INNOVATIVE
SPINE CARE

10903 Sheldon Road • Tampa, FL 33626
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www.GotSpinePain.com

(Please Print Clearly)

Patient / Physician Agreement

FAILURE TO FOLLOW PHYSICIAN ORDERS

"Physician Orders" are meant to improve and/or resolve the patient's medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician care and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can include but is not limited to missing, postponing, or refusal of additional tests to rule out, confirm, or discover illness. Also, missing postponing, or refusal of making scheduled appointments can be considered failing to follow physician's orders. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

PRESCRIPTION REFILLS

Please don't wait until you run out of medicine to call for a refill. In fact, call at least two days ahead. In order to protect you, your doctor must review your medical file before renewing a prescription. Therefore please do not call for medications after hours or on weekends when records are unavailable. It could take up to 48 hours after you call before your doctor can review your file and call in any prescription. The files are reviewed and prescriptions are called to pharmacies at the end of office hours after all patients have been seen. By law, doctors cannot order refills for certain narcotics over the phone. A written prescription is required in those cases. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

MEDICAL RECORDS

Your records are kept in strict confidence as part of our permanent file. We will release copies only if we have your written permission. We prefer to mail copies of records, but we will give them to you in person to hand-carry if time is critical. Please give us at least 48 hours notice prior to coming in and picking up records as it does take some time to get things together for you. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

STATEMENT OF FINANCIAL RESPONSIBILITY

I the undersigned realize that all medical and surgical charges incurred by me or my dependent/s are my financial responsibility. All court fees, attorney fees, and other fees necessary to collect this amount are payable by me. I grant consent to Innovative Spine Care to use and disclose my protected health information for the purposes of diagnosing or providing treatment and conducting surgical operations. My protected health information includes demographic information which is collected from me, created or received by my physician or another health care provider, and my employer. This protected information relates to my past, present, and future physical and mental health condition/s. I can receive from Innovative Spine Care a copy of the Notice of Privacy Practices prior to signing this document and understand it is subject to change. I understand that diagnosis and treatment of me by Innovative Spine Care may be conditioned upon my consent as evidenced by my signature on this document. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

CONFIDENTIALITY

The physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method that can assist with the care of the patient. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

INDIVIDUAL PATIENT AUTHORIZATION

Name the people and/or organization and their relationship to you that are authorizing to use and/or disclose your personal health information:

_____

IRREVOCABLE MEDICAL LIEN

I hereby do authorize any and all parties, including any insurance company and my attorney (if applicable), to pay directly to Innovative Spine Care sums as may be due and owing for medical services rendered to me and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Innovative Spine Care. If applicable, I also authorize my attorney to release any and all information without limitation regarding any legal proceedings, judgments, or settlements that will aide in the recovery of Innovative Spine Care's unpaid sum.

I fully understand that I am directly and fully responsible to Innovative Spine Care for all medical bills incurred by me for services rendered in consideration of waiting for payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I hereby further give my authorization to Innovative Spine Care to record a Uniform Commercial Code Form (UCC-1) to protect this medical lien and to send any unpaid sum to the Tortfeaser. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IN THE PATIENT INTAKE FORMS IS ACCURATE.

Patient/Guardian Signature:_____ Date:_____