

The Surgical Practice of Jed P. Weber, M.D.
Coastal Neurosurgery & Spine
646 Virginia Street, Suite 701
Dunedin, FL 34698
Phone: (727) 734-9088 Fax: (727) 734- 9066

Patient Authorization Form

Patient Full Name:

Mailing Address:

Home Phone:

Work Phone:

Mobile Phone:

Date of Birth:

Social Security Number:

Marital Status:

Email Address:

Primary Insurance:

Address:

Phone Number:

Group Name:

Subscriber Name:

Subscriber ID:

Date Of Birth:

Group Number:

Secondary Insurance:

Address:

Phone Number:

Medigap? Supplemental?

Subscriber Name:

Subscriber ID:

Date Of Birth:

Group Number:

Adjuster Name:

Phone Number:

Claim Number:

Employer Name:

Address:

Work Phone #:

Emergency Contact & Relation:

Pharmacy Name:

Emergency Phone #:

Pharmacy Phone #:

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to «FacilityName» for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service.

Signature of Responsible Party: _____ Date: _____

Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: _____ Date: _____

Patient's Name: _____

MEDICAL INFORMATION

Reason for today's evaluation? _____

List your main complaints from worst to least?

How were you injured? MVA ___ Work-Related ___ Fall ___ Non-traumatic ___ Other ___

If other explain: _____

Date of injury or onset of symptoms? _____ If MVA, approximate damage to vehicle: \$ _____

Have you had a previous neck or back problem prior to the current problem? Yes ___ No ___

If YES, explain:

Are you Right Handed [] Left Handed [] or Ambidextrous []

Have you had any of the following treatments for your current problem?

	No	Yes	Dates of Treatment:	Medical Provider:
Physical Therapy	_____	_____	_____	_____
Exercise Therapy	_____	_____	_____	_____
Chiropractic Treatment	_____	_____	_____	_____
Traction	_____	_____	_____	_____
Mainpulation w/Anesthesia	_____	_____	_____	_____
Trigger Point Injections	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____
Epidural Steroid Injections	_____	_____	_____	_____

Patient's Name: _____

CURRENT MEDICATIONS: Please list ALL medications you currently take to include vitamins, herbal supplements, over-the-counter medications as well as pain medications, muscle relaxors or anti-inflammatories:

Medication & Strength:	Dosage:	Frequency:	Reason Taking:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PAST MEDICAL HISTORY: Have you ever been treated for any of the following:

	No	Yes		No	Yes
Heart Attack or MI	_____	_____	Bleeding Disorders	_____	_____
High Blood Pressure	_____	_____	Anemia	_____	_____
Thyroid Disease	_____	_____	Osteoporosis	_____	_____
Ulcer or Reflux	_____	_____	Pacemaker (list type)	_____	_____
Cancer (explain below)	_____	_____	Hepatitis (A, B or C)	_____	_____
Asthma	_____	_____	HIV or AIDS	_____	_____
Epilepsy or Seizures	_____	_____	Liver or Kidney Disease	_____	_____
Stroke or CVA or TIA	_____	_____	Emphysema or COPD	_____	_____
Diabetes Mellitus	_____	_____	Obstructive Sleep Apnea	_____	_____
Anxiety or Panic Disorder	_____	_____	Previous Drug Abuse	_____	_____
Claustrophobia	_____	_____	Previous Alcohol Abuse	_____	_____

If YES, explain details or list any other serious medical conditions not listed above:

Patient's Name: _____

MEDICATION ALLERGIES & ADVERSE REACTIONS:

Name of Medication	Type of Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SURGICAL HISTORY:

Type of Surgery	Date	Surgeon	City
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any type of metal in your body? (i.e. pacemakers, aneurysm clips, rods, screws, plates, pins, shrapnel, etc): Yes___ No___ If YES, Explain: _____

HOSPITALIZATIONS

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____

Patient's Name: _____

FAMILY HISTORY

Please list any serious family illnesses to include cancer (*type*), heart disease, heart attack, stroke, diabetes, high blood pressure and/or cholesterol, mental illnesses, alzheimer's dementia, etc:

Family Member:	Family Illness	Living (<i>circle</i>)	<i>Additional Details:</i>
Father	_____	Yes No	
Mother	_____	Yes No	
Brother #1	_____	Yes No	
Brother #2	_____	Yes No	
Sister #1	_____	Yes No	
Sister #2	_____	Yes No	
Child#1	_____	Yes No	
Child#1	_____	Yes No	

Other Serious Family Illnesses: Yes___ No___ Relation _____

Please Explain: _____

SOCIAL HISTORY

Smoking: Do you or have you smoked cigarettes in the past? Yes ___ No ___ Never ___

If YES, how many packs per day and for how long? PPD: _____ Years: _____

If you quit smoking tobacco, what date did you quit? _____

Alcohol: Do you consume alcohol > 3 times per week? Yes___ No___

If YES, in an average week, how many beers or drinks do you consume? _____

Occupation: _____ Part Time ___ Full Time ___ Retired ___

Are you currently on short term disability? ___ Long term disability? ___

If YES, why and how long have you been on disability? _____

Patient's Name: _____

REVIEW OF SYSTEMS

Do you currently have or have had any problems with: *Circle One:* *Details:*

Constitutional

Fever or Chills YES NO
Weight Loss or Gain (circle) YES NO
Chronic Fatigue YES NO
Night Sweats YES NO

Eyes

Wear Glasses or Contacts YES NO
Dry Eyes YES NO
Double Vision YES NO
Blurred Vision YES NO
Vision Loss YES NO
Glaucoma YES NO
Cataracts YES NO
Previous Injuries YES NO

Ear, Nose, Throat and Mouth

Wear Hearing Aids YES NO
Hearing Loss YES NO
Balance Disturbance YES NO
Speech Difficulties YES NO
Post Nasal Drip YES NO
Sinus Headaches YES NO
Sore Throats YES NO
Swallowing Problems YES NO

Cardiovascular

Chest Pain or Angina YES NO
 Date of last: EKG: _____ Stress Test: _____
High Blood Pressure YES NO
Irregular Heart Rate YES NO
History of Heart Murmur YES NO
High Cholesterol YES NO
Swelling in Ankles/Feet YES NO
History of DVT YES NO
Cardiac Stents YES NO
Cardiac Catheterization YES NO
Pacemaker YES NO

Patient's Name: _____

REVIEW OF SYSTEMS CONTINUED:

Respiratory

Shortness of Breath YES NO
Chronic Cough YES NO
Bloody Sputum YES NO
History of Pneumonia YES NO
History of PE (pulmonary embolism) YES NO

Gastrointestinal

Indigestion or Heartburn YES NO
Nausea YES NO
Vomiting YES NO
Abdominal Pain YES NO
Diarrhea YES NO
Constipation YES NO
Blood in Stool YES NO

Genitourinary

Frequent Urinary Tract Infections YES NO
Blood in Urine YES NO
Difficulty Starting or Stopping Stream YES NO
Loss of Urine YES NO
Loss of Urine with Cough or Sneeze Only YES NO
Kidney Stones YES NO

Musculoskeletal

Neck Pain YES NO
Back Pain YES NO
Arm Pain YES NO
Arm Numbness and Tingling YES NO
Arm Weakness YES NO
Loss of Range of Motion in Arm/Shoulder Joints YES NO
Leg Pain YES NO
Leg Numbness and Tingling YES NO
Leg Weakness YES NO
Loss of Range of Motion in Leg Joints YES NO
Arm or Leg Length Discrepancy YES NO
Joint Pain or Swelling YES NO
Osteoporosis YES NO

Last Bone Density (DEXA) Test: _____

Skin (Integumentary)

Skin Disease YES NO
Rashes YES NO

Patient's Name: _____

REVIEW OF SYSTEMS CONTINUED:

Neurological

Headaches YES NO
Disorientation YES NO
Difficulty with Speech YES NO
Fainting Spells or "Blacking Out" YES NO
Problems with Memory YES NO

Psychiatric

Anxiety YES NO
Depression YES NO
Suicidal Thoughts YES NO
Hallucinations YES NO
History of Dementia YES NO
Other Psychiatric Disorders: _____

Endocrine

Excessive Thirst or Urination YES NO
Hormone Problems YES NO

Hematologic / Lymphatic

Persistent Swollen Glands or Lymph Nodes YES NO
Blood Transfusion YES NO
If Yes, When? _____

Allergic / Immunologic

Food Allergies YES NO
Immunologic Disorders YES NO

Male Reproduction:

Difficulty with Erection YES NO
Diminished Sexual Drive YES NO
Prostate Enlargement YES NO

Female Reproduction:

Pregnant YES NO
Menopause YES NO
Tubal Ligation or Hysterectomy YES NO

The above information is accurate to the best of my knowledge:

Print Name *Patient Signature* *Date*

I have reviewed the above medical information: _____
Provider Signature *Date*

DOCTOR – PATIENT RESOLUTION AGREEMENT

Patient's Full Name: _____,

The physicians and staff at "Coastal Neurosurgery and Spine" believe that good relationships between physicians and their patients are critical to providing excellent healthcare. One major obstacle to such good relationships are disputes which may develop between doctor and patient as to financial and insurance matters, the payment for surgical services, and the quality and propriety of medical care rendered and surgical services rendered (called "disputes"). These types of disputes often result in threats of litigation and unpleasant lawsuits. Therefore, "Coastal Neurosurgery and Spine" has developed a Dispute Resolution Program to address and resolve any and all disputes which may arise between Jed P. Weber, M.D. or his employees or staff (called "physicians") and any patients or family members (called "patient").

Your signing this Agreement, on behalf of the patient, confirms your agreement to abide by the Dispute Resolution Program. Our physicians have approved this program and will be bound by this Agreement.

Any and all disputes arising between the patient or patient's representative, The physicians, employees, or staff shall be resolved as follows:

The physician and patient, or their representatives, agree to enter into good faith negotiations in order to resolve any and all business or medical disputes between the parties as early as reasonably possible. In the event that these discussions and negotiations fail, the patient and physician agree to undertake voluntary, non-binding mediation, utilizing the services of a certified mediator under the laws of Florida, to assist in the resolution of the dispute. If mediation fails, then all controversies and disputes between patient and physician, of any nature, including disputes regarding insurance matters, payment for surgical services and medical care, disputes and claims arising out of medical care provided, or type and quality of medical services provided, must ultimately be resolved at arbitration as provided in the Florida Arbitration Code (Ch. 62 F.S.). The arbitration shall be binding on the parties and is in lieu of all civil lawsuits or trials by judge or jury. Each party shall choose one arbitrator, and the two arbitrators shall select a third arbitrator . All parties shall be provided discovery as permitted under the Florida Rules of Civil Procedure. The decision or the arbitrators will be binding and enforceable under Florida law.

Both patient and physician agree to abide by the Dispute Resolution Program described above. We have carefully reviewed this Agreement prior to execution and agree to be bound by the procedures outlined above.

For the Doctors

Witness

By: _____

Print Name: _____

Position: _____

Dated: _____

Witness

For the Patient

Witness as to Patient

Print Name: _____

Dated: _____

Witness as to Patient

Patient's Name: _____

NARCOTIC & PAIN MEDICATION CONTRACT

1. I acknowledge that Dr Weber's office does not prescribe narcotic pain medications at the first office visit. I agree to take narcotic pain medications as directed by my medical provider. I acknowledge that it is improper to increase the dose or take higher number of tablets and/or decrease the time between prescribed dosages without first talking with my medical provider.
2. I will use only one pharmacy. If I change pharmacies, I will notify Dr. Weber's office of the location, phone number of the new pharmacy as well as the reason I changed pharmacy locations.
3. I agree to receive prescriptions for narcotic pain medications from only one medical provider and will notify Dr Weber's office immediately if I receive any of the narcotic pain medications listed below in sections 7 and 8 from other medical providers.
4. I understand that driving a motor vehicle or operating a boat under the influence of a narcotic pain medication or muscle relaxors is against the law.
5. I am aware of possible side effects associated with taking narcotic pain medications include but are not limited to: constipation, dizziness, nausea, vomiting, fatigue, sedation, tolerance (*decreased effectiveness of the medication*), dependency and addiction.
6. Symptoms such as itching, shortness of breath, chest pain, blotches on the skin, wheezing may be allergic reactions to the medications. I will discontinue the medication immediately and contact my medical provider and/or report to the emergency room if I develop any of these symptoms.
7. I acknowledge that prescriptions for **Ultram, Vicodin, Lortab, Norco, Codeine or Darvocet** can be called or faxed into a pharmacy. If I need a refill, I will contact my pharmacy for a refill request. The pharmacy will then fax a refill authorization request form to the office which will be signed and faxed back within 2 business days.
8. Prescriptions for **Oxycodone, Percocet, Oxycontin, Roxicodone, MS Contin, Demerol, Duragesic Patches, Methadone and Diluadid** cannot be called or faxed into a pharmacy. They require a written prescription that must be signed by the physician and picked up at our office.
9. I agree to take a random drug screen if requested to do so. If I test positive for any non-prescribed medications or drugs that have not been prescribed for me by a medical provider, I will be discharged from Dr Weber's practice and not seen again.
- 10. Medications will only be filled between the hours of 9 am to 3 pm, Monday through Thursday, excluding holidays. Medications will not be refilled at any other time. Please allow 48 hours for medications to be refilled.**
11. Patients are responsible for their narcotic pain medications. Lost or stolen prescriptions will not be refilled.

I have read the above information and agree to comply:

Print Name: _____

Signature: _____

Date: _____