muscle) Discogram

Previous Interventions **(Circle)**

Epidural Steroid Injections Facet Block/Injection Radiofrequency Ablation Knee Injections Shoulder Injections
Spinal Cord Stimulator Trial / Implant Trigger Point Injections
Other :

Current Medications. Include Dose (mg) and # per day	6.
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.

Circle all medications that you've tried in the past

Ibuprofen	**Tylenol**	**Nortriptyline**	**Amitriptyline**	**Gabapentin**	**Lyrica**	**Flexeril**	**Butrans**
Robaxin	**Zanaflex**	**Skelaxin**	**Hydrocodone**	**Oxycodone**	**Oxycontin**	**Morphine**	**Tramadol**
MS Contin	**Methadone**	**Dilaudid**	**Suboxone**	**Nucynta**	**Fentanyl**	**Opana**	

PATIENT INITIALS _____

Are you currently working? YES || NO Occupation:_____
If no, reason for not working _____

Marital Status: Single Married Separated Divorced Widowed

Do you have children? YES || NO # of children: _____

Social Habits

Smoking: Yes || No _____ packs/day

Alcohol: Yes || No _____ drinks/day

Marijuana: Yes || No

Do you have a history **Addiction/Dependency:** Yes || No

Do you have a Family History positive for?	Please check
Lung Disease	
Diabetes	
Drug Addiction	
Cancer	
Stroke / Bleeding disorders	

SCREEN AND OPIOID ASSESSMENT FOR PATIENTS WITH PAIN—REVISED (SOAPP®-R)

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in the home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					

Patient Signature _____

Date _____

PATIENT INITIALS _____

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers

OPIOID RISK TOOL (ORT)

(Office Use Only)	YES	NO		
Does anyone in your FAMILY have a history of substance abuse?				
• Alcohol			1	3
• Illegal Drugs			2	3
• Prescription Drugs			4	4
Do YOU have a history of substance abuse?				
• Alcohol			3	3
• Illegal Drugs			4	4
• Prescription Drugs			5	5
Do you have a history of pre-adolescent sexual abuse? (Age 5-12)			3	0
Do you have one of the following?				
• Attention Deficit, Obsessive Compulsive, Bipolar, Schizophrenia			2	2
• Depression			1	1

Patient Signature _____

Date _____

PATIENT INITIALS _____

Patient: **MANA** SPINE REVIEW OF SYSTEMS

GENERAL WELL-BEING:
❑ Weight Loss ❑ Weight Gain ❑ Fever / Chills
❑Fatigue ❑ loss of appetite

LYMPH:
❑ Bleed Easily ❑ Bruise Easily ❑ Enlarged Lymph Nodes

NEUROLOGICAL:
❑ Dizziness ❑ Headache
❑ Tremors ❑ Numbness / Loss of sensation
❑ Weakness ❑ Memory Problems / Confusion

CARDIOVASCULAR:
❑ Shortness of Breath ❑ Chest Pain
❑ Palpitations ❑ Swelling

RESPIRATORY:
❑ Coughing ❑ Coughing up Blood ❑ Wheezing

EARS, NOSE, THROAT, MOUTH:
❑ Ulcers ❑ Sinus Problems ❑ Hearing Problems
❑ Ringing in the Ears ❑ Difficulty Swallowing ❑ Sore Throat

EYES:
❑ Vision Changes ❑ Contacts / Glasses
❑ Excessive Tearing / Eye Discharge

MUSCULOSKELETAL:
❑ Stiffness / limited motion ❑ Muscle Pain ❑ Back pain

GASTROINTESTIONAL:
❑ Diarrhea ❑ Constipation
❑ Nausea / Vomiting ❑ Bloody Stools
❑ Pain with bowel movement ❑ Abdominal Pain

URINARY / GYNECOLOGIC:
❑ Blood in Urine ❑ Painful Urination ❑ Urgency or Frequency

PSYCHOLOGICAL:
❑ Depression ❑ Severe Mood Swings ❑ Anxiety
❑ Confusion ❑ Severe Agitation

ENDOCRINE:
❑Excessive thirst ❑ heat or cold intolerance ❑ unexplained bone fractures

OTHER:_____

_____

MANA SPINE

Prescription, Personal Information, and Billing Release Authorization

I, _____, give permission for the following person(s) to pick up prescriptions and or any of my personal health information, to include super sensitive information on my behalf. I understand that no prescriptions will be released other than to the person(s) listed below. Please Note – Person(s) listed below will be required to present driver's license or other state/ federally issued photo ID when picking up prescriptions, billing information, and/or any personal health information.

1. Name: _____
   Relationship: _____
   Phone number: _____

2. Name: _____
   Relationship: _____
   Phone number: _____

3. Name: _____
   Relationship: _____
   Phone number: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Mana Spine where my information is maintained. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that the information in my record may include sensitive information about behavioral or mental health services, treatment for alcohol and/or drug abuse. It may also contain information related to sexually transmitted disease, Acquired Immuno-Deficiency Syndrome (AIDS), and infection with Human Immunodeficiency Virus (HIV). I understand that any disclosure of this information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules. _____ (patient initials)

_____ Please print name

_____ Relationship to patient

_____ Signature

_____ Date

AUTHORIZATION FOR RELEASE OF RECORDS

Patient Authorization for Use and Disclosure of Protected Health Information
Mana Spine takes your privacy seriously. We will not disclose your medical records (protected health information) to any party without your signed consent, except as stipulated in our Notice of Privacy Practices. This form authorizes Mana Spine to release your medical records to parties indicated. This Authorization will expire six months from the date signed. I hereby authorize Mana Spine to transfer, release or obtain information on:

Name of patient : _____

Date of Birth: _____

Social Security Number: _____-_____-_____

Obtain From:	**Send or Fax to:**
_____	_____
Physician / Institute	Physician / Institute
_____	_____
Address	Address
_____	_____
City, State, Zip	City, State, Zip
_____ Phone _____ Fax	_____ Phone _____ Fax

Please Check Specific Information Requested
Date(s) of Treatment: All dates [ ] Or Specific Dates: _____ thru _____
[ ] All Medical Records
[ ] The most recent 2 years of pertinent information (Chart notes, labs, x-rays, and special test)
[ ] Specific information (please specify): _____

Purpose for which the disclosure is being made
(check one)
[ ] Attorney [ ] Insurance [ ] Doctor [ ] Personal

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Mana Spine where my information is maintained. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that the information in my record may include sensitive information about behavioral or mental health services, treatment for alcohol and/or drug abuse. It may also contain information related to sexually transmitted disease, Acquired Immuno-Deficiency Syndrome (AIDS), and infection with Human Immunodeficiency Virus (HIV). I understand that any disclosure of this information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

_____ (patient initials)

Relationship to patient: (check one)

_____ [ ] Self [ ] Legal Guardian [ ] Power of attorney Print name of signer

_____ _____

Signature Date

I **decline** opioid therapy as part of my care plan, including after procedures.
Please sign and date below.

_____ _____ / /

signature print date

If opioid therapy is part of your care plan at any point in time, the following agreement is mandatory. ***As part of practice protocol, MANA SPINE does not prescribe over 60mg of Oral morphine equivalence (OME) per day (24hr) for chronic non-malignant pain.***

Opiate Agreement

I, _____, am requesting treatment with opiate pain medication(s) because other therapies, treatments, and/or medication(s) that I have previously received and had not provided me with adequate relief of pain. I understand:
- That it is unlikely that any medication(s) will completely remove or eliminate my pain.
- Opiate pain medication(s) will be prescribed for me for humane reasons as long as my pain continues at the present level or intensity, provided that I follow all terms of this agreement.

My provider has discussed potential long-term opiate therapy with me in detail and I understand some of the possible complications that may occur are:
- Chemical/Physical dependence and addiction
- Severe constipation which could require medical treatment difficulty with urination
- Drowsiness
- Nausea, itching
- Slowed breathing or respirations, potential for coma
- Reduced or absent sexual desire and/or function
- Organ damage, failure; or death

I further understand that if I take all my medication(s) sooner than prescribed or if I suddenly stop taking my medication(s), that I could have opiate withdrawal symptoms that can be painful and life threatening.

Female patients only: I understand that there are both known and unknown risks/ hazards to an unborn infant if the mother takes opiate medication(s). The risks/hazards include but are not limited to opiate addiction of the infant with opiate withdrawal after birth. I assume full responsibility for notifying my provider if I suspect or confirm that I am pregnant. I further understand that a different plan of treatment, without the use of opiates, will be tried during pregnancy.

Patient Initials:_____ Date: / /

Terms/Agreements

- I agree to receive opiate medication prescriptions ONLY from the providers at Mana Spine
- In order to obtain a refill for opiate medication(s), I understand that an appointment must be scheduled with the provider. I further understand that it is my responsibility to sure that I have enough medication to last through the weekend, holiday and/or after hours (5pm- 8 am).
- I understand Mana Spine does not accept telephone requests for opiate prescriptions and I must be seen at my regularly scheduled appointment with the provider to receive an opiate prescription.
- I will inform Mana Spine if I change my primary care provider
- I hereby authorize a release of information that allows the providers(s) and/or staff to communicate and collaborate with any other health care provider in my care.
- I will notify Mana Spine immediately if I experience medication side effects.
- I understand that if a serious issue effect occurs after hours, on a holiday or during the weekend, that I should immediately seek Emergency assistance from the nearest hospital.
- Prescription dosage(s) have been thoroughly explained to me by my provider and I understand that I SHALL NOT change dosage amounts and/or alter the time schedule of the prescribed medication(s) without directions to do so by my provider.
- I understand that opiate medications(s) should be kept in a safe place at all times and that I am responsible for the security of my medication. It has been thoroughly explained to me that the policy does not allow for replacement of misplaced, spilled, inaccessible, or lost opiate medication(s) or prescription (s).
- I understand that if my medication(s) or prescriptions(s) are stolen that I must deliver a police report to my provider and they will contact the police for verification of the report. A second event such as above may lead to termination of this Agreement.
- I understand the benefits of opiate medications will be evaluated regularly using the following criteria: Increase in general level of functioning, increase in life activities, decrease in the intensity of pain, absence of unacceptable or intolerable adverse side effects.
- I agree to participate in pain related psychological testing as deemed appropriate by my provider and/or the team of health care provider(s).
- I agree to submit a random urine and or/blood screens for other medications and drugs.

Patient Initials:_____ Date: / /

- I have been given information about the use of opiate medication, including possible risks| and adverse side effects such as the development of tolerance, dependence, addiction, and withdrawal and after thoroughly reviewing the information; I believe the benefits will be greater than the risks.

- I will not hoard or alter opiate prescription.

- I will not drink alcohol within 24-48 hours of taking opiate medication(s).

- I agree to allow Pharmacies to contact Mana Spine to discuss my medications and understand prior authorizations required by my insurance may delay medication use

Opiate Treatment Monitoring:

During this period, I understand that I might have my opiate medication discontinued at any time for any reason, per a decision by my provider and the health care team. Upon notification of such discontinuance, I will be provided with a 30 day supply of appropriate medication(s). I further understand that during this period, I might be referred to an addiction specialist or to a drug detoxification program. In addition, I also realize that I might be immediately referred to an inpatient drug detoxification program and NO further medication will be provided. I attest to the following (initial below):

_____ I am not using illegal drugs or prescription drugs prescribed for someone other than myself.

_____ I (am/am not) not undergoing treatment for substance (drugs or alcohol) dependence or abuse.

_____ I have never been involved in the sale, illegal possession, or transport of drugs.

(Female only) I am not pregnant and I will inform the medical staff at Mana Spine if I become pregnant or intend to become pregnant. I understand there may be harmful effects on an unborn infant if I take opiate medication(s).

_____ An opiate information form was provided.

_____ I have read or had it read to me

_____ I understand the possible side effects and complications of opiate therapy.

Release

I release my provider, the team of health care providers, the team of health care providers, and Mana Spine from liability for any medical and social conditions or consequences related to opiate medication(s) therapy and/or discontinuance of opiate medication(s).

Patient Initials:_____ Date: / /

Acknowledgement/Agreement

I hereby acknowledge that the content of this agreement has been explained to me. In addition, I have either read the agreement or had it read to me. I was offered many opportunities to ask questions and discuss any unclear aspects of this Agreement.

I acknowledge that I fully understand that my failure to comply with any term(s) set forth within this agreement will result in a termination of this agreement and possibly of my care and medications at Mana Spine

Patient Signature & Date: _____

Provider Signature & Date: _____

Witness Signature & Date: _____

Patient Initials:_____ Date: / /

FINANCIAL POLICY

1. Co-payments. Copayments for clinic visits are due at the time of service. If you are unable to make your co-payment at the time of service, Mana Spine reserves the right to reschedule your appointment until a time that you are able to make your copayment. Payment for any outstanding balance is due at your appointment.

2. Procedure Pre-payment. Mana Spine collects your payment for a procedure at the time when the procedure is scheduled. Your pre-payment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment, you may request a refund according to our refund policy, below. We reserve the right to reschedule your procedure until prepayment has been made.

3. Missed Appointments and Late Arrivals. If you are more than 15 minutes late, we may reschedule your appointment. Missed procedures without contacting our office at least 24 hours prior to the scheduled procedure is subject to a $58 charge. These charges are your responsibility and will not be billed to any insurance carrier. Payment must be received before your next office visit.

INSURANCE PAYMENTS I BENEFITS AND AUTHORIZATION

4. Financial Responsibility. Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.

5. Coverage Changes and Timely Submission. It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which Mana Spine must submit a claim on your behalf to your insurer. If Mana Spine is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.

6. Self-Pay : Mana Spine will see patients for procedure only therapy who are not insured. We also may provide care under a letter of protection from their legal counsel in the setting of personal injury accident.

7. Referrals. Referral and prior authorization requirements vary widely among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by Mana Spine, it is your responsibility to be aware of this fact, and to obtain this referral.

8. Prior Authorization and Non-Covered Services. Mana Spine may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. Mana Spine, as a courtesy to our patients, makes a good faith effort to determine if services we order are covered by your insurance plan, and, if so, whether or not prior authorization for treatment is required. If it is determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf.

Patient Initials: _____

9. **Out of Network Payments**. If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to Mana spine. Out of network charges may have higher deductibles and copayments.

10. Reassignment of Balances. If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.

11. Collection of Unpaid Accounts. If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Mana Spine reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Mana Spine for any expenses we incur to collect on your account, including reasonable attorneys' fees and collection costs. **Returned Checks.** Returned checks will be subject to a $38 returned check fee.

12. Refunds. Refunds for overpayment or prepayment on cancelled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow four to six weeks for your request to be processed. Send requests to: Medenet Inc. Attn: Mana Medical Group, LLC PO BOX 24716, Tampa, FL 33623

13. Statements. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.

OWNERSHIP DISCLOSURE

I understand that Mana Spine is a physician-owned medical practice comprised of the offices of specialty care providers, and associated ancillary services. These ancillaries may include, but may not be limited to, laboratory, radiology/diagnostic, physical therapy, and ambulatory surgery center services. During the course of my care, I may be referred to one or more of these departments. I have the right to choose where to receive these services, and I understand that I am not obligated to receive these services at a Mana Spine associated ancillary department

AGREEMENT AND ASSIGNMENT OF BENEFITS

I have read and understand the financial policy of Mana Spine, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to Mana Spine (Mana Medical Group LLC). I understand that I am financially responsible for all services I receive from Mana Spine. This financial policy is binding upon you and your estate, executors and / or administrators, if applicable.

Signed: _____ Date: _____