The Spine Center
Charles S. Theofilos M.D., PA
11621 Kew Gardens Ave, Suite 101
Palm Beach Gardens, FL 33410
561-630-3870
561-630-3680 FAX
www.thespinecenter.com

Name:_______________________________________ **DOB**: _________________________

Thank you for scheduling an appointment in our Palm Beach Gardens/Port St. Lucie office

on _______________________________.

Enclosed you will find our New Patient Information Packet to be completed and brought to our office the day of your appointment. A map is enclosed for your convenience.

For your first visit, you MUST bring with you, the following:

- **All Prior Radiology Films**
- **MRIs**
- **Cat Scans**
- **X-Rays**
- **All corresponding Radiology Reports**
- **All Insurance information, including your insurance card**
- **A copy of your driver's license**
- **Completed New Patient Packet**

A few other things to remember:

1. YOU MUST ARRIVE *30 MINUTES PRIOR* TO YOUR APPOINTMENT. If your paperwork is completed, this will help to alleviate an excessive wait time. But, please understand that your first appointment is very comprehensive and may take 2-3 hours to complete.

2. If needed, you MUST have a referral or an authorization from your Primary Care Physician. Please understand that we cannot see you, if we do not have this.

3. To avoid a cancellation fee from being posted to your account, you must give our office 24-hours notice if you need to cancel or reschedule.

Sincerely,

The Staff at The Spine Center
newpatient@thespinecenter.com
561-630-3870 x139

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Name: ________________________ **Date:** __________ **Age**: ______**DOB**:________________

What is the reason for today's visit? ____

Please check off any symptoms you have or have had in the last year

GENERAL
- ◻ Chills
- ◻ Depression
- ◻ Dizziness
- ◻ Fainting
- ◻ Fever
- ◻ Forgetfulness
- ◻ Loss of sleep
- ◻ Loss of weight
- ◻ Nervousness
- ◻ Numbness
- ◻ Sweats

GASTROINTESTINAL
- ◻ Poor appetite
- ◻ Bowel Changes
- ◻ Constipation
- ◻ Diarrhea
- ◻ Indigestion
- ◻ Nausea
- ◻ Stomach pain
- ◻ Vomiting
- ◻ Vomiting blood

EYES,EARS, NOSE
- ◻ Bleeding Gums
- ◻ Blurred vision
- ◻ Cross eyed
- ◻ Difficulty Swallowing
- ◻ Double vision
- ◻ Earache
- ◻ Ear discharge
- ◻ Hay fever
- ◻ Hoarseness
- ◻ Loss of hearing
- ◻ Nosebleeds
- ◻ Persistent cough
- ◻ Ringing in Ears
- ◻ Vision flashes
- ◻ Vision-Halos

Women Only
- ◻ Abnormal Pap Smear
- ◻ Bleeding between periods
- ◻ Extreme menstrual pain
- ◻ Hot flashes
- ◻ Nipple discharge
- ◻ Pain with intercourse
- ◻ Vaginal discharge

Other___________________________
Date of last period: _______________
Is there any chance you might be pregnant? ____
Number of children: __________

MUSCLE/JOINT/BONE (pain, weakness or numbness)
- ◻ Head
- ◻ Neck
- ◻ Shoulder
- ◻ Legs
- ◻ Arms
- ◻ Mid back
- ◻ Low back
- ◻ Buttocks

GENITO-URINARY
- ◻ Blood in urine
- ◻ Frequent urination
- ◻ Lack of bladder control
- ◻ Lack of bowel control
- ◻ Painful urination

CARDIOVASCULAR
- ◻ Chest pain
- ◻ High Blood Pressure
- ◻ Irregular Beat
- ◻ Low blood pressure
- ◻ Poor Circulation
- ◻ Rapid Heartbeat
- ◻ Swelling of ankles
- ◻ Varicose Veins

MEN ONLY
- ◻ Breast lump
- ◻ Erection difficulty
- ◻ Lump in testicles
- ◻ Penis discharge
- ◻ Sore on penis
- ◻ Other

SKIN
- ◻ Bruises easily
- ◻ Change in moles
- ◻ Chronic sore throat
- ◻ Hives
- ◻ Itching
- ◻ Rash
- ◻ Scars

CONDITIONS **Check conditions that you have or have had in the past**

- ◻ Aids
- ◻ Alcoholism
- ◻ Anemia
- ◻ Appendicitis
- ◻ Arthritis
- ◻ Asthma
- ◻ Bleeding disorder
- ◻ Bronchitis
- ◻ Cancer
- ◻ Cataracts
- ◻ Chemical dependency
- ◻ Chicken pox
- ◻ Diabetes
- ◻ Emphysema
- ◻ Epilepsy
- ◻ Glaucoma
- ◻ Goiter
- ◻ Gout
- ◻ Heart Disease
- ◻ Hepatitis __
- ◻ Hernia
- ◻ Herpes
- ◻ High Cholesterol
- ◻ HIV Positive
- ◻ Kidney Disease
- ◻ Liver Disease
- ◻ Measles
- ◻ Migraine Headaches
- ◻ Mitral Valve prolapse
- ◻ Mononucleosis
- ◻ Multiple sclerosis
- ◻ Mumps
- ◻ Pacemaker
- ◻ Pneumonia
- ◻ Prostate problem
- ◻ Psychiatric Care
- ◻ Rheumatic Fever
- ◻ Scarlet fever
- ◻ Shingles
- ◻ Stroke
- ◻ Suicide attempt
- ◻ Thyroid: Hypo/ Hyper
- ◻ Tonsilitis
- ◻ Tuberculosis
- ◻ Ulcers
- ◻ Vaginal infections
- ◻ Venereal disease

The Spine Center
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Name:____ **DOB:** ______________________________

Have you ever had a blood transfusion? □ No □ Yes If yes, please give date. _______________________________

Medications: List all medications you are currently taking	**Dosage**	**How Often**	**How long have you been taking it?**	**Prescribed by:**

Do you currently have a pain management physician or any physician prescribing pain medications? □ yes □ no
If yes what is the physician's name? ____

ALLERGIES:	Reaction	**Health Habits**	How much do you use?
		□ Alcohol	
		□ Caffeine	
		□ Drugs	
		□ Tobacco	
		□ Other	

Previous Spine injuries or treatment:
If you are being evaluated or are receiving treatment for an accident related injury please complete the following:

	Dates	Did the pain resolve after treatment? Please explain:
□ Neck pain (cervical)		
□ Low back pain (lumbar sacral)		
□ Mid back pain (thoracic)		

Name:____ **DOB**: _____________________________

Occupation:

Occupation: ____________________________ Name of employer: __________________________________

Please mark if your occupation involves:

□ Hazardous Substances □ Heavy Lifting □ Stress □ Other __________________

FAMILY HISTORY **Please fill in any health information about your family**

Relation	Age	State of Health	Cause of death	√ if any blood relatives had:	Relation:
Father:				□ Arthritis/ Gout	
Mother:				□ Asthma/ Hay Fever	
Brothers:				□ Cancer	
				□ Chemical Dependency	
				□ Diabetes	
				□ Heart disease/ Stroke	
Sisters:				□ High blood pressure	
				□ Kidney disease	
				□ Neurological disorders	
				□ Tuberculosis	
				□ Other	

MISC:

____
____
____
____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omission that I may have made in the completion of these forms.

____ ________________________
Patient Signature **Print Name**

____ ________________________
Witness Signature **Date**

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RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS AND PAYMENT FOR SERVICES RENDERED

CONSENT FOR THE RELEASE OF MEDICAL RECORDS

By signing below, I agree that Charles S. Theofilos ,M.D., P.A. has the right to request any and all previous medical records. I understand that my health or medical information may be used or released for purposes of treatment, payment or health care operations.

I authorize Charles S. Theofilos ,M.D., P.A., to release copies of my records as necessary to process claims, obtain reimbursement or payment from an insurance company, HMO, or other third party payer or attorney. I further authorize Charles S. Theofilos ,M.D., P.A. to furnish information from my medical records to other treating physicians, other medical care facilities, hospitals, home health agencies, ancillary service providers or other health care providers for my continued care and treatment. I understand that my health information and medical records may be transmitted to me, my insurers or other health care providers by telephone, regular mail, email or facsimile.

ASSIGNMENT OF BENEFITS AND PAYMENT

I hereby authorize and assign payment directly to Charles S. Theofilos ,M.D., P.A. for all medical benefits to which I am entitled, but not to exceed my indebtedness for the treatment received. This irrevocable assignment to Charles S. Theofilos ,M.D., P.A. shall apply to all benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by Charles S. Theofilos ,M.D., P.A. All payment for services rendered by Charles S. Theofilos ,M.D., P.A. shall be made payable to and mailed directly to: Charles S. Theofilos ,M.D., P.A.

The assignment of insurance monies does not alter the undersigned's obligation to pay, and I understand that the filing of a claim for payment with a medical insurance carrier or other third party payer is not equivalent to payment, but only an accommodation for my benefit.

I understand that I am fully responsible for any balance not paid by my insurance, and I agree to pay any outstanding balance including co-payments and deductible amounts. If my account has to be referred to a collection agency or an attorney, I will pay all costs of the collection, including reasonable attorney's fees and costs.

I will also be financially responsible for any scheduled appointments not cancelled 24 hours prior to appointment time. There is a 24-hour cancellation policy for all office visits. If any appointment is not cancelled or if I fail to show, I understand that my account will be charged as follows:

- Follow up, New Patient, and X-Ray appointments will be charged the full fee of the visit.
- MRI appointments will be charged $750.00.

LIMITED POWER OF ATTORNEY

I hereby appoint Charles S. Theofilos ,M.D., P.A. and any of its duly authorized agents to be my agent and attorney-in-fact for the limited purpose of endorsing and depositing, for the benefit of Charles S. Theofilos ,M.D., P.A., any and all checks and/or paperwork received for payment of services rendered up to the amount of my bill. This appointment means that Charles S. Theofilos ,M.D., P.A., or its authorized agents may deposit any and all checks or other financial instruments received from my insurer or any person as payment for my treatment services without my endorsement.

I have read and fully understand the conditions listed above with respect to the release of information, assignment of benefits, and financial responsibility. I understand that this form will remain in effect for so long as I am being treated by Charles S. Theofilos ,M.D., P.A., unless it is revoked by me in writing.

_________________________________ _________________________________
Signature of Patient **Print Name**

_________________________________ _________________________________
Witness signature **Date**

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NOTICE TO OUR PATIENTS:

"Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This is provided pursuant to Florida law."

______________________________ ______________________
Patient Signature **Print Name**

______________________________ ______________________
Witness Signature **Date**

I understand Charles S. Theofilos, MD, PA owns and operates the following located within The Spine Center in all locations:

Physical Therapy/Oxygen Rehab
X-ray
North Palm MRI
In-office Procedure Suite

______________________________ ______________________
Patient Signature **Print Name**

______________________________ ______________________
Witness Signature **Date**

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Name:_______________________________________ **DOB:** _________________________

The Spine Center will need to call you regarding your healthcare. By completing the information below you are giving us authorization to contact you and to leave you a message.

- ☐ Home Phone: ________________________________
- ☐ Cell Phone: ________________________________
- ☐ Work Phone: ________________________________
- ☐ Email: ________________________________
- ☐ Fax: ________________________________
- ☐ Other: ________________________________

I hereby authorize the continuous release of all my medical records/films/ and x-rays to the following persons. This authorization is in full force and effect unless and until revoked by me in writing. (Examples: Spouse, Children, Attorney, Employer etc)

NAME	PHONE/FAX/EMAIL	RELATIONSHIP

<u>Who should we contact in case of an emergency</u>?

NAME: ______________________________
RELATIONSHIP: ______________________________
PHONE: ______________________________

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I am entitled to the Spine Center's Privacy Notice upon my request.

______________________________ ______________________________
Patient Signature **Print Name**

____
Date

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Name:____ **DOB:** ______________________________

INSTRUCTIONS FOR DIRECT PAYMENT TO MEDICAL CENTER

Auto Insurance: ________________________
Claim #: ________________________ **DOA:** _________________
Patient Name: ____

I hereby instruct and direct you, my insurance carrier, to pay by check and to remit the payment directly to the address below. If my current policy prohibits payment directly to the medical center, then I hereby also instruct you to make the check payable to the medical center and myself and mail to:

CHARLES S. THEOFILOS MD PA
11621 Kew Gardens Ave Suite 101
Palm Beach Gardens FL 33410

Please remit payment for the professional or medical expenses allowable and otherwise payable to me under my current policy as payment toward charges for professional services rendered.

INSURANCE AUTHORIZATION
I direct payment of the benefits I am entitled to under the provision of my insurance policy directly to Charles S. Theofilos, M.D., P.A. I understand I am fully responsible for any balance not paid by my insurance including co-payments or deductible amounts.

MEDICAL RECORDS RELEASE AND REQUEST
I authorize Charles S. Theofilos, M.D., P.A. to release copies of my records to my insurance company and/or attorney, if applicable.

I authorize Charles S. Theofilos, M.D., P.A. the right to request any and all previous medical records. I authorize facsimile or electronic transmittal of these records.

POWER OF ATTORNEY
I agree that Charles S. Theofilos, M.D., P.A. and any of its duly authorized agents be given full Power of Attorney to perform any requisite and necessary act, including endorsing or signing my name, on any and all checks and/or paperwork received for payment of services rendered.

I will be financially responsible for any scheduled appointments not cancelled 24 hours prior to appointment time.

Patient Signature____**Date**____________________

Witness Signature____**Date**____________________