# *Coastal Orthopedic Pain & Spine Center*

5800 49th Street N., Suite S-205, St. Petersburg, FL 33709 7895 Seminole Blvd, Suite 101, Seminole, FL 33772

Name: _____ Date: _____
Last First Middle

## GENERAL PATIENT INFORMATION

Date of Birth: _____ Age: _____

Sex: Male Female (Please circle one)

Social Security #: _____-_____-_____

Address: _____

_____

Home Phone: (_____) _____

Cell Phone: _ (_____) _____

Employer: _____

Work Phone: (_____) _____

Emergency Contact:

Name: _____

Phone: (_____) _____

Primary Care Physician: _____

Referring Physician: _____

## ABOUT YOUR VISIT TODAY:

Please tell us where your pain is: _____

_____

For how long? _____

Is this related to: auto accident? Y N
work related accident? Y N **Open Legal Case?** Y N

other injury? _____

Who has treated you for this condition in the past?

_____

## MEDICATIONS/ ALLERGIES

Did you bring a list of your current medications? Y N
If not, please list them here:

1._____2._____
3._____4._____
5._____6._____
7._____8._____

**Are you allergic to any medications**? Y N

| Medication | What happens? |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient: _____

Birth date: _____ SS#: _____

Insurance Company: _____

Group #: _____ Member ID #:_____

Secondary Insurance Company: _____

Subscriber Name: _____

Birth date _____ SS#:_____

Relationship to Patient: _____

Group #: _____ Member ID #:_____

PLEASE READ THE FOLLOWING STATEMENT
AND SIGN BELOW.

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above stated insurance company/ companies and assign directly to Amitabh Gupta M.D.P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
**Patient Signature** **Date**

**********

**Medicare Authorization:** I request that payment of authorized Medicare benefits be made on my behalf to Amitabh Gupta M.D. P.A. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agencies any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
**Patient Signature** **Date**

*EMAIL =*
*PHARMACY INFO:*

# HIPAA Patient Questionnaire

1. Please list the family members or other person, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

---

---

2. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**.

Name:_____ Phone Number: _____

Name:_____ Phone Number: _____

Name:_____ Phone Number: _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

   _____

   _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked “CONFIDENTIAL”: Yes: _____ No: _____

5. Please print he telephone number where you want to receive calls about your appointments, lab and x-ray results or other health care information if other than your home phone number: _____

6. Can confidential messages (ie., appointment reminders) be left on your telephone answering machine or voicemail? Yes: _____ No: _____

7. **I understand the Privacy Protection Act.**

   PATIENT NAME: _____ (guardian if under 18 years)

   _____ _____

   PATIENT/GUARDIAN SIGNATURE DATE

## PAST MEDICAL HISTORY

Please check any of these other medical conditions that you have or have had in the past:

| | HAVE | HAD | | HAVE | HAD | | HAVE | HAD |
|---|---|---|---|---|---|---|---|---|
| AIDS | ☐ | ☐ | Epiliepsy | ☐ | ☐ | Mumps | ☐ | ☐ |
| Appendicitis | ☐ | ☐ | Glaucoma | ☐ | ☐ | Pacemaker | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Heart disease | ☐ | ☐ | Pneumonia | ☐ | ☐ |
| Asthma | ☐ | ☐ | Hepatitis | ☐ | ☐ | Polio | ☐ | ☐ |
| Bleeding disorders | ☐ | ☐ | Herpes | ☐ | ☐ | Prostate problem | ☐ | ☐ |
| Breast Lump | ☐ | ☐ | High cholesterol | ☐ | ☐ | Rheumatic fever | ☐ | ☐ |
| Cancer | ☐ | ☐ | HIV Positive | ☐ | ☐ | Scarlet fever | ☐ | ☐ |
| Cataracts | ☐ | ☐ | Kidney disease | ☐ | ☐ | Stroke | ☐ | ☐ |
| Chemical dependency | ☐ | ☐ | Liver disease | ☐ | ☐ | Thyroid problems | ☐ | ☐ |
| Chicken pox | ☐ | ☐ | Measles | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Migraine headaches | ☐ | ☐ | Ulcers | ☐ | ☐ |
| Emphysema | ☐ | ☐ | Multiple Sclerosis | ☐ | ☐ | Venereal disease | ☐ | ☐ |
| Other | ☐ | ☐ | | ☐ | ☐ | | ☐ | ☐ |

## SURGICAL HISTORY

Please list any and all surgeries you have had

| Surgery | When? |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## SOCIAL HISTORY

Please check which substances you use and describe how much you use

Recreational Drugs _____
Tobacco _____
Caffeine _____
Other

## FAMILY HISTORY

Is there a family history of:

Cancer
Heart disease
Stroke
Diabetes
Liver disease
Kidney disease
Other

Grandfather _____
_____
Grandmother _____
_____
Father _____
_____
Mother _____
_____
Siblings _____
_____

## SIGNATURES

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 omissions that I may have made in the completion of this form.

Patient Signature: _____ Date: _____

Attending Staff: _____

Reviewed by: AMITABH GUPTA M.D._____ Date: _____

# Coastal Orthopedic Pain & Spine Center

## Review of Systems

**PLEASE ENCIRCLE ONLY THE ONES YOU HAVE, LEAVE THE REST ALONE**

**GENERAL/ CONSTITUTIONAL**

Change in appetite Chills Fever

**OPHTHALMOLOGIC**

Blurred vision Discharge Ocular Pain

**ENDOCRINE**

Cold Intolerance Excessive Thirst Heat Intolerance Weight Loss

**RESPIRATORY**

Cough Shortness of breath at rest Shortness of breath with exertion Wheezing

**CARDIOVASCULAR**

Chest pain at rest Chest pain with exertion Irregular heartbeat

**GASTROINTESTINAL**

Abdominal Pain Diarrhea Nausea Vomiting

**GENITOURINARY**

Blood in urine Difficulty urinating Frequent Urination

**MUSCULOSKELETAL**

Painful Joints Weakness

**SKIN**

Dry skin Itching Rash

**NEUROLOGIC**

Dizziness Fainting Headache

# Coastal Orthopedic Pain & Spine Center

## Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or other health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those whom we feel are in need of your health care information and information about your treatment, payment or health care operations in order to provide health care that is in your best interest.

We would like to inform you that some of the treatment may be performed in and open-air environment and if you prefer a more private setting, please inform us and we will do everything to accommodate your wishes.

We send out marketing information from time to time and if you do not want any information sent to you, please inform us that you would like to opt out and will not send anything to you that have anything to do with marketing.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for the purposes of treatment, payment or other health care operations. These entities are most often not required to obtain patient consent. In addition, we would like you to know that we do not release or sell information to telemarketers, mailing houses or e-commerce Internet marketers.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your Personal Health Information (PHI).

If you choose to give consent in this document, at some time in the future you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied upon this or a previously signed consent.

If you have any objections to this form, please ask to speak with our Health Insurance Portability and Accountability Act (HIPAA) compliance officer.

You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice. By signing below, you acknowledge receipt in the form of a copy of Compliance Assurance Notification and acceptance of this privacy policy.

Patient Signature: _____ Date: _____

**HIPAA NOTICE OF PRIVACY PRACTICES**

**AMITABH GUPTA MD PA** Effective Date: September 23, 2013

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

**I. Your Rights.**

You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.

You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.

You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization.

You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at 727-526-8000

**II**. **We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each**:

We may provide your Health Information to other health care professionals — including doctors, nurses and technicians — for purposes of providing you with care.

Our billing department may access your information — and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

**III. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization**. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:

To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form.

As Required By Law.

For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings. In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding.

To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes.

For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.

For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

**IV**. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

Fundraising. Should our practice use patient information for fund raising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in with written notice.

• Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI will require a separate written authorization. • Use or Disclosure of Psychotherapy Notes. *Written a*uthorization is required if our practice intends to use or disclose psychotherapy notes. • Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPAA regulations. Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance Form".

**V. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:**

Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

Change of Ownership. In the event that our Business is sold or merged with another organization, your Health Information/record will become the property of the new owner. Electronic Exchange. Your information may be shared with other providers, labs and radiology groups through our EMR/EHR system

**VI. Our Duties.**

We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.

We are also required to abide by the terms of this Notice.

We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information — even if it was created prior to the change in the Notice. If any such amendment is made that materially changes this Notice, we will send you another copy.

**VII. Complaints to our Practice and the Government.**

You may make complaints to our HIPAA Privacy Officer or the Secretary of the Department of Health and Human Services ("DHHS") if you believe your rights have been violated. We will review all complaints in a professional manner and keep you informed of your rights as our patient.

We promise not to retaliate against you for any complaint you make about our privacy practices.

**VIII. Contact Information.**

You may contact us about our privacy practices or file a complaint by calling our Privacy Officer: _GITA GUPTA_____ at __727-526-8000___

You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S. W.,

Washington, D.C. 20201, Telephone: 202-619-0257, Toll Free: 1-877-696-6775

**Patient Signature _____** **Date _____**