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?_____

Date of Injury:_____

Injury Type:☐Auto Accident ☐Work Comp ☐Litigation ☐Other

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

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

Primary Care Physician:_____

_____ _____
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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John H. Shim, M.D.

Private Financial Contract

By signing this agreement, I am aware that John Shim, M.D. does not participate with my insurance plan(s).

I understand and acknowledge that **John H. Shim, M.D. and/or Florida Sports, Orthopaedic & Spine Medicine** reserves the right to bill or not to bill available health insurance, Personal Injury Protection (PIP), or Med Pay carriers. I agree to release **John H. Shim, M.D. and Florida Sports, Orthopaedic & Spine Medicine** from any contractual arrangement and/or fee schedule and I am responsible for paying the full amount of medical bills. I agree that this document shall constitute an irrevocable letter of protection against the proceeds of any settlement or verdict related to my injury or loss claim.

I understand that I am directly and fully responsible to **John H. Shim, M.D. and/or Florida Sports, Orthopaedic & Spine Medicine** for all professional bills for medical services rendered to me, and this agreement is made solely for the physician's additional protection in consideration of his awaiting payment. I further understand that such payment is not dependent upon any settlement, judgement, or verdict which I may eventually recover and in the event that I do not obtain any settlement, judgement, or verdict with regard to the above referenced injury or loss claim, I am still responsible for any outstanding balance due to **John H. Shim, M.D and/or Florida Sports, Orthopaedic & Spine Medicine.**

I authorize **John H. Shim, M.D.** to endorse any check written in both our names where the check is in payment for services rendered regarding my injury or illness. If an attorney is representing me, I authorize the attorney to pay directly to **John H. Shim, M.D**. any outstanding balance that may be due for professional services rendered to me. I understand that **John H. Shim, M.D** will not accept any sums less than the full amount owed from my attorney without his prior written consent. I further agree and direct that the amounts owed to **John H. Shim, M.D. and/or Florida Sports, Orthopaedic & Spine Medicine** shall be paid in full prior to any disbursement to me by my attorney and direct my attorney promptly.

By signing this contract, I agree not to submit bills or have them submitted on my behalf for services provided by **John H. Shim, M.D** to my health insurer, PIP, or Med Pay carrier. In the event they are submitted and payment is made to **John H. Shim, M.D.** and/or I shall remain liable for any balanced owed. **John H. Shim, M.D.** will not accept application of a fee schedule by any health insurer, PIP, or Med Pay carrier. I shall remain liable for any balance owed if **John H. Shim, M.D. and/or Florida Sports, Orthopaedic & Spine Medicine** elects to return any payment to the health insurer, PIP, or Med Pay carrier.

I agree that in the event this document or the underlying debt is litigated, the prevailing party shall be awarded reasonable attorney's fees as well as costs.

If I have an attorney that represents me, I hereby authorize **John H. Shim, M.D.** to furnish the attorney on record, with a full report of examinations, diagnosis, treatment, prognosis concerning the injury or illness for which I am being treated. If I currently do not have an attorney representing me, but retain an attorney in the future or change my attorney on record, I will notify **John H. Shim, M.D. and Florida Sports, Orthopaedic & Spine Medicine** within two weeks of doing so.

By signing this agreement, I am entering into this financial agreement with **John Shim, M.D and Florida Sports, Orthopaedic & Spine Medicine** on a voluntary basis, recognizing that I am entitled to seek medical care by other providers that are in-network providers for my health plan. Furthermore, by signing below I acknowledge full acceptance of the terms of this contract. I have been advised if my attorney does not wish to cooperate in protecting the physician's interest, **John H. Shim, M.D and/or Florida Sports, Orthopaedic & Spine Medicine** may declare the entire balance due.

Attorney Name:_____

Print Name:_____ Date:_____ Time:_____

Patient Signature:_____

Physician or Physician Representative:_____

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John H. Shim, M.D.

AUTO WAIVER OF BENEFITS & RIGHTS UNDER THE PIP LAW

Please read, initial each section, and sign below:

Initial:

_____ I understand and acknowledge that under Florida PIP Law that if I have PIP benefits remaining that I have certain rights afforded to me under this law and may be entitled to the application of the PIP fee schedule and I may not be held liable for charges/bills in excess of such fee schedule limits for medical services provided.

_____ I hereby voluntarily relinquish the PIP fee schedule and its associate provisions for medical services provided to me by **John H. Shim, M.D. and/or Florida Sports, Orthopaedic & Spine Medicine**. I agree and understand that I am responsible for the balance of any charges/bills not paid by PIP insurance or other sources.

_____ PIP fee schedule shall not apply to full or any portion of **John H. Shim, M.D**. billed charges

_____ I recognized and understand that I have been advised that I may consult with my attorney before signing this waiver and I have three (3) business days following execution of this waiver to cancel this waiver.

_____ The provisions of this waiver and the Private Financial Contract shall supersede any oral or written agreement now existing or hereafter entered between myself and **John H. Shim, M.D.**

_____ I have selected **John H. Shim, M.D.** as my physician of choice to provide medical treatment for my injury or illness and would not be able to engage or continue to engage his services without this waiver

_____ I expressly state that this waiver is made freely and voluntarily with full knowledge of its terms. I have read and understand the entire Waiver, Private Financial Contract and all questions have been answered to my satisfaction.

Print Name:_____Date:_____Time:_____

Patient Signature:_____

Physician or Physician Representative:_____

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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)