MIAMI BACK & NECK SPECIALISTS
GEORGIY BRUSOVANIK, MD

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

PATIENT INTAKE & INFORMATION PACKET

Today's Date: _____ **Sex:** **Male** or **Female** **Age:** _____

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

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

Employer: _____ **Occupation:** _____

Marital Status: Single Married Divorced Widow **Children:** _____ (How many?)
[Circle one]:

Address: _____ **Apartment**: # _____

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

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

Email: _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____ **Relationship to Patient:** _____

Primary Care Physician (PCP): _____ **PCP Phone #** _____

Referral Source: *Check One*: ☐ **Doctor** ☐ **Hospital** ☐ **Patient** ☐ **Internet** ☐ **Social Media** ☐ **Other**

Name of Referral Source: _____

Pharmacy Name: _____ **Pharmacy Phone #:** _____

Pharmacy Address: _____

INSURANCE INFORMATION:

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

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

Policy Holder's Name: _____
Last First Middle Initial

Policy Holder's Date of Birth: _____/_____/_____ **Policy Holder's Sex:** **Male** or **Female**

Policy Holder's Employer Name: _____

Work Address: _____
Policy Holder STREET APT # CITY STATE ZIP CODE

Work Telephone: _____ **Occupation:** _____
Policy Holder *Policy Holder*

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

CHIEF COMPLAINT: Please state the main reason for your visit today?

_____

TYPE OF INJURY: WORK AUTO SPORTS FALL OTHER **DATE OF INJURY:** _____/_____/_____

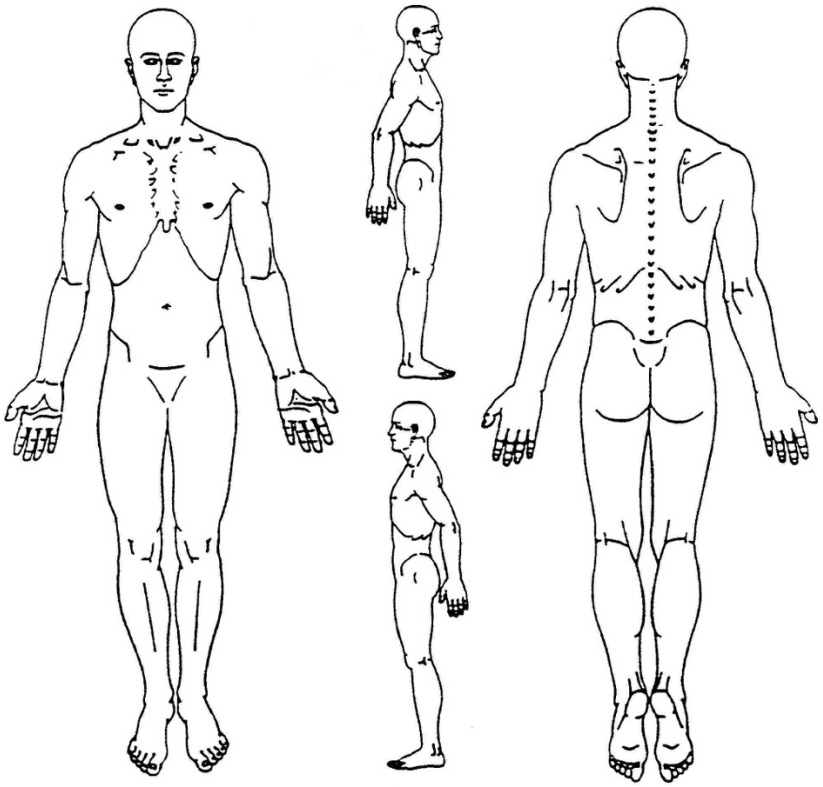
How long have you had pain for? _____ **Years** _____ **Months** _____**Weeks** _____ **Days**

Where is the LOCATION of your pain?

☐ Neck	☐ Right Shoulder	☐ Right Hand	☐ Right Lower Leg
☐ Mid-Back	☐ Left Shoulder	☐ Left Hand	☐ Left Lower Leg
☐ Low-Back	☐ Right Forearm	☐ Right Thigh	☐ Right Foot
☐ Buttocks/Gluteus	☐ Left Forearm	☐ Left Thigh	☐ Left Foot

Please complete the following PAIN DIAGRAM by using the LETTERS below to indicate your symptomatic areas on the diagram:

P	**PAIN**
N	**NUMBNESS**
T	**TINGLING**
W	**WEAKNESS**



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Current PAIN LEVEL 0 to 10 *(No pain)* **0 1 2 3 4 5 6 7 8 9 10** *(Worse pain)*

TYPE of PAIN → ☐ Sharp ☐ Stabbing ☐ Dull ☐ Shooting ☐ Radiating

Duration of PAIN → ☐ Constant ☐ Intermittent ☐ Not Applicable

Duration of NUMBNESS → ☐ Constant ☐ Intermittent ☐ Not Applicable

What makes your symptoms ☹ WORSE? ☐ Standing ☐ Sitting ☐ Lying down ☐ Walking ☐ Other: _____

What makes your symptoms ☺ BETTER? ☐ Standing ☐ Sitting ☐ Lying down ☐ Walking ☐ Other: _____

What MEDICATIONS have you tried for your symptoms? ☐ Did not try any Medications.

- _____ *Medication* Did Medication Help? YES NO
- _____ *Medication* Did Medication Help? YES NO
- _____ *Medication* Did Medication Help? YES NO
- _____ *Medication* Did Medication Help? YES NO

Where and When did you try PHYSICAL THERAPY? ☐ Did not try Physical Therapy.

- Name of Physical Therapy Center: _____ How many sessions? _____
- Dates of Physical Therapy: _____ Did Physical Therapy help? YES NO

What EPIDURALS/INJECTIONS have you tried for your pain? ☐ Did not try Epidurals/Injections.

- _____ Injection Type/Level _____ Date of Injection _____ Doctor YES NO Did Injection Help?
- _____ Injection Type/Level _____ Date of Injection _____ Doctor YES NO Did Injection Help?
- _____ Injection Type/Level _____ Date of Injection _____ Doctor YES NO Did Injection Help?

What other TREATMENTS have you tried for your symptoms? ☐ Did not try other Treatments.

☐ Home Stretching/Exercises ☐ Massage Therapy ☐ Cupping ☐ Other: _____

☐ Chiropractic care ☐ Acupuncture ☐ Yoga/Pilates ☐ Other: _____

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ALLERGIES: Do you have any Allergies to Medicines?

☐ _____ Medication _____ Reaction ☐ _____ Medication _____ Reaction

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

☐ _____ *Medication* _____ *Dose (ml/mg)* ☐ _____ *Medication* _____ *Dose (ml/mg)*

☐ _____ *Medication* _____ *Dose (ml/mg)* ☐ _____ *Medication* _____ *Dose (ml/mg)*

☐ _____ *Medication* _____ *Dose (ml/mg)* ☐ _____ *Medication* _____ *Dose (ml/mg*

☐ _____ *Medication* _____ *Dose (ml/mg)* ☐ _____ *Medication* _____ *Dose (ml/mg)*

FAMILY HISTORY: What illnesses/health conditions did/does your MOTHER FATHER or SIBLINGS?

☐ **High Blood Pressure:** Mother Father Sibling ☐ **Heart Disease:** Mother Father Sibling

☐ **Diabetes:** Mother Father Sibling ☐ **Cancer:** Mother Father Sibling ☐ **Bleeding Disorder:** Mother Father Sibling

SURGICAL HISTORY:

- _____ Surgery/Procedure _____ Date of Surgery _____ Doctor _____ Hospital
- _____ Surgery/Procedure _____ Date of Surgery _____ Doctor _____ Hospital
- _____ Surgery/Procedure _____ Date of Surgery _____ Doctor _____ Hospital
- _____ Surgery/Procedure _____ Date of Surgery _____ Doctor _____ Hospital
- _____ Surgery/Procedure _____ Date of Surgery _____ Doctor _____ Hospital

SOCIAL HISTORY:

- ○ **Do you Smoke?** **YES** **NO** If yes, how many cigarettes/packs per day? _____
- ○ **Are you a Former Smoker?** **YES** **NO** If yes, when did you quit? _____
- ○ **Do you Drink Alcohol?** **YES** **NO** If yes, how much per week? _____
- ○ **Do you use Illicit Drugs?** **YES** **NO** If yes, what kind and how often? _____

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PATIENT (PAST & CURRENT) MEDICAL HISTORY:

☐ Alzheimer	☐ Diverticulitis or Diverticulosis	☐ Irritable Bowel Syndrome (IBS)	☐ Peripheral Vascular Disease
☐ Anemia	☐ Erectile Dysfunction	☐ Juvenile Rheumatoid arthritis	☐ Psoriatic Arthritis
☐ Anxiety	☐ Epilepsy or Seizures *(Circle One)*	☐ Kidney Stone	☐ Pulmonary Embolism
☐ Arrythmia (Irregular Heartbeats)	☐ Fibromyalgia	☐ Leukemia or Myeloma *(Circle One)*	☐ Pulmonary Hypertension
☐ Atrial Fibrillation	☐ GERD/Heartburn	☐ Liver Disease/Cirrhosis	☐ Renal Insufficiency/ Kidney Failure
☐ Avascular Necrosis	☐ Gout	☐ Low Blood Pressure	☐ Restless Leg Syndrome
☐ Bladder Incontinence	☐ Heart Attack/Myocardial Infarction	☐ Lupus	☐ Rheumatoid Arthritis
☐ Bladder Infections	☐ Heart Disease/Coronary Artery Disease (CAD)	☐ Lyme Disease	☐ Shingles
☐ Bleeding Disorder	☐ Heart Murmur	☐ Migraine Headaches	☐ Sickle Cell Disease
☐ Cancer Type:	☐ Hemophilia	☐ Multiple Sclerosis	☐ Sjogren's Syndrome
☐ Cerebral Palsy	☐ Hepatitis A B C D E *(Circle One)*	☐ Neuropathy	☐ Sleep Apnea
☐ Chemotherapy or Radiation *(Circle One)*	☐ Herpes Zoster	☐ Osteoarthritis	☐ Spina Bifida
☐ Congestive Heart Failure (CHF)	☐ High Blood Pressure	☐ Osteopenia	☐ Stroke or Transient Ischemic Attack (TIA)
☐ Crohn's Disease	☐ High Cholesterol	☐ Osteoporosis	☐ Ulcerative Colitis
☐ Deep Vein Thrombosis (DVT) / Blood Clots	☐ HIV or AIDS *(Circle One)*	☐ Pacemaker	☐ Vertigo
☐ Depression	☐ Hyperthyroidism	☐ Pancreatitis	☐
☐ Diabetes (*Circle One)* Type 1 or Type 2	☐ Hypothyroidism	☐ Parkinson's	☐

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PATIENT REVIEW OF SYSTEMS:

(Please mark all that apply)

GENERAL/CONSTITUTIONAL	OPTHALMOLOGIC (EYES)	EAR, NOSE & THROAT (ENT)
☐ Changes in Appetite ☐ Fever ☐ Night Sweats ☐ Unexplained Weight Loss	☐ Blurry Vision ☐ Dry Eyes	☐ Difficulty Swallowing ☐ Dry Mouth ☐ Ringing in Ears ☐ Snoring
CARDIOVASCULAR	**RESPIRATORY**	**GASTROINTESTINAL**
☐ Chest Pain at Rest ☐ Chest Pain with Exercise ☐ Swelling in Hands/Feet	☐ Cough ☐ Shortness of Breath	☐ Abdominal Pain ☐ Blood in Stools
GENITOURINARY	**PERIPHERAL VASCULAR**	**HEMATOLOGY**
☐ Blood in Urine ☐ Difficulty Urinating ☐ Frequent Urination ☐ Painful Urination	☐ Cold Extremities ☐ Decreased Sensation in Extremities	☐ Bleeding Problems ☐ Easy Bruising
ENDOCRINE	**MUSCULOSKELETAL**	**NEUROLOGIC**
☐ Cold Intolerance ☐ Excessive Thirst ☐ Heat Intolerance	☐ Joint Stiffness ☐ Limping Gait ☐ Painful Joints ☐ Swollen Joints	☐ Balance Problems ☐ Dizziness ☐ Headaches ☐ Loss of Strength in Extremities ☐ Tingling/Numbness in Extremities
SKIN	**PSYCHIATRIC**	
☐ Rash	☐ Psychiatric Condition ☐ Suicidal Thoughts	

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HIPAA INFORMATION, NOTICE OF PRIVACY PRACTICES & CONSENT FORM

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 manager 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.

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PATIENT CARE AGREEMENT

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, worker's 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:** _____

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GVB MD, LLC

2800 Biscayne Blvd., Suite 1010 Miami, FL 33137-4559
Phone No. (305) 467 - 5678 • Fax No: (305) 503 - 7006

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION AUTHORIZED REPRESENTATIVE

I, the undersigned, represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby designate, authorize, and convey directly to, GVB MD, LLC **and any of its duly authorized agents, officers, clinical staff and employees** as my Statutory Derivative Beneficiary **(SDB),** commonly known as a Designated Authorized Representative, and a Claimant under the "Patient Protection and Affordable Care Act"' (PPACA), existing ERISA and other applicable federal and state laws, of all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by GVB MD, LLC., regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize GVB MD, LLC to release all medical information necessary to process my claims under HIPAA.

I hereby authorize any plan administrator or fiduciary, insurer, and/or attorney to release to the Designated Authorized Representative(s) (GVB MD, LLC) any and ALL Plan documents including Governing Plan Documents, including, but not limited to a written explanation of how level of benefit payments are determined for out-of-network providers, Summary Plan Description **(SPD),** Summary of Benefits and Coverage **(SBC),** 5500 Form (Plan Annual Return), **Certificate for PPACA Grandfathered Health Plan**, where applicable insurance policy and/or settlement information upon written request from the Designated Authorized Representative(s) (GVB MD, LLC) **and any of its duly authorized agents, officers, clinical staff and employees** or the attorneys in order to claim certain medical benefits in connection for healthcare services provided to the undersigned. This includes, but is not limited to, receiving disbursement benefit checks for claims submitted, member's right to appeal claims denials, as well as to claim any applicable statutory penalties on behalf of the plan participant and beneficiary. I authorize the use of this signature on ALL my insurance and/or employee health benefit claims submission.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, hereby assign, authorize and/or convey to GVB MD, LLC and any of its duly authorized agents, officers, clinical staff and employees to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, cause of action, or other right I may have to such group health plans, heal insurers or tortfeasor insurer(s) under any applicable insurance policies, employee benefit plan(s) or public policies with respect to medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I received from GVB MD, LLC, and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable legal remedies (including damages arising from ERISA breach of fiduciary duty

claims), including, but not limited to: **(1)** the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and **(2)** the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of **ERISA as provided in 29 *C.F.R.* §2560.5031(b) (3)** with respect to any healthcare expense incurred as a result of the services I received from GVB MD, LLC and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. This assignment also includes any rights to recover attorney's fees and cost for such action brought by the provider as my assignee and designated authorized representative.

By signing this form, I also understand that this provider does not have a contract with my insurance plan, the fees for services will be as they are listed on www.fairhealthconsumer.org.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Signature of Insured / Patient/ Guardian	**Date**
Print Name of Insured / Patient / Guardian	**Date**

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Medical Records Request and Authorization to Release Healthcare Information

INTRUCTIONS: Please sign at the bottom to authorize **RELEASE** or **REQUEST** of Medical Records to/from another medical practice/organization.

Patient Name: _____ Patient Date of Birth: _____

OFFICE USE: **Medical Records to be released:** **TO** or **FROM**	**OFFICE USE:** **Medical Records to be released:** **TO** or **FROM**
Miami Back & Neck Specialists **Georgiy Brusovanik, MD** 2800 Biscayne Blvd. Suite #1010 Miami, FL 33137 Phone# 305-467-5678 Fax # 305-821-6782	_____ Medical Practice/Organization _____ Doctor/Medical Professional _____ Address of Medical Practice/Organization _____ Phone # _____ Fax #

Type of Information to be Released

☐ ALL RECORDS

☐ Requesting ALL RECORDS for dates of service between _____ through _____

☐ All records relating to the following CLINIC NOTES, OPERATIVE REPORTS, INJECTION REPORTS, TREATMENT, DIAGNOSIS, and/or CONDITION: _____

☐ Other: _____

Purpose of Release of Medical Records

☐ Continuation of Care ☐ Legal

☐ Transferring Care to another Provider ☐ Coordination with School

☐ Copies for my own use ☐ Other: _____

Authorization for General Release of Information

I understand that:

- Disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- By authorizing this disclosure, I may be authorizing the release any records relating to my drug or alcohol use, my mental health, information related to my reproductive care (such as birth control or pregnancy), and any sexually transmitted diseases, including HIV/AIDS, to the extent that any such information is contained on the records I am requesting.
- I can cancel this authorization at any time by writing to the Health Information Services Department. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.
- This authorization will expire 90 days from the date signed below unless another date or event is entered here _____.

Signature of Patient/Legal Representative

_____ _____

Signature of Patient or Legally Responsible Party **Date of Signature**

_____ _____

Print Name of Patient or Legally Responsible Party **Relationship to Patient, if not signed by Patient**