ShimSpine

John H. Shim, M.D.

PATIENT REGISTRATION

Please complete all of the fields below. This information is required to help us expedite any services or treatment you may require.

Patient Name: _____ **Sex**: ☐M ☐F
(Last, First, Middle Initial)

Date of Birth: / / **SS#**_____

Address:_____

City:_____ **State**:_____ **Zip**:_____

Phone:_____ **Cell Phone**:_____

Email:_____@_____

Marital Status: ☐S ☐M ☐D ☐W ☐SEP

Emergency Contact Name:_____

Emergency Contact Phone:_____

Who may we thank for referring you?_____

For the purposes of testing or treatment, what is your primary insurance? ☐None

Ins Carrier: _____ Ins Type:☐HMO ☐PPO ☐POS ☐EPO

_____ _____
Signature **Date**

BayCare Outpatient Center ▪ 12780 Race Track Road Suite 200 ▪ (813) 814-9251 ▪ Fax: (813) 814-9261
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John H. Shim, M.D.

Patient Name:_____

CONSENT FOR TREATMENT / PAYMENT AGREEMENT

Thank you for choosing our practice. I, the undersigned, for myself or on behalf of the aforementioned patient, hereby authorize the physician, employees, and staff of Florida Sports Orthopaedic & Spine Medicine to administer such medical or surgical care as may be indicated for the diagnosis and treatment of the aforementioned patient.

Payment in Full is expected at the time of service. We accept **Credit Cards, Debit Cards, and Checks.**

It is our office policy to charge patients a $100 fee if they fail to show for a scheduled office appointment without giving 24 hours notice.

I understand that John H. Shim, M.D. is not a participating provider with any health insurance plans and as such, John H. Shim, M.D. and/or Florida Sports Orthopaedic & Spine Medicine reserves the right to bill or not to bill your health insurance carrier for medical care provided. In the event that we bill your health insurance carrier for out of network benefits, I agree to be responsible for any billed amounts not covered or paid by my insurance carrier.

I understand and agree that I am responsible for any cost incurred for legal or collection fees necessary to satisfy my financial obligation to Florida Sports Orthopaedic & Spine Medicine including reasonable attorney fees, court costs, or collection expenses.

I understand and agree that photocopies of this form will be valid.

_____

Signature of Patient or Responsible Party **Date**

MEDICARE PATIENTS ONLY

I understand that Dr. John Shim has opted out of Medicare and is not a participating provider. As such, I understand that Dr. Shim / FSOSM will not submit nor allow anyone else to submit a claim for services provided to a Medicare Beneficiary. I am aware that I have the right to seek treatment by a physician or practitioner who has not opted out of Medicare. By signing this agreement, I or my legal representative accept full responsibility for the physician's charges by entering into this private contract.

_____

Signature of Patient or Responsible Party **Date**

_____

Physician (or authorized agent)

ShimSpine
John H. Shim, M.D.

PRESCRIPTION DRUG POLICY

The law requires responsible usage of drugs by doctors and patients. If you accept a prescription from one of our providers at any one of our locations, you are also accepting the responsibility to use the drug for yourself and only as prescribed. Our responsibility is to prescribe the medications in an appropriate dosage and amounts with clear instructions. We will answer any questions you have about the drug prescribed.

Drugs have the potential for abuse and are regulated closely by the state and federal agencies. More closely controlled drugs (narcotic, pain medications, and tranquilizers) require even more responsibility on your part. Pain medications are in the same family of narcotics as stronger more harmful drugs such as morphine or heroin. Actually pain pills can block your perception of pain but when they wear off, you feel the pain more because your own body has not made endorphins **(natural pain pills)** and the body thinks that the body does not needs its own natural remedy. When the pills wear off, you may experience worse pain before. Therefore, we must be careful in the prescribing of these medications to ensure they are medically necessary. We will accept **NO** excuses for medication loss or theft and will not order replacements. We will **NOT** prescribe narcotics if you are using them other than exactly as prescribed or receiving them from another source.

Many drugs are appropriate for short term use only. Our office policy is to prescribe pain medication only if necessary and in your best interest post surgically for the 90 days following your procedure. If you are not a surgical patient we will prescribe a narcotic pain medication for no more than **(30) thirty days** from the last visit. Any request past **(30) thirty days** will require you to come into the office for an appointment to be reassessed as to need. We may also require the consultation of other specialist to help decide on the course of action when we disagree about your continued use of a substance. We may decide not to refill any medication even within the **(30) day period** if it is deemed not medically necessary. Otherwise, we hold to a **NO NARCOTIC POLICY.**

Our office requires a **(48) hour call in policy** for refills of any prescription. Please call for refills before 12:00pm on Fridays and before 4:00pm on other weekdays. Medications will not be filled after normal business hours or over the weekend. Failure to follow these policies will force our practice to terminate our professional relationship and may require us to file a report with the **Department of Professional Regulation** or the local police.

If you are in agreement with all information stated above, please sign and date on the line below.

_____ _____

Signature of Patient or Patient Guardian **Date**

_____

Printed Name of Patient/Guardian

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John H. Shim, M.D.

ARBITRATION AGREEMENT – DOCTOR / PATIENT

This agreement is made between Florida Sports, Orthopaedic & Spine Medicine to include; Sang H. Choi M.D., Steven C. Mirabello M.D., John H. Shim M.D., Mark D. Torke M.D. and Casey O'Donnell D.O., their agents: Physician Assistants, employees, servants or any of the foregoing, referred to hereinafter as "Physician" and…

Referred to hereinafter as the "Patient". It is the intention of the parties of this agreement to bind not only themselves, but also their heirs, personal representatives, guardians or any persons deriving their claims through or on behalf of the Patient.

It is understood by the Patient that he or she is not required to use the aforesaid Physician or any of the physicians named for orthopaedic care, treatment and surgery and the numerous other physicians in the state of Florida and West Central Florida are qualified to perform orthopaedic care, treatment and surgery.

It is further understood that in the event of any controversy or dispute which might arise between the physicians and patient, regardless of whether the dispute concerns the medical care rendered, payment of surgical fees or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682, Florida Statutes. This arbitration shall be binding and shall be in lieu of and instead of any trial by judge or jury. Each party shall be entitled to the discovery provided for Rules 1.280-1.390, Florida Rules of Civil Procedure. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court or competent jurisdiction in and for Pinellas County, Florida.

This agreement shall remain in effect for all treatment and surgery provided the patient presently and at any future date.

In witness whereof, I (we) have set our hand this date _____

_____ _____

Physician (or authorized agent) **Patient Signature**

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John H. Shim, M.D.

NOTICE OF PRIVACY POLICY ACKNOWLEDGEMENT

The Notice of Privacy Practice tells you how we may use and share your health records. It also describes your rights with regards to your health records.
I acknowledge that the Florida Sports, Orthopaedic & Spine Medicine Notice of Privacy Policy has been made available to me. A paper copy of this Notice will be provided at my request. This Notice is also available for review at the office front desk.

_____ _____

Signature **Date**

HIPAA DISCLOSURE AUTHORIZATION

_____ _____

PATIENT NAME **PATIENT MEDICAL RECORD #**

_____ _____

DATE OF BIRTH **PHONE NUMBER**

In order to abide by Federal and State HIPAA requirements, Florida Sports Orthopaedic & Spine Medicine CANNOT and WILL NOT disclose ANY protected health information to anyone (**including family members and spouses**) without your written consent. This includes post-surgery questions, appointment verifications, and billing inquiries.

I hereby authorize use or disclosure of protected health information about me to the following individuals:

_____ _____

NAME **RELATIONSHIP**

_____ _____

NAME **RELATIONSHIP**

_____ _____

NAME **RELATIONSHIP**

☐ **I choose NOT to have any protected health information released to anyone.**

May we leave a message and/or appointment reminder? ☐ **Yes** ☐ **No**

May we text you appointment reminders? ☐ **Yes** ☐ **No**

Phone number for messages & appointment reminders: _____

Do you consent to receiving email (unencrypted) from us regarding your treatment? ☐ **Yes** ☐ **No**

I understand I may add individuals or revoke this authorization at any time.

_____ _____

Signature **Date**

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NAME:_____ **DATE:** _____

Height:_____ Weight_____

PHARMACY NAME & LOCATION:

_____

_____

CURRENT MEDICATIONS: ☐ None

Drug / Strength / Frequency Taken

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES: ☐ None

_____

_____

MEDICAL HISTORY OF THE PATIENT:

(Check all that apply in the past & present)

☐Anemia
☐Artificial Joints
☐Asthma
☐Back Pain
☐Blood Clots/DVT
☐Bowel Disorders
☐COPD
☐Cancer:_____
☐Chronic Sinus/Rhinitis
☐Claustrophobic
☐Coronary Artery Disease
☐Depression
☐Diabetes
☐Diverticulitis
☐Emphysema
☐Fibromyalgia
☐GERD/Reflux/Ulcers
☐Gallbladder Disease
☐Gout
☐Had reaction to anesthesia?
☐Head Trauma/Injury
☐Heart Problems / Heart attack
☐Hepatitis / HIV / AIDS
☐Hernia
☐High Cholesterol
☐High Blood Pressure
☐Kidney Disease / Stones
☐Liver Disease
☐Lung Disease
☐Neurologic Disorder
☐Neuropathy
☐Osteoporosis
☐Pacemaker
☐Peripheral Vascular Disease
☐Polio
☐Rheumatoid Arthritis
☐Seizures/Epilepsy
☐Sleep Apnea
☐Spinal Stenosis
☐Stroke/ TIA
☐Thyroid Problems
☐Tuberculosis
☐Urinary Tract Infection(s)
☐Other:_____

Are you Pregnant? ☐No ☐Yes

Date of Last Bone Density Test: _____

SURGICAL HISTORY: ☐ None

Procedure: Date:

_____

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY:

Occupation:_____

Marital Status:

☐Married ☐Separated
☐Single ☐Widowed
☐Divorced ☐Domestic Partner

Alcohol Use: ☐Yes ☐No

If Yes, how often?

☐Occasional ☐ < 3 times/wk ☐> 3 times/wk

Tobacco Use: ☐Yes ☐No ☐ Quit

☐Cigarettes____ pks/day
☐Cigars_____ /day
☐Chew_____ cans/day

Recreational Drug Use: ☐Yes ☐No ☐ Past

FAMILY HISTORY:

Mother ☐Cancer ☐Diabetes ☐Osteoporosis

Father ☐Cancer ☐Diabetes ☐Osteoporosis

REVIEW OF SYSTEMS:

☐Weight Gain___lbs
☐Weight Loss___lbs
☐Fatigue
☐Fever

☐Glasses or Contacts
☐Blurred Vision

☐Ringing in Ears
☐Hearing Aids
☐Nosebleeds
☐Bleeding Gums

☐Chest Pain
☐Palpitations / Tachycardia
☐Pacemaker

☐Headaches
☐Dizziness
☐Seizures
☐Loss of Sensation
☐Vertigo

☐Heartburn
☐Rectal Bleeding
☐Abdominal Pain

☐Joint Pain
☐Arthritis
☐Muscular Weakness
☐Stiffness
☐Muscular Pain

☐Blood Clots
☐Easy Bruising
☐Bleeding Tendency

☐Shortness of Breath
☐Cough
☐Wheezing

☐Nervousness
☐Depression
☐Anxiety

☐Blood in Urine
☐Burning with Urination
☐Feeling of Urgency

(Please write on back of this form if you need additional space to answer any of the above)