memorialneurospine
MEMORIAL HEALTH

Stephen Scibelli, M.D.
Michael A. Munz, M.D.
L. Alan Smith, M.D.

Dear Patient,

Thank you for choosing Memorial NeuroSpine. Our goal is to ensure that you receive the very best in patient care. In order for us to make your appointment as productive as possible we ask that you bring the following to your appointment:

- All applicable **X-Rays** (report and disks)
- All applicable **CT Scans** (report and disks)
- All Applicable **MRI studies** (report and disks)
- **EMG/Nerve Conduction Studies** (report)
- **Physician reports from the following:** (Neurology, Orthopedics, Pain Management, & Neurosurgery)

Please arrive at least 45 minutes prior to your appointment in order to complete necessary paperwork.

Thanks for allowing us the opportunity to treat you.

Please sign and date this form arid return it to us at your appointment.

Thank you.

________________________ ________________________

Signature Address

E-Mail Adress:____________________________________

3627 University Boulevard South, Suite #355 - Jacksonville, Florida 32216
Phone (904) 296-2522 • Fax (904) 296-8173

MEMORIAL NEUROSPINE
3627 UNIVERSITY BLVD S SUITE 355
JACKSONVILLE, FL 32216
PHONE (904) 296-2522 FAX (904) 296-8173

Dear Patient: ________________________________

This letter is to confirm your appointment with our office on

____________________ at __________________ with________________________________

PLEASE BRING YOUR FILMS OR CD WITH THE REPORT; ALSO PLEASE BRING ANY PRIOR RECORDS THAT MAY BE RELEVANT TO YOUR VISIT: IT IS YOUR RESPONSIBILITY TO HAVE THESE REPORTS/RECORDS WITH YOU. YOUR APPOINTMENT WILL BE RESCHEDULED IF YOU ARRIVE WITHOUT THEM. IT IS HIGHLY UNLIKELY THAT ANOTHER FACILITY WILL MAIL THEM TO OUR CENTER. PLEASE INSURE WE HAVE THEM PRIOR TO YOUR VISIT IF YOU HAD THEM MAILED TO US. IF THE TESTING WAS DONE AT A MEMORIAL OR ORANGE PARK HOSPITAL FACILITY THEN WE DO NOT NEED YOU TO BRING THE FILMS.

Please complete the enclosed packet and bring it with you on your scheduled appointment day. The release of PHI form should be completed with the names of any individuals you authorize us to speak with on your behalf (family, spouse, etc.) Please remember to bring your insurance card, identification, and copay with you.

ALL APPOINTMENTS MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE.

PAYMENT IS REQUIRED AT THE TIME OF SERVICE

Our office is located in the Medical Office Building adjoining Memorial Hospital on the right side. You will need to park and enter the building near the Wells Fargo Bank entrance.

Please feel free to contact the office with any questions you may have regarding your appointment. We look forward to meeting you.

The Staff at Memorial Neurospine

Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) ____________ (First) ____________ (MI) _____ Previous Name ____________

Address Line 1 ____________

City, State ____________ ZIP ____________

Home Phone ____________ Cell No. ____________ Work Phone ____________ Ext. ____________

Primary Care Provider (PCP) ____________ Referring Provider ____________

Rendering Provider Name (this practice) ____________ E-Mail Address: ____________

Date of Birth MM ______/DD ______/YYYY ______ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian/Pacific Islander☐Black/African American☐White☐Hispanic ☐Other ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ☐ ______

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name ____________

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name ____________ First Name ____________

Phone Number ____________ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient ____________ ☐ Guardian

Address Line 1 ____________

City, State ____________ ZIP ____________

Home Phone ____________ Work Phone ____________ Ext. ____________

Referring Provider Name ____________

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) ____________ (First) ____________ (MI) ____________

Guarantor Account Number ____________ Date of Birth MM ______/DD ______/YYYY ______

Social Security Number _____-_____-_____ Telephone ____________

E -Mail Address ____________ Sex ☐ F – Female ☐ M - Male

Address Line 1 ____________

City, State ____________ ZIP ____________

Employer____________ Employer Phone Number____________

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number____________ (_____)____________

Name of Insured____________ Patient Relationship to Insured____________

Subscriber ID (Policy Number)____________ Group ID____________ Copay Amount____________

Effective Date____________ Termination Date____________ Date of Birth MM ______/DD ______/YYYY ______

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number____________ (_____)____________

Name of Insured____________ Patient Relationship to Insured____________

Subscriber ID (Policy Number)____________ Group ID____________ Copay Amount____________

Effective Date____________ Termination Date____________ Date of Birth MM ______/DD ______/YYYY ______

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HCA Physician Services

MEMORIAL NEUROSPINE

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Memorial NeuroSpine** may include consent at satellite offices under common ownership.

I, the undersigned, authorize **Memorial NeuroSpine** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Memorial Neuroscience Center.

I acknowledge that I have been given **Memorial NeuroSpine** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.
Patient Initial: ____________

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____

Patient (or Responsible Party) Signature **Date**

Memorial NeuroSpine

Patient: ______________________ Referring Physician: ______________________

Date: __________ DOB: __________ Primary Care Physician: ______________________

Chief Complaint (reason for visit)

____

____

____

History of present illness:

Please check the following symptoms that you have:

☐ back pain ☐ leg pain ☐ tingling / numbness in leg

☐ neck pain ☐ arm pain ☐ tingling / numbness in arm

When did your symptoms begin? ____

____

Are you experiencing any problems controlling your bladder or bowel?

Bowl: ☐ Yes ☐ No Bladder: ☐ Yes ☐ No

Do you wake up at night because of your pain? ☐ Yes ☐ No

What makes your pain better? ☐ lying down ☐ sitting ☐ walking ☐ bending

Other: ______________________________

What makes your pain worse? ☐ lying down ☐ sitting ☐ walking ☐ bending

Are you currently working? ☐ yes ☐ no, due to pain ☐ retired ☐ disabled

Prior Treatments:

Medications: NSAIDS ________ Muscle relaxants ________ Narcotics ________

Steroids ________ None ________

Physical Therapy:

Date ________ Back exercise ________ Back school ________ Traction ________ Vax-D ________ None ________

Pain Management:

	Benefits
Epidural steroids ______________	______________
Nerve Blocks ______________	______________
Facet Blocks ______________	______________
IDET ______________	______________
Spinal Cord Stimulator ______________	______________
Intrathecal Pump ______________	______________
Chronic Narcotic pain suppression ______________	______________

None ________

Surgery:

Type:	Date:	Surgeon:
Diskectomy ______________	______________	______________
Decompression ______________	______________	______________
Fusion ______________	______________	______________
Other ______________	______________	______________
None ______________		

Cause of pain: ______________________

Date of onset: ______________________

Previous therapy: ______________________

PAIN HISTORY		EXAMINATION
Constent		bed
Intermittent		Chair
Steady		Walking-difficult
Exacerbation		Walking- full
Worse- Activity		Usual Work
Worse- Bed		
Worse- Emotion		Looks- Well
Sharp		Looks- ill
Crampy		Wasted
Aching		
Pressing		Bowel
Shooting		Bladder
Tearing		
Numb		Psychological
Burning		Hysterical
Tingling		Emotional
Crawling		Inappropriate
Hyperpathic		Psychotic
		Confused
		Drowsy
		Flat
		Depressed

PAIN

SENSORY LOSS

CRANIAL NERVES, HORNERS

Date

Name

Age

DOB

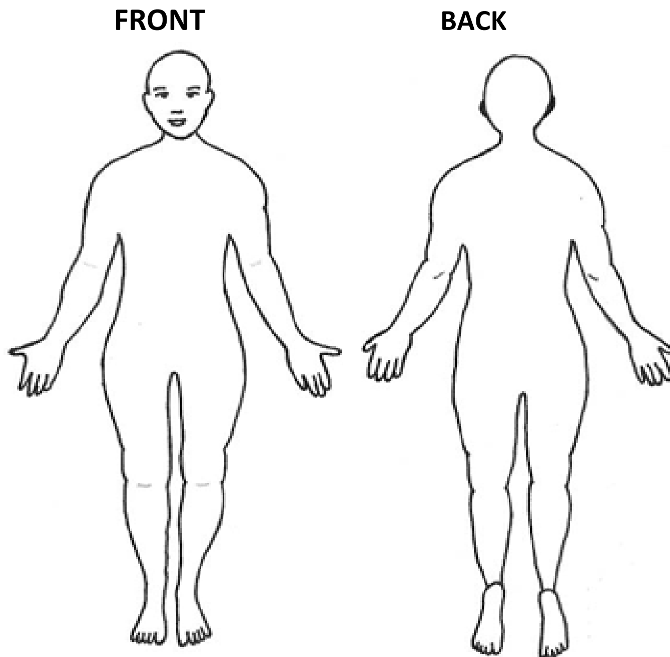
Reflexes	Co	Gag	B	S	T	F	H	A	P	A	P

Please mark which of these words describes your pain:

Throbbing	______
Shooting	______
Stabbing	______
Sharp	______
Cramping/Gnawing	______
Hot-Burning	______
Aching	______
Heavy	______
Tender	______
Splitting	______
Tiring-Exhausting	______
Sickening	______
Fearful	______
Punishing-Cruel	______

Please put a mark on the box to show how bad your usual pain has been these days.

	1	2	3	4	5	6	7	8	9	10	
NO PAIN											**WORST PAIN**



Please mark the areas of your pain on the figures

Date ______
Name ______
Age ______
DOB: ______

Memorial NeuroSpine

Patient: ______________________ Date: ____________

System Review:

• CONSTITUTIONAL SYMPTOMS

Good general health lately	☐ Yes	☐ No
Recent weight change	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Headaches	☐ Yes	☐ No

• EYES

Eye disease or injury	☐ Yes	☐ No
Wear glasses / contact lens	☐ Yes	☐ No
Blurred or double vision	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

• EARS / NOSE / MOUTH / THROAT ☐ Yes ☐ No

Hearing loss or ringing	☐ Yes	☐ No
Earaches or draining	☐ Yes	☐ No
Chronic sinus problems or rhinitls	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No
Mouth sores	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Bad breath or bad taste	☐ Yes	☐ No
Sore throat or voice change	☐ Yes	☐ No
Swollen glands in neck	☐ Yes	☐ No

• CARDIOVASCULAR

Heart trouble	☐ Yes	☐ No
Chest pain or angina pectoris	☐ Yes	☐ No
Palpitation	☐ Yes	☐ No
Shortness of breath with walking or lying flat	☐ Yes	☐ No
Swelling of feet, ankles or hands	☐ Yes	☐ No

• RESPIRATORY

Chronic or frequent coughs	☐ Yes	☐ No
Spitting up blood	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Asthma or wheezing	☐ Yes	☐ No

• GASTROINTESTINAL

Loss of appetite	☐ Yes	☐ No
Change in bowel movements	☐ Yes	☐ No
Nausea or vomiting	☐ Yes	☐ No
Frequent diarrhea	☐ Yes	☐ No
Painful bowel movements or constipation	☐ Yes	☐ No
Rectal bleeding or blood in stool	☐ Yes	☐ No
Abdominal pain or heartburn	☐ Yes	☐ No
Peptic ulcer (stomach or duodenal)	☐ Yes	☐ No

• GENITOURINARY

Frequent urination	☐ Yes	☐ No
Burning or painful urination	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Change in force of strain when urinating	☐ Yes	☐ No
Incontinence or dribbling	☐ Yes	☐ No
Kidney stones	☐ Yes	☐ No
Sexual difficulty	☐ Yes	☐ No
Male - testicle pain	☐ Yes	☐ No
Female - pain with periods	☐ Yes	☐ No
Female - irregular periods	☐ Yes	☐ No
Female - vaginal bleeding	☐ Yes	☐ No

Female - # of pregnancies _____ # of miscarriages _____

Female - date of last pap smear ______________

• MUSCULOSKELETAL

Joint pain	☐ Yes	☐ No
Joint stiffness or swelling	☐ Yes	☐ No
Weakness of muscles or joints	☐ Yes	☐ No
Muscle pain or cramps	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Cold extremities	☐ Yes	☐ No
Difficulty in walking	☐ Yes	☐ No

• INTEGUMENTARY (skin, breast)

Rash or itching	☐ Yes	☐ No
Change in skin color	☐ Yes	☐ No
Change in hair or nails	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No
Breast pain	☐ Yes	☐ No
Breast discharge	☐ Yes	☐ No

• NEUROLOGICAL

Frequent or recurring headaches	☐ Yes	☐ No
Light headed or dizzy	☐ Yes	☐ No
Convulsions or seizures	☐ Yes	☐ No
Numbness or tingling sensations	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Head injury	☐ Yes	☐ No

• PSYCHIATRIC

Memory loss or confusion	☐ Yes	☐ No
Nervousness	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No

• ENDOCRINE

Glandular or hormone problem	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Excessive thirst or urination	☐ Yes	☐ No
Heat or cold intolerance	☐ Yes	☐ No
Skin becoming dryer	☐ Yes	☐ No
Change in hat or glove size	☐ Yes	☐ No

• HEMATOLOGIC / LYMPHATIC

Slow to heal after cuts	☐ Yes	☐ No
Bleeding or bruising tendency	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Phlebitis	☐ Yes	☐ No
Past transfusion	☐ Yes	☐ No
Enlarged glands	☐ Yes	☐ No

• ALLERGIC / IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	☐ Yes	☐ No
Morphine, Demerol, or other narcotics	☐ Yes	☐ No
Novocaine or other anesthetics	☐ Yes	☐ No
Aspirin or other pain remedies	☐ Yes	☐ No
Tetanus antitoxin or other serums	☐ Yes	☐ No
Iodine methiolate or other antiseptics	☐ Yes	☐ No

Other drugs / medications ______________

Known food allergies ______________

Memorial NeuroSpine

Patient: ______________________________ Date: ______________

Current Medications (both prescription and OTC)

Medication Name	Dosage	Frequency

Medicine Allergies: ____

Special Questions:

Change in Handwriting ________________

Problem with stairs ____________________

Fine finger movement difficulties ________________

Walking or balance problems ______________________

____

______________________________ ______________

Patient Signature Date

Section A: This section must be completed for all Authorizations

Patient Name:	Date of Birth:	Patient's Phone:	Last 4 digit SSN (optional):
Provider's Name:	Recipient's Name:		
Provider's Address:	Address 1:		
	Address 2:	Recipient's Phone:	
	City:	State:	Zip:

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.,* USB drive, CD/DVD)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.,* paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.,* virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	*Date(s):*	*Description:*	*Date(s):*	*Description:*	*Date(s):*
☐ All PHI in medical record		☐ Operative information		☐ Labor/delivery summary	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing information		☐ UB-04:	
☐ Clinical test		☐ Transfer forms		☐ Other:	
☐ Medication sheets		☐ ER information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient:

Memorial NeuroSpine: Patient HIPAA Acknowledgment and Consent Form

Patient Name: ____

Date of Birth: ____

______(Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

______ (Patient initials) **Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

______ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).
The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is______________________________.
The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is______________________________.
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my request for future communications via email and/or text.
__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.
__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.
NOTE: This revocation only applies to communications from this Practice.
Patient Name: ______________________________

Patient/Patient Representative Signature: ______________________________

Date: ______________________ *Time:* ______________

Consent for Photographing or Other Recording for Security and/or Health Care Operations
____ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient Initials) I do not consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.
____ (Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:
Name: ______________________________ Date: ______________
Name: ______________________________ Date: ______________

____ (Patient initials) I do not want to designate anyone to pick-up my prescription order.

Patient Signature ______________________________ Date: ______________________

Patient Name (Printed): ______________________________ DOB: ______________________

Stephen Scibelli, M.D.
Michael A. Munz, M.D.
L. Alan Smith, M.D.

MEMORIAL NEUROSPINE

Please supply us with your email address so that we can follow up with you regarding your experience in our office. You will receive an email requesting you to rate your experience with our office.

Thank you!

First Name	**Last Name**	**E-mail Address**
____________	____________	____________

Please place an X by the name of the physician you saw:

Dr. Lewis Smith: ____________

Dr. Stephen Scibelli: ____________

Dr. Michael Munz: ____________

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IS THE REASON FOR YOUR VISIT TODAY WORKERS COMP? Y/N

IS THE REASON FOR YOUR VISIT TODAY AN AUTO ACCIDENT? Y/N

IF YES, PLEASE PROVIDE THE INSURANCE INFORMATION.

INSURANCE CARRIER NAME: ______________________________

CLAIM NUMBER: ______________________________

CLAIM ADDRESS: ______________________________

DATE OF ACCIDENT: ______________________________

ADJUSTORS NAME/PHONE #: ______________________________

PATIENT SIGNATURE: ______________________________ DATE: ________

IF THIS IS AN AUTO ACCIDENT AND YOU HAVE A LETTER OF PROTECTION, MEMORIAL NEUROSPINE **DOES NOT** ACCEPT LETTERS OF PROTECTION. THE PATIENT WOULD BE RESPONSIBLE FOR PAYMENT AFTER AUTO IS EXHAULSTED.

I ______________________________ CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT.

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Memorial NeuroSpine

Insurance Waiver

I understand that my eligibility for coverage by (name of insurance company) cannot be confirmed at this time. I wish to receive medical service from (name of physician). If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Signature of Patient/Legal

____

Date:

____

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