

PATIENT MEDICAL REGISTRATION

New Patient Checklist

Patient's Name: «PatientFullName»

DOB: «PatientDOB»

Patient # «PatientNumber»

_____ Identification Card/Insurance Card(s) obtained & *scanned properly*

_____ Insurance Set Correctly/ Eligibility Verified

_____ Verified authorization/Referral Information/Ailment created

_____ **** *Deductible/Copay collected***

_____ E-mail address obtained and invite to portal has been sent.

_____ Complete referral source field

_____ Enter Pharmacy

_____ For Medicare patients make sure DMERC has been added.

_____ ***All required forms filled out/signed/dated***

Employee's Signature: _____ Date: _____

***** Packets must be completed, signed & scanned in order to proceed with treatment**

PATIENT MEDICAL REGISTRATION

Patient Name: «PatientFullName»

DOB: «PatientDOB»

Social Security Number: _____

Date of Visit: «ApptDate»

Physician: «ApptProviderName»

Patient Number: «PatientNumber»

YOUR INFORMATION	
Primary Insurance: «PlanName» Member ID: «ClaimMemberID» Group #: «GroupNumber» Policy Holder: «SubscriberName» Policy Holder DOB: «SubscriberDOB» Policy Holder SSN: _____	Secondary Insurance: «SecPlanName» Member ID: «SecPlanClaimMemberID» Group#: «SecPlanGroupNumber» Policy Holder: «SecPlanSubscriberName» Policy Holder DOB: «SecPlanSubscriberDOB» Policy Holder SSN: _____
Primary Residence Address: «PatientAddrLine1» «PatientAddrLine2» City/State/Zip: «PatientAddrCSZ»	Secondary Residence Address: _____ City/State/Zip: _____
Primary Phone: «PatientPhoneNumber»	Cell Phone: «PatientMobilePhone»
Work Phone: «PatientWorkPhone»	Preferred Phone Method: (Circle One) Home Cell Email Text Message
Is this appointment due to motor vehicle accident? YES/ NO Injured Body Part: _____ Date of Injury: _____	
Is this appointment due to a slip and fall/Liability? YES/ NO Injured Body Part: _____ Date of Injury: _____	
Is this a Worker's Compensation appointment? YES/ NO Injured Body Part: _____ Date of Injury: _____	
Is Case closed? YES/ NO or N/A Is an Attorney involved? YES/ NO Attorney Name: _____	
Preferred Language: _____ Occupation: _____	
Marital Status: «PatientMaritalStatus» Employment Status: «EmploymentStatus» Employer: _____	
Ethnicity: Hispanic _____ Non-Hispanic _____ Race: Asian _____ African American _____ Caucasian _____ American Native/ Alaskan _____ Other: _____	
Primary Care Physician: _____ Cardiologist (if applicable): _____	
Referred Physician: «RefProviderFirstLastName»	
Do you have Internet Access? Yes or No Email Address: «PatientEmail»	
Emergency Contact: _____ Ph# _____	Pharmacy: «PatPharmacyName» «PatPharmacyPhone»

IF PATIENT IS A MINOR:

PARENT/LEGAL GUARDIAN NAME: _____ SSN#: _____ DOB: _____ PHONE: _____

ADDRESS: _____

Insurance and Authorization
(Please read and sign below)

I hereby authorize Florida Joint & Spine Institute, P.A. to furnish information to insurance carriers concerning my illness and treatments and understand that I am responsible for any amount not covered by insurance. I authorize any holder of medical or other information about me to release to the social security administration and health care financing administration or its intermediaries or carriers, or to the billing agent of this Physician or supplier. I permit a copy of this authorization to be used in place of the original, and this as a direct assignment of my rights and benefits under the applicable insurance policy to Florida Joint & Spine Institute, P.A. Payment is expected at the time professional services are rendered. We will wait up to sixty (60) days for payment from your insurance company. If the insurance company has not paid within sixty (60) days, we will expect the balance in full from you at that time. We accept cash, check, Visa, Mastercard, American Express, Discover, and Care Credit. In the event that any litigation is required to collect the sums due from you under this agreement, Florida Joint & Spine Institute, P.A. shall be entitled to recover from you, all its legal costs and expenses, including reasonable attorney fees, before trial, at trial and in any appellate proceedings. In the event that the account is delinquent, all collection agency fees will be the responsibility of the guarantor. I authorize Medicare crossover secondary insurance payments to the provider who accepts assignment (medigap). I hereby authorize payment directly to the named doctor of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of treatment, and authorize release of any information relating to this claim. I have read and stated financial policy of Florida Joint & Spine Institute, P.A. and agree to abide by the terms as stated above.

Your signature acknowledges that you have read and understand the Terms and Conditions set by Florida Joint & Spine Institute, P.A.

Patient Signature

«ApptDate»

PATIENT MEDICAL REGISTRATION

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my individually identifiable health information and medical record information by **Florida Joint & Spine Institute, P.A.** in order to carry out treatment, payment or health care operations. You are encouraged to review The Practice's Notice of Privacy Practices for a more complete and detailed description of the potential release and use of such information and have the right to review such Notice prior to signing this form.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. However, **Florida Joint & Spine Institute, P.A.** is not required to agree to such restrictions.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **Florida Joint & Spine Institute, P.A.** reserves the right to change their Notice and Practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should **Florida Joint & Spine Institute, P.A.** change their Notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I, «PatientFullName», consent to receiving emails, texts, (SMS), auto-dialed and/or artificial or pre-recorded message to my cellular phone or to any telephone number or email provided by me to Florida Joint & Spine Institute or its affiliates and their agents including, without limitation, any account management companies and independent contractors including debt collectors. I understand that consenting to the above is not required before I receive service from Florida Joint & Spine Institute.

RESTRICTIONS: I wish to have the following restrictions to the use or disclosure of my health information:

RELEASE OF INFORMATION: I hereby authorize Florida Joint & Spine Institute, P.A. to release information regarding my treatment to the following individual(s):

_____ I do **NOT** give my permission to Florida Joint & Spine Institute, P.A. to leave **ANY** medical information related to my treatment to anyone other than myself.

MESSAGES: I hereby authorize Florida Joint & Spine Institute, P.A. to leave messages regarding office visits and appointment confirmations, as well as any other medical information related to my treatment at the following phone number(s):

Method:	Phone Number w/Area Code:
Home Phone	
Cell Phone	
Work Phone	
Other (specify):	

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Florida Joint & Spine Institute, PA Notice of Privacy Practices. I understand it is my responsibility to notify the practice in writing of any changes to the above information.

I have read and understand the terms of this consent. By signing below, I am "only giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

«PatientFullName»

Printed Name

Social Security Number

Patient/Authorized Representative Signature

Relationship to Patient

«ApptDate»

Date

FOR OFFICE USE ONLY

[] Consent received by _____ on _____.

[] Consent refused by patient, and treatment refused as permitted.

[] Consent added to the patient's medical record on _____.

PATIENT MEDICAL REGISTRATION

Florida Joint & Spine Institute, P.A.

Financial Policy

Thank you for choosing Florida Joint & Spine Institute, P.A. as your health care provider. We are committed to the success of your treatment. The medical services provided by our office are services you have elected to receive which imply a financial responsibility on your part.

Our office verifies all insurances prior to your first appointment. The information obtained from the patient's insurance carrier is not a guarantee of payment. It is only a review of the patient benefits. Upon our receipt of the insurance company claim payment, our office will address any discrepancies that arise due to incorrect information provided at the time of benefit verification. Ultimately, payment for services rendered is the patient's responsibility.

Forms of payment: We accept cash, check, debit and all major credit cards, Care Credit, HSA and FSA. **EFFECTIVE 08/01/24: **All credit card transactions will incur a surcharge of 2.99% per transaction.** **Excludes, debit, Care Credit, HSA and FSA transactions

Care Credit: Care Credit is a dedicated resource available to our patients for use when paying for procedures not covered by insurance. Care Credit offers a 6-month no-interest plan for amounts above \$200. For more information, please contact one of our office staff or call 1-800-365-8295. You may also apply online at www.carecredit.com. Patients having procedures who do not qualify for Care Credit have the option of making monthly payments until the amount is paid in full. Please keep in mind, the procedure will not be scheduled or performed until the balance is paid in full!

Accident Insurance: Our office does not accept or file accident insurance. This includes, but is not limited to, school insurance, homeowner's insurance, and private plans.

Automobile Insurance: Any incident involving an automobile must be filed under the patient's automobile insurance carrier. This includes non-collision accidents such as closing a car door on a finger or sustaining an injury while lifting a load out of a car trunk. Patients that only have automobile insurance will be considered a Self-Pay Patient. Since, Florida is a "no fault" state, the patient will be responsible for providing our office with the following information prior to scheduling an appointment: patient's auto insurance information, claim adjustor's name and contact number, claim number, date of accident, and health insurance information. Prior to scheduling your appointment, our office will contact your insurance company to verify benefits. As of January 1, 2013, Florida law states that if you are injured in an accident you are required to obtain medical treatment within 14 days or there is NO PIP COVERAGE FOR ANY MEDICAL BENEFITS!

Collections: If you fail to pay your account, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 25% of the debt, and all costs, and expenses, including reasonable attorneys' fees that we incur in such collection efforts.

Co-Payments: Co-payments are collected at the time of registration. Patients who are unable to pay their copayment may not be seen. Our practice is obligated to collect co-payments by your insurance company.

Deductibles / Coinsurance: Patients with deductibles will be required to pay a \$150.00 deposit at check in. The remaining balance, coinsurance and or deductible will be collected at check-out based upon the insurance allowable. Patient credits will be applied to the next visit or refunded if no other appointment is necessary.

Referrals: If your insurance plan requires a referral from your primary care physician, it is your responsibility to obtain the written and/or electronic referral prior to scheduling an appointment. If a referral is not obtained prior to your appointment, the appointment will be cancelled until a referral is provided.

Minors: Minors will not be treated without a parent/guardian present. In matters of child custody, Florida Joint & Spine will bill the insurance carrier for the parent signing the consent forms. The parent signing the consent for services will be responsible for any outstanding balance, unless a court order is provided stating otherwise.

Medical Records: Patients are encouraged to register for our patient portal to obtain a summary of each visit. Requests for medical records must be made in writing and signed by the patient or legal representative. Pre-payment may be required prior to the release of your medical records. DISCS: Radiology imaging (X-rays) will be provided on disc. The fee for the radiology disc is \$7 (pick up) and \$15 (mailed to patient). Pre-payment is required! Please allow a minimum of 10 business days for processing.

Letters & Form Completion: Form completion is not considered part of your normal medical care provided by our office, but a separate service for which you will be charged a fee. We reserve the right to decline completing any form(s). You will be charged a fee based upon your form/letter needs. **Pre-payment is required!** Please allow up to 2 weeks for your letter/form(s) to be completed. To ensure accuracy and avoid delay, **the patient is responsible for** completing all fields pertaining to the employee, providing a Job Description, signing a consent, and paying all fees. The following fees apply: Letters (Jury Duty, Trip Cancellations, etc.) = \$15; Disabled Parking Permits = \$15; Return to Work Release = \$15 Disability/ADA Forms = \$35; FMLA = \$30. **Additional fees may be assessed at our discretion.**

Medicare Supplement Insurance: We are a participating provider with the Medicare Part B program; and as such we are obligated to write off the difference between what Medicare pays us for the services rendered to you (the "allowed amount") and our usual and customary charge. Medicare pays 80% of the "allowed amount" to us directly. The remaining 20% and your annual deductible are the patient's responsibility by federal law.

Non-Covered: Patients are required to make payment for any balance not covered by the insurance plan. If you are unsure whether a service is covered by your plan, ultimately it is your responsibility to contact your insurance company to review your benefits.

No-Show: A \$75 new patient, \$50 established patient or a \$150 procedure no show fee will be applied to the patient's account when the patient has not given our office adequate notice (more than 24 hours) of an office appointment cancellation. Two no show appointments will result in a letter to the patient and primary care physician. Three no show appointments will result in termination of care. If a patient who has not established with the practice misses their first appointment on three separate occasions, they will not be scheduled for any further appointments.

PATIENT MEDICAL REGISTRATION

Refunds: Patients will be refunded any overpayment once all claims on the account have been processed and the patient has been released from care. The accounts payable department will issue a refund check in a timely manner.

Self-Pay: All new patients without proof of insurance will be required to pay a deposit at the time of service in the amount of \$341.00. For follow-up appointments, the patient will be required to pay \$182.00 at the time of service. All new fracture care patients will be required to pay a deposit at the time of service in the amount of \$650. For follow-up appointments, the patient will be required to pay \$264.00 at the time of service. Patients scheduled for injections and other office procedures may be required to pay additional amounts at the time of service. PATIENTS SHOULD BE AWARE THIS IS ONLY A DEPOSIT! THE TOTAL CHARGES MAY BE MORE OR LESS THAN THE INITIAL DEPOSIT COLLECTED. Any remaining balance for the visit will be collected at check out.

Self-pay Bundle Pricing (HealthMe): We are pleased to offer direct pricing to patients who have a high deductible, are not in network or who may not have health insurance coverage. We are able to offer this pricing to our self-pay patients when payment is made in full at time of service. Please visit our website www.floridajointspine.com to view pricing and make a purchase. Patients must provide the Redemption code at time of check in.

Surgery Cancellation Fee: Patients who cancel their surgery with less than 48 hours' notice will be charged a \$200.00 fee for the late cancellation. Surgery will not be rescheduled until the fee is paid.

Surgery Pre-payment: Patients are required to pay their portion of the surgical fee two (2) business days prior to the surgery. Patients unable to pay may be required to have their surgery rescheduled.

Travelers Insurance for International Patients: Any international patients who have Canadian, International health care insurance or traveler's insurance, automatically become Self Pay patients. The patient will be responsible for charges at the time of service. It is the patient's responsibility to file their claim with the insurance company. Our office would be happy to assist you with this.

Worker's Compensation: If a patient is injured on the job, it must be reported to the employer unless the patient is worker's compensation exempt. The initial appointment is to be handled through the worker's compensation adjuster. If the employee is worker's compensation exempt, you must provide a copy of the State exemption. Any non-participating worker's compensation carrier will be required to sign our worker's compensation agreement before making any appointments for the patient. The adjuster will be required to provide any non-English speaking patient with a translator.

Physician Phone Calls: When calling the office to speak with your doctor or another member of the office we will do our best to return your phone call within 48 hours. Since we are not an urgent care clinic, if you have an emergency, we advise that you go to your nearest emergency room.

Psychological Evaluation: Because of the nature of our treatment, there may be occasions when the physician determines that a psychological evaluation is necessary. For example, many healthcare plans require evaluations prior to intrathecal pump or spinal cord stimulator trials. We reserve the right to discontinue care if you fail to obtain an evaluation as requested

Staff: We require our staff to address our patients with professionalism and we ask our patients to do the same. If at any time our staff feels that your tone or language is offensive or abusive, we expect them to terminate the conversation immediately and notify their immediate supervisor or practice administrator. We will document your record and depending on the severity of the situation, you may be discharged from the practice.

I understand that it is my responsibility to inform Florida Joint & Spine, P.A. of any changes in my health insurance information and/or contact information. I understand and accept the terms of this Financial Policy.

«PatientFullName»
Printed Name

«PatientDOB»
Date of Birth

Patient/Legal Representative Signature

Relationship to Patient

«ApptDate»
Date

Patient Name: «PatientFullName»

DOB: «PatientDOB»

Patient #: «PatientNumber»

PATIENT MEDICAL REGISTRATION

Current Medication:

Start Date	Medication Name	Dose	Frequency	Prescribing Practitioner	Reason for Medication	End Date

Do you have any allergies: _____

Have you tried any of the following medications:

Start Date	Medication Name	Dose	Frequency	Prescribing Practitioner	Reason for Medication	End Date
	Kadian					
	Lidoderm Patch or cream					
	Lyrica					
	Methadone					
	Mobic (Meloxicam)					
	MS Contin (Morphine)					
	Neurontin (Gabapentin)					
	Nucynta (Tapentadol)					
	Opana (Oxymorphone)					
	Percocet (Oxycodone)					
	Oxycontin					
	Robaxin					
	Skelaxin					
	Soma					
	Suboxone					
	Toradol					
	Ultram					
	Voltaren Gel					
	Zanaflex (Tizanidine)					

What makes your pain better:

Sitting Standing Resting Cold Therapy Heat Therapy Walking/Exercise

What makes your pain worse:

Sitting Standing Resting Cold Therapy Heat Therapy Walking/Exercise

Describe your pain, circle all that apply:

Aching Burning Exhausting Shooting Tiring Stabbing Nagging Gnawing
Numb Sharp Miserable Tender Unbearable

PATIENT MEDICAL REGISTRATION

Medical History:

Surgical History:

Heart Attack	Yes	No	Cervical Epidural Injection	Yes	No
Arrhythmia	Yes	No	Lumbar Epidural Injection	Yes	No
High Blood Pressure	Yes	No	Caudal Epidural Injection	Yes	No
Are you taking a Blood Thinner	Yes	No	Stellate ganglion block	Yes	No
Heart Murmur	Yes	No	Lumbar sympathetic block	Yes	No
Stroke	Yes	No	Trigger point injection	Yes	No
Chronic Obstructive Pulmonary Disease	Yes	No	Discogram	Yes	No
Do you have a pacemaker or defibrillator?	Yes	No	Occipital nerve block	Yes	No
Asthma	Yes	No	Spinal cord stimulator	Yes	No
GERD	Yes	No	Intrathecal pump	Yes	No
Cancer	Yes	No	Spinal Fusion	Yes	No
Diabetes	Yes	No	Decompression Surgery	Yes	No
Epilepsy or Seizure disorder	Yes	No	Hardware Placement	Yes	No
Anemia	Yes	No	Kyphoplasty	Yes	No
Currently taking blood thinner	Yes	No	Please list other surgeries below:		
Neuropathy	Yes	No			
Osteoporosis	Yes	No			
Rheumatoid Arthritis	Yes	No			
Hepatitis	Yes	No			
Kidney Disease/Renal Disorder	Yes	No			
Spinal Stenosis	Yes	No			
Herniated Disc	Yes	No			

Circle the number that corresponds to the severity of your pain on a scale of 0-10.

“0” means no pain and “10” is the worst pain you can imagine.

At its worst: 0 1 2 3 4 5 6 7 8 9 10

At its best: 0 1 2 3 4 5 6 7 8 9 10

Family Medical History:

Cancer-Type: _____

Family Unknown: _____

Diabetes: _____

CVA Stroke: _____

Other: _____

Hypertension: _____

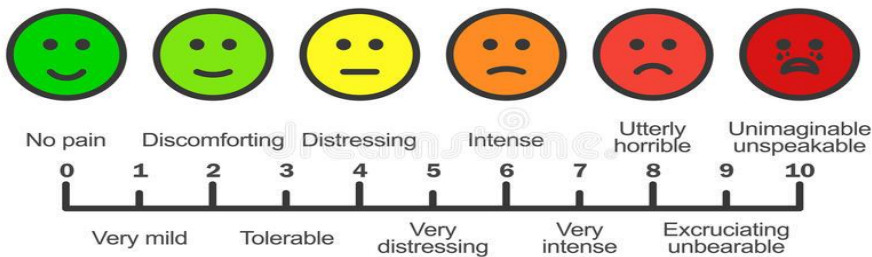
PATIENT MEDICAL REGISTRATION

REVIEW OF SYSTEMS

symptoms today: _____		Circle if you have any of the following today:	
Covid Vaccine ☐ Yes ☐ No	Medical power of attorney: Yes No Name of power attorney: _____		
General	Cardiovascular	Metabolic	Skin
Fever Weakness Chills Weight Gain or Weight Loss	Palpitations / Murmur Leg Swelling / Edema Syncope / Fainting	Cold Intolerance Heat Intolerance	Rash Skin Lesions Skin Infections Redness Itchy Skin
Ears, Nose & Vision	Gastrointestinal (GI)	Neurological	Blood Disorders
Blurred Vision Nosebleeds Headaches Vertigo /Dizziness	Constipation Diarrhea Nausea Vomiting	Difficulty Walking Dizziness Poor Coordination Muscle Weakness	Bleeding Bruising
Respiratory	Urinary	Recent Falls	Endocrine
Difficulty Breathing Recent Infections Wheezing Cough	Difficulty Urinating Frequent Urination Blood in Urine	YES NO Date: / / Where: _____	Excessive Thirst Excessive Sweating
Patient Status Update			
Allergies Change: _____	Primary care physician/Specialist: _____	Medication Changes: _____	
_____	_____	_____	
_____	_____	_____	

Circle the number that corresponds to the severity of your pain on a scale of 0-10.

"0" means no pain and "10" is the worst pain you can imagine.



PREVIOUS TREATMENTS

Physical Therapy _____
Home Exercises _____
NSAID's Medication _____
Cortisone Knee Injection ____
(Without Relief)
Rest, Ice Compression, Elevation

Tobacco Use:

Current Former Never
Type: _____
Packs/Day: _____
Years Used: _____

Patient Signature: _____ Date: «CurrentDate» _____

PATIENT MEDICAL REGISTRATION

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates *low* risk for future opioid abuse, a score of 4 to 7 indicates a moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

INSTRUCTIONS: Mark each box that applies, in the column that corresponds with your gender.

	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal Drugs	2	3
Prescription Drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Prescription drugs	5	5
Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disorder		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals:		

Name: _____ Date: _____

Questionnaire developed by Lynn R Webster, MD to assess risk of opioid addiction

Webster LR, Webster R Predicting aberrant behaviors in Opioid-treated patients preliminary validation of the Opioid risk tool. Pain Med 2005; 6 (6): 432

Patient Name: «PatientFullName»
Date of Visit: «ApptDate»

DOB: «PatientDOB»

Patient #: «PatientNumber»

PATIENT MEDICAL REGISTRATION

OSWESTRY PAIN DISABILITY QUESTIONNAIRE

This questionnaire has been designed to give your Physician information as to how your pain has affected your ability to manage in everyday life. Please answer every section and mark only the ONE box which best applies to you at this moment.

SECTION 1 — PAIN INTENSITY

- ☐ I can tolerate the pain that I have without the use of medication.
- ☐ The pain is bad but I can manage without taking pain medication.
- ☐ Pain medication gives me complete relief from pain. Pain medication gives me moderate relief from pain. Pain medication gives me very little relief from pain
- ☐ Pain medication has no effect on the pain and I don't use it

SECTION 2 — PERSONAL CARE (Dressing)

- ☐ I can take care of myself normally without an increase in pain
- ☐ I can look after myself normally but it increases in pain
- ☐ It is painful to take care of myself, requiring me to be slow and careful
- ☐ I need some help but manage most of my personal care. I need help every day in most aspects of self-care
- ☐ I do not get dressed. I wash myself with difficulty and stay in bed

SECTION 3 - LIFTING

- ☐ I can lift heavy weights without increasing my pain. I can lift heavy weights but it does increase pain
- ☐ Pain prevents me from lifting heavy weights off the floor, manage able if conveniently Coca ted.
- ☐ Pain prevents me from lifting heavy objects off the floor, but I can manage light to medium weights.
- ☐ I can lift only very light weights
- ☐ I cannot lift or carry anything at all

SECTION 4 — WALKING

- ☐ Pain does not prevent me from walking any distance. Pain prevents me from walking more than one mile. Pain prevents me from walking more than 1/2 a mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can only walk using a cane or crutches
- ☐ I am in bed most of the time.

SECTION 5 — SITTING

- ☐ I can sit on any chair as long as I want
- ☐ I can only sit in my favorite chair as long as I like Pain prevents me sit ting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes. Pain prevents me from sit ting more than 10 minutes. Pain prevents me from sit tang at all

SECTION 6• STANDING

- ☐ I can stand as long as I like without increasing my pain I can stand as long as I like but it i increases my pain.
- ☐ Pain prevents me from standing for more than one hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

SECTION 7 - SLEEPING

- ☐ Pain does not prevent me from sleeping well. I can sleep well only using medication.
- ☐ Even with medication, I have |less than 6 hours of sleep.
- ☐ Even with medication, I have less than 4 hours of sleep.
- ☐ Even with medication, I have less than 2 hours of sleep.
- ☐ Pain prevents me from sleeping at all

SECTION 8 - SEX LIFE

- ☐ My sex life is normal and causes no increases in my pain.
- ☐ My sex life is normal but causes some increase in my pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by my pain.
- ☐ My sex life is nearly absent because of my pain.
- ☐ Pain prevents any sex life at all.

SECTION 9 – SOCIAL LIFE

- ☐ My social life is norm al and does not increase my pain
- ☐ My social life is normal but increases my pain.
- ☐ My pain has no effect on my social life apart from limiting my more energetic interests, such as dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home. I have no social life because e of my pain

SECTION 10 - T RAVELING

- ☐ I can travel anywhere without t increasing my pain.
- ☐ I can travel anywhere but it increases my pain.
- ☐ My pain is bad but I manage trips over two hours.
- ☐ My pain restricts me to journeys of less than one hour.
- ☐ My pain restricts me to short, necessary trips under 30 minutes.
- ☐ My pain prevents me traveling except to my medical appointments or to the hospital /Printed Name: _____

PATIENT MEDICAL REGISTRATION

Patient Name: «PatientFullName»

DOB: «PatientDOB»

Patient #: «PatientNumber»

Dear Patient,

Florida Joint & Spine Institute has selected **MyHealthRecord.com** for your **patient portal access**. We encourage all our patients to register for our patient portal.

From the patient portal, you can view a **summary** of each visit, exchange secure messages with your **healthcare team**, **request appointments**, **request a prescription refill**, and **pay your bill**.

To register for our patient portal, you must receive an email invitation from the office. Once you receive the email invitation, please follow these instructions to set up your account:

- Click on the link in the email to access the portal (myhealthrecord.com).
- Enter your name exactly as it is on file with the office. Otherwise, you will be denied access.
- Enter your date of birth.
- Enter your mailing zip code. Please make sure we have the correct zip code on file, or you will be denied access.
- Once all the information is entered correctly, you will be prompted to create a username and answer two (2) security questions.
- Next, you will be prompted to confirm your email address to proceed.
- You will receive an email with a PIN code. You must enter the PIN code to create your password and continue the registration process.
- Once the process is complete, you will log into the portal using your username and password.
- You will be prompted to accept the "Registration Disclaimer" to continue.

If you have any questions, please call the office at 863-385-2222 and one of our staff will assist you.

Thank you,
Florida Joint & Spine Team

5115 US Hwy 27 North · Suite · 100 Sebring, FL 33870 · Ph 863-385-2222 · Fax 863-382-8765
146 Ave B NW · Winter Haven, FL 33881 · Ph 863-299-3210 · Fax 863-299-2968



Florida Joint and Spine Institute



www.floridajointandspineinstitute.com

FLjointspine



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