Minimally Invasive Spine and Orthopedic Surgery
Georgiy Brusovanik, MD
www.spinedoctormiami.com
Phone: 305-467-5678
Fax: 305-821-6782

PATIENT INTAKE AND INFORMATION PACKET

Today's Date: _____

First Name: _____ **Last Name**: _____ **Middle Initial**: _____

Date of Birth: _____/_____/_____ **Social Security #**: _____-_____-_____

Sex: _____**M** _____**F** **Age:**_____ **Marital Status**: Single Married Divorced Widow
[Circle one]:

Address: _____ **Apartment**: # _____

City: _____ **State**: _____ **Zip Code**: _____

Home Telephone #: _____ **Mobile/Cellular**: _____

Insurance Company: _____
[Please enter Insurance Company name as it appears on your insurance card]

Group #: _____ **Policy/Member #**: _____

Policy Holder's Name: _____
LAST FIRST INITIAL

Insured's Date of Birth: _____/_____/_____ **Insured's Sex:** _____**M** _____**F**

Employer Name: _____

Work Address: _____
STREET APARTMENT CITY STATE ZIP CODE

Work Telephone: _____ **Position**: _____

Hialeah: 7100 W 20th Ave Suite #513 Hialeah, FL 33016 **South Miami:** 6141 Sunset Drive Suite #102 South Miami, FL 33143

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PATIENT NAME: _____ **DATE OF BIRTH:** ____/____/____

REFERRAL: Were you referred by a Doctor or Patient? If so, who? **AGE:** _____

_____

CHIEF COMPLAINT: Main reason for your visit today? _____

_____

ACCIDENT: Is your injury the result of an Accident? **YES** **NO** **DATE OF ACCIDENT:** ____/____/____

MEDICINES: What Medications, Vitamins or Supplements do you take?

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

ALLERGIES: Do you have any Allergies to Medicines?

_____ _____ _____ _____

SOCIAL HISTORY:

- Do you Smoke? **YES** **NO** If so, how many cigarettes/packs per day? _____
- Do you Drink Alcohol? **YES** **NO** If so, how much per week? _____
- Do you use any Illicit Drugs? **YES** **NO** If so, what kind and how often? _____

SURGICAL HISTORY: Type of surgery & dates?

_____ _____

_____ _____

_____ _____

FAMILY HISTORY:
What illnesses or health conditions did your **MOTHER**, **FATHER** and/or **SIBLINGS** suffer from?

☐Anemia	☐Enzyme Deficiencies	☐Osteoporosis
☐Arthritis	☐Heart Disease/CAD	☐Prostate Disease
☐Asthma	☐Hepatitis	☐Stomach Ulcer/Reflux
☐Blood Clots/DVT	☐High Blood Pressure	☐Stroke/Seizures
☐Cancer	☐High Cholesterol	☐Thyroid Disease
☐COPD/Lung Disease	☐HIV/AIDS	☐Vascular Disease
☐Depression	☐Irregular Heartbeat	☐
☐Diabetes	☐Liver Disease	☐
☐Ehlers Danlos Syndrome	☐Marfan Syndrome	☐

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PATIENT MEDICAL HISTORY:

☐ Alzheimer	☐ Diphtheria	☐ Insomnia/Sleep Disorder	☐ Prostate Enlargement/Benign Prostatic Hypertrophy (BPH)
☐ Anaphylaxis	☐ Diskitis	☐ Irregular Heartbeats/ Arrhythmia	☐ Pulmonary Embolism
☐ Anemia	☐ Diverticulitis or Diverticulosis	☐ Irritable Bowel Syndrome (IBS)	☐ Pulmonary Hypertension
☐ Anesthesia Problems	☐ Eczema	☐ Jaundice	☐ Psychiatric Care
☐ Anxiety	☐ Emphysema (COPD)	☐ Joint Replacement	☐ Renal Dialysis
☐ Arthritis	☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Renal (Kidney) Insufficiency/Failure
☐ Artificial Heart Valve	☐ Fibromyalgia	☐ Kidney Stone	☐ Rheumatic Fever
☐ Asthma	☐ GERD/Heartburn	☐ Leukemia or Myeloma	☐ Rheumatoid Arthritis
☐ Atrial Fibrillation	☐ Glaucoma	☐ Liver Disease/Cirrhosis	☐ Seasonal Allergies
☐ Back Problems	☐ Gout	☐ Low Blood Pressure	☐ Sexually Transmitted Diseases
☐ Bladder Infections	☐ Heart Attack	☐ Lung Disease	☐ Shingles
☐ Bleeding Disorder	☐ Heart Disease/Coronary Artery Disease (CAD)	☐ Lupus	☐ Sickle Cell Disease
☐ Blood Clots/DVT	☐ Heart Murmur	☐ Malaria	☐ Sleep Apnea
☐ Blood Transfusions	☐ Heart Palpitation	☐ Migraine Headaches	☐ Smallpox
☐ Bronchitis (COPD)	☐ Heart Valve Disease	☐ Mitral Valve Prolapse (MVP)	☐ Spina Bifida
☐ Cancer	☐ Hemorrhoids	☐ Neurological Disease	☐ Stroke or Transient Ischemic Attack (TIA)
☐ Cardiac Stents	☐ Hemophilia	☐ Neuropathy	☐ Thyroid Disease: Hypothyroidism or Hyperthyroidism
☐ Cataracts	☐ Hepatitis A B C D E *Circle One*	☐ Osteoporosis or Osteopenia	☐ Tuberculosis
☐ Chemotherapy or Radiation	☐ Herpes Zoster	☐ Pacemaker	☐ Tumor or Growth
☐ Congenital Deformities	☐ High Blood Pressure	☐ Pancreatitis	☐ Ulcerative Colitis
☐ Congestive Heart Failure	☐ High Cholesterol	☐ Parkinson's	☐ Vertigo
☐ Crohn's Disease	☐ History of Falls	☐ Peptic (Stomach) Ulcer	☐
☐ Dementia	☐ HIV or AIDS	☐ Peripheral Vascular Disease	☐
☐ Depression	☐ Infection	☐ Pneumonia	☐

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☐ Diabetes	☐Infectious Mononucleosis (MONO)	☐Polio	☐

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REVIEW OF SYSTEMS:		
Constitutional	☐Unexplained Weight Loss ☐Change in Appetite ☐Fever	☐Fatigue ☐Night Sweats
Eyes	☐Changes in Vision ☐Blurry Vision	☐Double Vision
Ears	☐Hearing Difficulty ☐Hearing Aids	☐Ringing in Ears
Nose/Throat	☐Nosebleed ☐Difficulty Swallowing	☐Dentures ☐Bleeding Gums
Respiratory	☐Chronic Cough ☐Shortness of Breath	☐Difficulty Breathing ☐Snoring
Cardiovascular	☐Fainting ☐Chest Pain with Exercise ☐Chest Pain at Rest ☐Abnormal Chest X-ray	☐Abnormal EKG ☐Palpitations ☐Foot/Ankle Swelling
Gastrointestinal	☐Stomach Pain ☐Blood in Stools ☐Nausea/Vomiting	☐Diarrhea ☐Blood in Urine ☐Constipation
Musculoskeletal	☐Joint Swelling ☐Muscle Weakness	☐Joint Pain
Neurological	☐Headaches ☐Loss of Consciousness ☐Numbness/Tingling of Hands ☐Numbness/Tingling of Feet	☐Dizziness ☐Memory Loss ☐Speech Difficulties
Endocrine	☐Excessive Thirst ☐Heat Intolerance	☐Cold Intolerance
Hematological	☐Bruise Easily ☐Bleed Easily	☐Skin Sores ☐Skin Rashes
Spine	☐Neck Pain ☐Groin Numbness ☐Balance Problems ☐Pain shooting to Legs ☐Pain shooting to Arms/Shoulders	☐Back Pain ☐Incontinence ☐Difficulty Walking ☐Swollen Lymph Nodes

HIPAA INFORMATION, NOTICE OF PRIVACY PRACTICES & CONSENT FORM

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The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. *What is HIPAA all about?* Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Dept. of Health & Human Services at: www.hhs.gov

We have adopted the following policies:

1. Patient's information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. The normal course of providing care means that patient records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. Additionally, we may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents, which may include PHI, by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your PHI will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your PHI and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, ON THIS _____ DAY OF _____, 20_____ DO HEREBY
Patient Name Date Month Year

CONSENT AND ACKNOLWEDGE MY AGREEMENT TO THE TERMS SET FORTH IN THIS **HIPAA INFORMATION, NOTICE OF PRIVACY PRACTICES & CONSENT FORM** AND ANY SUBSEQUENT CHANGES IN OFFICE POLICY. I UNDERSTAND THAT THIS CONSENT SHALL REMAIN IN FORCE FROM THIS TIME FORWARD.

PATIENT CARE AGREEMENT

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I, _____, in exchange for receiving treatment from Dr. Georgiy Brusovanik, MD (including all of his employees), hereby acknowledge and accept the following terms.

_____**(Initials).** Notice of No Medical Malpractice Insurance: Under Florida law, physicians are generally required to carry medical malpractice insurance *or* otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **DR. GEORGIY BRUSOVANIK, M.D.** & **GVB MD, LLC d/b/a Miami Back & Neck Specialists HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE**. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law. I, as a patient of this office and Dr. Brusovanik, fully understand and acknowledge the information provided above. Nevertheless, I have decided to still be a patient in the office of Dr. Georgiy Brusovanik, MD.

_____**(Initials).** Consent for Treatment: I voluntarily consent to the rendering of care, including the administration of anesthetics, injections, performance of diagnostic and/or surgical procedures. I understand that I am under the care & supervision of Dr. Brusovanik and it is the responsibility of the staff to carry out his instructions.

_____**(Initials).** Assignment of Medical Benefits & Authorization for Treatment and Release of Information: I hereby assign payment directly to Dr. Brusovanik, or any other provider offering services through Miami Back & Neck Specialists (a d/b/a owned by GVB MD, LLC) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. **I understand that I am financially responsible for my health insurance deductible, my co-pay, the charges not covered by this assignment, and/or for any and all charges that the insurance carrier declines to pay**. It is further agreed that any credit balance, resulting from payment of insurance or other services may be applied to any other accounts owed to said physician(s) by the insured.

_____**(Initials).** Release of Information: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or the patient or to the family member or employer of the patient for all or part of the physician(s)' charges, including but not limited to, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

_____**(Initials).** Limitation on Damages, Arbitration, Attorneys' fees: With the exception of any collection action, I agree to resolve any and all claims or controversies, whether in tort or contract, arising from the care and treatment received from Dr. Georgiy Brusovanik, including but not limited to claims for medical malpractice, exclusively by binding arbitration. Such arbitration will be governed by the then current rules of the American Arbitration Association, and any court of competent jurisdiction may enter the arbitrator's decision as a final judgment. I further agree that the damages, including economic and non-economic damages recoverable in such a claim or controversy arising from the care and treatment received from Dr. Georgiy Brusovanik should not exceed $100,000.00 under any circumstances; and that I am not entitled to recover punitive damages in any such claim or controversy. I agree that each party shall bear their own attorneys' fees and costs arising from any such proceeding.

Print Name of Patient/Insured: _____

Signature of Patient/Insured: _____ **Date:**_____