Sherban Spine Institute

DEMOGRAPHIC INFORMATION

Name:_____ Date of Birth:_____ Sex: Male Female

Address:_____

Phone:_____ Email address:_____

Emergency Contact:_____ Phone:_____

NO FAULT

Understand that without majority of the above information, you or your back-up insurance may be billed in lieu of missing information about your NO FAULT claim. The more information we have, the timelier we can process requests.

AUTO INSURANCE INFORMATION *(for the vehicle you were in at the time of the accident)*

Insurance Company Name and Address:_____

Policy Holder Name:_____ Relationship to Policy Holder: _____

Policy Number:_____ Claim Number: _____

ATTORNEY INFORMATION

Attorney Name:_____ Phone:_____

ACCIDENT INFORMATION/ INFORMATION ABOUT YOUR PAIN

Date of accident:_____ **Type of injury:** Motor Vehicle Accident Slip and Fall Other

You were the: Driver Passenger **Were you wearing a seat belt?** Yes No

Description of the accident/injury:_____

_____

Did you receive treatment after the accident? Yes No **Where?** _____
If no, when was the first time you sought medical treatment?_____

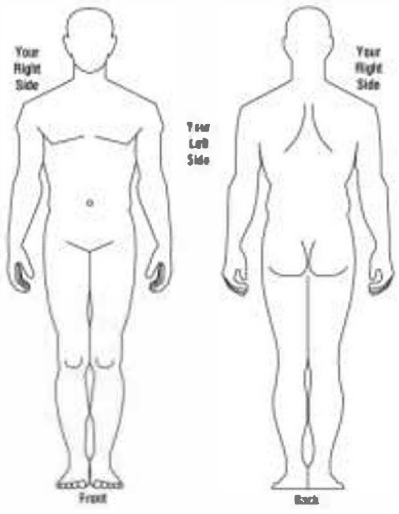
Have you had ANY previous injury? *(due to a car accident or slip and fall)* Yes No
If yes, please describe:_____

Since the onset of your pain, is it: Better Unchanged Worse

Mark the areas where you feel pain and/or discomfort - Rate the pain in each area from 1-10: 1=mild 10=severe

_____Neck
_____Mid Back
_____Low back
_____Shoulder (Left/Right)
_____Arm (Left/ Right)
_____Elbow (Left/Right)
_____Wrist (Left/Right)
_____Hand (Left/Right)
_____Hip (Left/Right)
_____Leg (Left/Right)
_____Knee (Left/Right)
_____Ankle (Left/Right)
_____Foot (Left/Right)

Please mark the location of your pain using the symbols below:
///// : Ache **xxxx** : Pain **oooo** : Tingling **- - - -** : Numb



Please describe the type of pain you are having? *(Circle all that apply)*
Sharp Aching Shooting Burning Cramping Throbbing Stabbing Itchy Sore Dull Tight Stinging

How often do you have this pain? *(Circle all that apply)*
Constant Intermittent Daily Every few days Weekly or less Monthly or less

Do you have any of the following?

*Body/muscle stiffness	Yes	No	Circle which applies: Mild Moderate Severe
*Radiating pain? *(Pain that shoots from one area to another)*	Yes	No	Describe:_____
*Tingling, pins and needles or burning sensations?	Yes	No	Describe:_____
*Feelings of muscle weakness?	Yes	No	Describe:_____
*Any bowel/bladder changes?	Yes	No	Describe:_____
*Increased pain from coughing or sneezing?	Yes	No	Describe:_____

What makes the pain worse? *(Circle all that apply)*
Any/all activity Bending Running Reaching Lifting Weight Prolonged Walking Lying down/sleeping
Prolonged Sitting Prolonged Standing Changing Positions Twisting/Rotation

What makes the pain better? *(Circle all that apply)*
Rest Movement Heat Therapy Elevation Medication Changing Positions Nothing

TREATMENT
What type of therapy have you had after this accident? *(Circle all that apply)* **Has the therapy helped?** Yes No
Chiropractic Physical and/or Occupational Therapy Acupuncture Modalities-Ultrasound, Electrical Stim, Hot/Cold packs

Are you currently attending therapy? Yes No **If no, when did you stop therapy?**_____

Have you had any type of injections for this problem? Yes No

If so, what type of injections did you have? *(Circle all that apply)* **Did the injections help?** Yes No
Epidural Injection Trigger Point Injections; Location:_____ Facet Injections Other:_____

MEDICAL HISTORY
Do you have or have you had any of the following? *(Check all that apply)*

__High Blood Pressure	__Stroke	__Asthma	__Arthritis
__High Cholesterol	__Diabetes Mellitus, Type I	__Emphysema	__Multiple Sclerosis
__Hepatitis or liver Disease	__Diabetes Mellitus, Type II	__Thyroid Issues	__Osteoarthritis
__HIV/AIDS	__CHF	__Headaches	__GERD
__Deep Vein Thrombosis (DVT)	__Heart Disease	__Dizziness	__Constipation
__Kidney Disease	__Heart Attack	__Peripheral Neuropathy	__Cancer
__Seizure Disorder	__COPD	__Depression	__Drug or Alcohol Dependency

List medications you are currently taking:_____

_____

Medication Allergies:_____

Surgical History:_____

_____

Mother: Alive Deceased Health issues:_____
Father: Alive Deceased Health issues:_____

SOCIAL HISTORY
Do you smoke tobacco? Yes No How much?_____ **Do you drink?** Yes No How much?_____

Are you Left or Right handed? Left-handed Right-handed **Height?** _____ **Weight?** _____

Occupation?_____ **Have you missed work?** Yes No **How Much time?**_____

NARCOTICS AGREEMENT

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe to you.

The long term use of such substances, such as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long time benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason, the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

I, _____ understand that:
(printed patient name)

1. The overuse of narcotic medication can result in serious health risks.
2. You should not drive or operate machinery while taking narcotic medications.
3. All prescriptions must be filled at one (1) pharmacy only and prescribed by one (1) doctor only, this includes emergency department prescriptions.
4. You agree to a random urine drug testing.
5. This medication will be strictly monitored and ALL of the medications will be filled at the SAME pharmacy. The pharmacy I have chosen is below:

Pharmacy:_____ **Phone #:**_____

6. Early refill requests will not be honored & I will take my medication ONLY as prescribed.
7. I am responsible for MAKING & KEEPING scheduled appointments. I understand that I will need to be seen approximately EVERY month while I am being prescribed narcotic medications.
8. I understand that if I am not able to keep my appointments my medications will not be refilled.
9. I will call the office **48-72 hours ahead** of my refill date. P# 844-733-3774
10. I WILL NOT obtain narcotic medication from any provider while obtaining medications from Sherban Spine Institute/or associates. If it is found that other providers are prescribing for me, Dr. Sherban and/or his associates reserve the right to discontinue prescribing medications and/or discharge me.
11. Your prescription or medications WILL NOT be replaced if they are lost, destroyed, stolen, get wet, misplaced etc. under any circumstances.
12. Notify us immediately if you become pregnant.

Patient signature:_____ Date:_____

Healthcare Provider:_____ Date:_____

*********SIGN BELOW ONLY IF YOU ARE CURRENTLY IN PAIN MANAGEMENT *********

IF YOU ARE ALREADY IN PAIN MANAGEMENT OR YOU ARE RECEIVING PAIN MEDICATIONS ELSEWHERE, PLEASE SIGN BELOW AND PROVIDE THE DOCTOR NAME AND PHONE NUMBER.

Patient signature:_____ Date:_____

Pain Management/Doctor's Name:_____ Phone:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my PHI (protected health information). 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 that treatment directly and indirectly.*

- *Obtain payment from third-party payers.*

- *Conduct normal healthcare operations such as quality assessments and physician certifications.*

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it Notice of Privacy practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Private Practices.

I understand that I may 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 printed Name:_____

Patient signature:_____ Date:_____

Sherban Spine Institute, P.A.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA RULE 164.508

Patient Name: _____ **DOB:** _____

INFORMATION TO BE RELEASED FROM

I hereby authorize the following practice to release the medical information stated below from the patient's medical record:

[ ] **Sherban Spine Institute**
2842 SE Federal Hwy Stuart FL, 34994
OR:

Organization: _____

Phone: _____ **Fax:** _____

INFORMATION TO BE RELEASED TO

Organization: _____

Phone: _____ **Fax:** _____

TYPE OF INFORMATION:

[ ] All healthcare information and records

[ ] Diagnostic tests including EKG's, lab results, and

X-ray reports

Other: _____

AUTHORIZATION

I understand that the information described above may be re-disclosed by the person or group that I hereby give Sherban Spine Institute and its contract representatives permission to share my information with, and that my information would no longer be protected by the federal privacy regulations. Therefore, I release Sherban Spine Institute, its workforce members, and its contract representatives from all liability arising from the disclosure of my health information pursuant to this agreement. I understand that I may inspect or request copies of any information disclosed by this authorization if the Sherban Spine Institute or its contract representatives initiated this request for disclosure. I understand that I may revoke this authorization by notifying Sherban Spine Institute through its contractor representatives, in writing, knowing that previously disclosed information would not be subject to my revocation request. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or eligibility for benefits

Patient Signature:_____ Date:_____

Sherban Spine Institute, P.A.

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ Date of Birth:_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Sherban Spine Institute to release my medical and/or billing information to the following individual(s):

1:_____ Relation to Patient:_____

2:_____ Relation to Patient:_____

3:_____ Relation to Patient:_____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

Patient Signature:_____ Date:_____

Sherban Spine Institute, P.A.

LETTER OF PROTECTION

Patient Name:_____ Date:_____

Attorney's Name:_____ Date of Injury:_____

I do hereby authorize and direct you, my attorney, to pay directly to Sherban Spine Institute, P.A., such sums as may be due and owing them for medical services provided to me by reason of injuries sustained on the above date, as well as monthly service charge on all sums from any settlement, judgment or verdict as may be necessary to adequately protect Sherban Spine Institute, P.A.

I fully understand that I am directly and fully responsible to Sherban Spine Institute, P.A. for all medical bills and service charges thereon submitted by said group for services provided to me and that this agreement is made solely for Sherban Spine Institute, P.A. additional protection and in consideration of their awaiting payment as set forth above. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover such fees. The undersigned agrees that he/she shall be responsible for attorney's fees and cost incurred to recover any balance due. I also understand that regardless of insurance, Sherban Spine Institute, P.A. does not reduce or adjust any of their usual and customary charges, whether or not they are participating with health insurance.

Patient Signature:_____ Date:_____

The undersigned, being the attorney of record for the above patient does hereby agree to observe all the terms above and agree to withhold such sums from any settlement, judgment or verdict REGARDLESS OF THE AMOUNT OF INSURANCE COVERAGE as may be necessary to adequately protect Sherban Spine Institute, P.A.. It is the policy of the practice to not reduce customary and reasonable charges incurred. The attorney agrees that prior to disbursement of any settlement proceeds, he/she will contact Sherban Spine Institute, P.A. to determine the total charges and the outstanding balance owed, and shall provide at least 72 hours' notice prior to disbursement, if the amount recovered is not sufficient to cover the full amount of charges outstanding.

Attorney Signature:_____ Date:_____

PLEASE DATE, SIGN AND RETURN ONE COPY TO SHERBAN SPINE INSTITUTE KEEP ONE FOR YOUR RECORDS. A PHOTOCOPY OF THIS FORM SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

Sherban Spine Institute, P.A.

Sherban Spine Institute, P.A. – Tax ID # 82-0919430

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek 627.428 damages from the insurer. If the provider s bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient s name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid. The patient agrees before the services are provided that the providers charges for services are reasonable, usual and customary.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. **Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. §673.3111.**

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter EUO) the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider s attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider and to request a copy of any statements or examinations under oath given by patient.

Express Consent and Release of information: I authorize this provider to: furnish an insurer, an insurer s intermediary, the patient s other medical providers, and the patient s attorney and hired experts via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file, and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney and experts in connection with any pending lawsuits. The patient s other medical providers are authorized to sign affidavits and testify justifying the patient s care and treatment. The insurer is directed to keep the patient s medical records from this provider private and confidential. The insurer is not authorized to provide the patient s medical records to anyone without the patient s and the provider s prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider s bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider s medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute and when the policy is exhausted.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider s prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient Name _____ **Patient Signature** _____

(Please Print) **(If patient is a minor, signature of parent/guardian)**

Date _____ **5/5/17**

Sherban Spine Institute

Phone: 1-844-733-3774
Fax: 1-844-752-8300

MEDICARE PRIVATE CONTRACT

This contract is entered into by and between Dr. Ross Sherban, D.O. (hereinafter "Physician"), whose principal medical office is located at 2842 Southeast Federal Highway, Stuart, Florida 34994, and _____ (hereinafter "Beneficiary"), who resides at _____, and shall become effective on this _____ day of _____, 20___, and shall expire two (2) years from the date of execution (the "opt out period"), unless otherwise renewed.

Physician Obligations
Physician has not been excluded from Medicare under sections 1128, 1156 or 1892 of the Social Security Act (NPI 1558892190).

Physician will retain the original contract for the duration of the opt-out period.

Physician will supply CMS with a copy of this contract upon request.

Physician understands that the current private contract remains in effect for two (2) years. If Physician again opts-out of Medicare, Physician will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

Beneficiary Obligations
Beneficiary or my legal representative accepts full responsibility for payment of charges for all services furnished by Physician.

Beneficiary or my legal representative understands that Medicare limits do not apply to what Physician may charge for items or services furnished.

Beneficiary or my legal representative agrees not to submit a claim to Medicare or to ask Physician to submit a claim to Medicare.

Beneficiary or my legal representative understands that Medicare payment will not be made for any items or services furnished by Physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

Beneficiary or my representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

Beneficiary or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

This contract cannot be entered into by Beneficiary or my legal representative during a time when I, Beneficiary, require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 3044.28 of the Medicare Carriers Manual.)

Beneficiary or my legal representative will receive or have received a copy of this contract, before items or services are furnished to me under the terms of this contract.

Provider's NPI: 1558892190 Provider's Specialty: Orthopaedic surgery of the spine

Provider's Signature: _____ Date: 6/25/2021

Patient's Signature: _____ Date: _____

Patient's Legal Representative Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Contact Name: _____ Phone #: _____

Contact Email: _____

Sherban Spine Institute, P.A.

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

EVALUATION + TREATMENT

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

Name *(PRINT or TYPE)*	Signature
Dr. Ross Sherban	

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OIR-B1-1571
Pub. 1/2004