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 ☐Other
(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?_____

Primary Care Physician/Internist:_____

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

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

_____ _____
Signature **Date**

309 State Street East Suite 201 Oldsmar FL 34677 ▪ (813) 814-9251 ▪ Fax: (813) 814-9261
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ShimSpine

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 ShimSpine 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 ShimSpine reserves the right to bill or not to bill your health insurance carrier for medical care provided.

I understand and agree that I am responsible for any cost incurred for legal or collection fees necessary to satisfy my financial obligation to ShimSpine 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 / ShimSpine 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.

OPIOID AND 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.

Provider Responsibility:

Prescription Limits for Acute Pain

A prescribing practitioner may prescribe up to a 3-day supply of a Schedule II Opioid to alleviate acute pain. However, a prescribing practitioner may prescribe up to a 7-day supply for acute pain if the physician determines. Refills are not permitted unless of a chronic condition, and non-opioid prescriptions can be prescribed up to 14 days.

Prescription Drug Monitoring Program

A prescriber or his/her designee has a duty to consult the Florida state website PDMP system to a patient's controlled substance dispensing history each time a controlled substance is prescribed.

Patient information

The patient needs to be aware in full detail regarding appropriate opioid use. Side effects such as tolerance, addiction, dependency, withdrawals, constipation and sedation while driving can occur. This medication is intended for the sole use of the patient and that no other medications of this nature should be obtained by any other physician. Random urine analysis could be requested at any time. Any misuse, abuse, or diversion of this prescription can lead to discharge from our practice.

Patient Responsibility:

I understand and commit to the following for the best treatment of my pain and the safest use of opioids. I will follow my treatment plan, tell provider all medications that I take (including over the counter medications), and take medications exactly as prescribed. My prescription will not be replaced if lost or stolen.

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 local law enforcement.

_____ _____

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 ShimSpine /Florida Sports, Orthopaedic & Spine Medicine to include; Sang H. Choi M.D., Steven C. Mirabello M.D., John H. Shim M.D., and Mark D. Torke M.D. , 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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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 ShimSpine 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, ShimSpine 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)