OSCEOLA NEUROHEALTH SURGICAL
ASSOCIATES

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: _____ DOB: _____ SS#: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Telephone#: _____

Cell Phone#: _____ Marital Status: _____ ☐ Male ☐ Female

Email: _____

Race: ❑ American Indian/Alaska Native ❑ Asian ❑ Native Hawaiian/Pacific Islander ❑ Black or African American ❑ White ❑ Declined

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic or Latino ❑ Declined Language: ❑ English ❑ Spanish ❑ Other _____

POLICY HOLDER INFORMATION—ONLY IF NOT PATIENT:

Name: _____ DOB: _____ SS#: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Telephone#: _____

Cell Phone#: _____ Marital Status: _____ ☐ Male ☐ Female

Relationship to patient: _____

EMPLOYMENT INFORMATION:

Employer: _____ Office Telephone: _____

Occupation: _____

PRIMARY INSURANCE:

Name: _____ ID#: _____ Group#: _____

SECONDARY INSURANCE (IF APPLICABLE):

Name: _____ ID#: _____ Group#: _____

EMERGENCY NOTIFICATION/ NEXT OF KIN

Name: _____ Relationship to patient: _____

Telephone Number: _____

Dr. Arriola and/or staff may discuss my medical condition with the following people:

1) _____ Relationship: _____

2) _____ Relationship: _____

3) _____ Relationship: _____

RELEASE OF INFORMATION/ ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process my insurance claim. I authorize and request payment of medical benefits directly to my physician. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that regardless of my insurance status I am responsible for any balance of my account.

PATIENT SIGNATURE OR RESPONSIBLE PARTY SIGNATURE **DATE**

OSCEOLA NEUROHEALTH SURGICAL
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PATIENT: _____ **DOB:** _____ **SS#:** _____

Gustavo Arriola, *M.D.*
Neurosurgeon

PATIENT CONSENT AND AUTHORIZATIONS

CONSENT FOR TREATMENT: I. the undersigned patient. parent, or legal guardian, do hereby present to myself (or the patient) for care and treatment at Osceola Neurohealth Surgical Associates and voluntarily consent to the rendering of such care or treatment, including performance of diagnostic and or surgical procedures. I understand that I am under the care and supervision of my physician and it is the responsibility of the practice and its staff to carry out the instructions of such physician. I understand that the physician furnishing services to me is an employee of the hospital, however, other services such as radiology, laboratory, and pathology may be provided by independent practitioners. All physicians expect payment in full upon receipt of a bill I will assist in billing appropriate insurance companies if insurance or other benefits are involved. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examination in the office. I understand that I am responsible for the outcome of care or treatment if I do not follow the care, service, or treatment plan.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to Osceola Neurohealth Surgical Associates and the physician accepting this assignment, of all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to Osceola Neurohealth Surgical Associates and their physician for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.

RELEASE OF MEDICAL INFORMATION: I, the undersigned patient, parent, or legal guardian, do hereby authorize Osceola Neurohealth Surgical Associates, its officers and employees, to release to any third party payor (such as an insurance company it government agency; Example: Blue Cross/Blue Shield of Florida or Medicare) any medical, psychiatric, alcohol, drug abuse, and/or HIV (AIDS or AIDS related complex) treatment information and records, in accordance with the policy of Osceola Neurohealth Surgical Associates and any applicable State or Federal Statues, concerning diagnosis and treatment for the above admission when requested by such third party payor for its use in connection with determining a claim for payment for such care, treatment and/or diagnosis. I authorize the release of any and all medical information to all physicians involved in my care and treatment. I do hereby release Osceola Neurohealth Surgical Associates from all liability that may arise from the release of the information requested.

FLORIDA LAW: Section 817.234 Florida Statutes, stipulates that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

FOR MEDICARE AND MEDICAID PATIENTS ONLY-CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII or/ Title XIX of the Social Security Administration or its intermediary-carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to Osceola Neurohealth Surgical Associates physician(s). I understand that I am responsible for any health insurance deductibles and coinsurance.

MEDICARE BENEFICIARY NOTICE OF NON-COVERED SERVICES: Medicare does (initials) not cover some inpatient, outpatient, and emergency services. Items not covered include. but not limited to. medications typically self-administered, annual testing and physicals.

ACKNOWLEDGEMENT OF RECEIPT OF AN IMPORTANT MESSAGE FROM MEDICARE(FOR MEDICARE PATIENTS ONLY): My signature only acknowledges my receipt of this message from Osceola Neurohealth Surgical Associates as dated below and does not waive any of my right to request a review or make me liable for any payment.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH MAYBE ON FILE AT OSCEOLA NEUROHEALTH SURGICAL ASSOCIATES

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she individually hereby obligates himself/herself to the account of Osceola Neurohealth Surgical Associates physician(s) in accordance with the regular rates and terms of the physicians(s). the undersigned will pay all costs and expenses including reasonable collection fees(which may include agency, attorney, interest or court fees) incurred or paid by the hospital or Osceola Neurohealth Surgical Associates in collection of this obligation by suit or otherwise. Furthermore, I hereby authorize and appoint the administrator of Central Florida Regional Hospital and/or Osceola Neurohealth Surgical Associates and/or its physician(s) or is successor designee as my attorney-in-fact to take measures in my behalf as may be necessary to collect such claims or insurance proceeds and to endorse any checks made payable to me for such claims or insurance proceeds by signing m) name as attorney-in-fact for me to any such checks and or insurance forms.

_____ _____
Patient's Signature Patient's representative/policy holder or spouse
Indicate relationship: _____

_____ _____
Witness Date

Patient unable to sign due to: _____

OSCEOLA NEUROHEALTH SURGICAL
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Neurosurgeon

OFFICE POLICIES

In an effort to clarify office policies for our patients, please read and understand the following policies. Hopefully this will reduce concerns and anxieties about your medical care in this practice.

1. **Please allow us at least 48 -72 hours for prescription refills. They will only be filled Monday - Friday between 8:30 a.m. - 5:00 p.m. For prescriptions to be refilled you must have been seen within the last 3 months.**

2. **A charge of $25.00 will apply for all Disability forms to be completed. Please allow us 7 -10 days to complete.**

3. **Request from Patients for letters in regards to work, insurance, or other matters will take at least 5 - 10 days to complete.**

Patient's Signature: _____ **Date:** _____

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Neurosurgeon

Acknowledgement of Receipt

By sign this Written Acknowledgement of receipt of Gustavo Arriola, M.D. notice of Privacy Practices (Acknowledgement). I here-by expressly acknowledge my receipt of Healthcare Partners, Notice of Patient Privacy Practices.

_____

Patient or Legal Representative Signature

Date: _____

Please Print Name:

_____

Acknowledgement not obtained because:

☐ **Patient or legal representative declined notice of patient privacy practices.**

☐ **Other (briefly explain)**

_____

Employee Signature: _____

Employee's Printed Name: _____

Date: _____

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Neurosurgeon

Patient Name:	Date of Birth:

Section V

Is this visit related to an injury due to a fall? ☐ No ☐ Yes
If Yes, did the accident occur in ☐ your home ☐ public location ☐ other
Date of Accident: _____ **(Claim must be filed with responsible party.)**

Is this visit related to an illness/injury due to automobile accident? ☐ No ☐ Yes
If Yes: Date of accident: _____

Section VI

Indicate which statements apply to you.

☐ I am entitled to Worker's Compensation for this service
☐ I am entitled to Black Lung benefits.
☐ I am entitled to VA benefits.
☐ I am entitled to ESRD benefits.
☐ I am entitled to COBRA benefits.
☐ I am entitled to other federal benefits. (UMWA, Government research programs, Hospice) Please explain:

_____

_____

_____

_____

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PATIENT SELF DETERMINATION ACT
QUESTIONNAIRE

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statues, please answer the following questions:

Declaration to Decline Life-Prolonging Procedure also known as a Living Will

☐ I have made such a declaration.

☐ I have **NOT** made such a declaration.

Health Care Surrogate

☐ I have a designated a Health Care Surrogate.

☐ I have **NOT** designated a Health Care Surrogate.

Durable Power of Attorney

☐ I have appointed a Durable Power of Attorney for Health Care decisions.

☐ I have **NOT** appointed a Durable Power of Attorney for Health Care decisions.

If you have the above documents, please provide us with a copy.

_____

Signature of Patient or Representative

Osceola Neurohealth Surgical Associates

New Patient Information Sheet

Gustavo Arriola, MD

Patient Name: _____ Date: _____

Primary Care Physician: _____ Referring Physician: _____

Please describe the reason for your visit: _____

Symptoms:

When did symptoms begin: _____

When does the pain/problem occur (i.e.: morning/night): _____

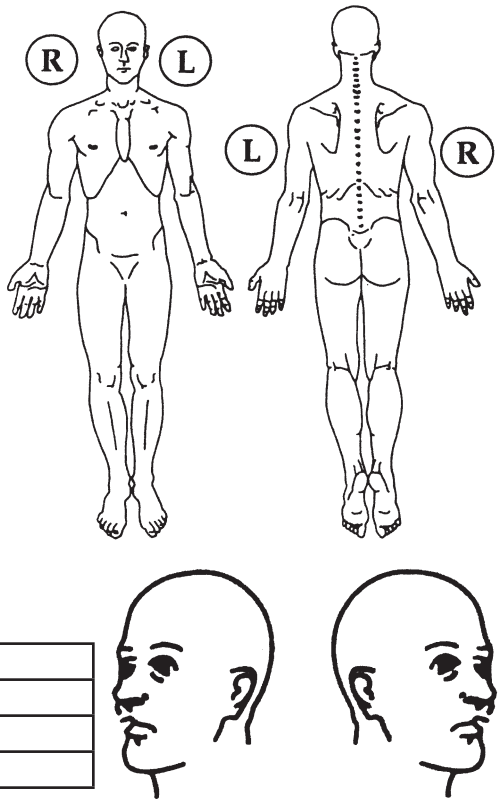
What aggravates the symptoms: _____

What reduces the symptoms: _____

Place check if you have other symptoms:

	Symptom	Occurrence	Location
	Numbness	☐ Constant ☐ Intermittent	
	Pins/Needles/Tingling	☐ Constant ☐ Intermittent	
	Sharp Pain	☐ Constant ☐ Intermittent	
	Dull/Achy Pain	☐ Constant ☐ Intermittent	

Shade the areas you have pain



Rate Your Pain

Pain Scale: 0 = No Pain 10 = Worse Pain

Today: _____ Past Week: _____

Please check current or previous therapy:

	Types of Therapy	Effect on your Symptoms	Month/Year
	Physical Therapy	☐ Better ☐ Worse ☐ No Change	
	Nerve Blocks	☐ Better ☐ Worse ☐ No Change	
	Medication Use	☐ Better ☐ Worse ☐ No Change	
	Chiropractor	☐ Better ☐ Worse ☐ No Change	
	Other	☐ Better ☐ Worse ☐ No Change	

DISABILITY STATUS	Yes	No	Type
Are you currently on disability?			
Have you applied for disability?			
Last Day you worked:			

Is this injury a result of?

Motor Vehicle Accident? ☐ Yes ☐ No

Work Related Injury? ☐ Yes ☐ No

Date of Injury: _____

If yes, to either of the above, explain how injury occurred:

ALLERGIES: ☐ None

List all known allergies to medication, food, or latex

NAME OF MEDICATION/FOOD/LATEX	TYPE OF REACTION

CURRENT MEDICATION: ☐ No Medications

List all medications you are taking

(Include over the counter, vitamins, and herbs)

NAME OF MEDICATION	DOSE/MG	FREQUENCY

NAME OF MEDICATION	DOSE/MG	FREQUENCY

MEDICAL HISTORY:

List all medical problems for which you are currently being treated (high blood pressure, diabetes, Heart)

MEDICAL PROBLEM

MEDICAL PROBLEM

SURGICAL HISTORY: ☐ No Hospitalization

List all surgical procedures or major hospitalizations and year of occurrence.

Year	REASON FOR HOSPITALIZATION

Year	REASON FOR HOSPITALIZATION

FAMILY HISTORY:

List pertinent family history (diabetes, heart disease, cancer, etc)

PARENTS	AGE	LIVING	DECEASED	MAJOR ILLNESS/CAUSE OF DEATH
Father				
Mother				
SIBLINGS				

SOCIAL HISTORY

Occupation: _____ If retired, list previous occupation: _____

Employer: _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of Children: _____

Who do you live with? _____

Highest grade of school completed:

☐ Elementary ☐ High School ☐ College ☐ Post Graduate

Alocohol Use: ☐ None

Amount: _____ per ☐ Day ☐ Week ☐ Month ☐ Year

Tobacco Use: ☐ None

_____ Packs/Cigars per day for _____ # of years. Quit smoking _____ years ago.

Street Drug Use: ☐ None

Type: _____ Frequency: _____ days/weeks/months. Date of last use: _____

REVIEW OF SYSTEMS: Please place check if you have or have had problems related to the following systems.

General		**Comments**	**Genitourinary**		**Comments**
	Unexplained Weight Loss			Incontinence/Retention	
Eyes/Ears				Prostate Enlargement	
	Double/Blurred Vision		**Musculoskeletal**		
	Hearing Loss			Arthritis/Location	
	Cataracts		**Endocrine**		
Pulmonary				Diabetes	
	Asthma			Thyroid	
	COPD/Emphysema		**Hematological**		
	Sleep Apnea			Blood Clots	
	Pneumonia in past year			Hemophilia	
	Shortness of Breath with exertion			Von Williebrands Disease	
Cardiovascular			**Neurological**		
	High Blood Pressure			Seizures	
	Heart Attack			TIA/Stroke	
	Pacemaker/AICD		**Psychiatric**		
	Valve Disease			Depression/Anxiety	
	Chest Pain		**Other**		
	Congestive Heart Failure				
Gastrointestinal			**Cardiac/Pulmonary Testing**		
	Heart Burn/Indigestion/Reflux			Stress Test	
	Bowel Incontinence			Heart Angiogram	
	Liver Disease/Hepatitis			Echocardiogram	
	Ulcers			Pulmonary Function Test	

Date: _____

Person Completing Form (please print): _____ Signature: _____