4308 Alton Road Suite 830
Miami Beach, Florida 33140
www.miamispine.com
305-532-0065

JONATHAN A. HYDE, M.D, FAAOS
Board Certified Spine Surgeon
American Board of Orthopedic Surgery

PATIENT'S INFORMATION REGISTRATION SHEET / INFORMACION DEL PACIENTE

PLEASE PRINT CLEARLY / POR FAVOR ESCRIBA LEGIBLEMENTE

TODAY'S DATE / FECHA DE HOY: ______________________________

PATIENT'S NAME/NOMBRE DEL PACIENTE: ____
Last/ *Apellido* First/*Nombre* Middle/*Segundo Nombre*

SEX/SEXO: ☐ Male /Masculino ☐ Female/ Femenino

BIRTH DATE/ FECHA DE NACIMIENTO: ___________________ **AGE / EDAD:** __________________________

MARITAL STATUS/ ESTADO CIVIL: ☐ Single/ Soltero ☐ Married/ Casado ☐ Divorced/Divorciado ☐ Widowed/ Viudo

RACE: ☐ American Indian / Indio Americano ☐ Asian /Asiático ☐ African American / Africano Americano
☐ Native Hawaiian or Pacific Islander / Nativo de Hawai o las Islas del Pacifico
☐ White / Blanco ☐ Other / Otro

ETHNIC ORIGIN / ORIGEN ÉTNICO: ☐ Hispanic / Hispano ☐ Non-Hispanic / No-Hispano ☐ Other/Otro

LANGUAGE / LENGUAJE: ____________________

SOCIAL SECURITY NUMBER/ NUMERO DE SEGURO SOCIAL: ____

PERMANENT ADDRESS/ DIRECCION PERMANENTE: ____
Street/ Calle Apartment #

City/ Ciudad: ______________________________State/ Estado: _______________Zip Code: __________________

LOCAL ADDRESS/ DIRECCION LOCAL: ____
Street/ Calle Apartment #

City/ Ciudad: ______________________________State/ Estado: _______________Zip Code: _________________

TELEPHONE INFORMATION/ INFORMACIÓN DE TELÉFONO:

Local Phone / Teléfono Local: ( ) ______________ Cell Phone /Teléfono Celular: ( ) __________________

Other Phone/ Otro Teléfono : ( ) ____

E-MAIL/CORREO ELECTRONICO: ____

COMMUNICATION PREFERENCE / PREFERENCIA DE COMUNICACIÓN: ☐ E-Mail ☐ Phone/ Teléfono ☐ Mail

PHARMACY NAME / NOMBRE DE FARMACIA : ____

Pharmacy Telephone / Teléfono de Farmacia: ____

Pharmacy Address / Direccion de Farmacia: ____

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INSURANCE INFORMATION / INFORMACIÓN DEL SEGURO

IS TODAY'S VISIT RELATED TO ANY OF THE FOLLOWING/ LA VISITA DE HOY ESTA RELACIONADA A ALGUNA DE LAS SIGUENTES?

☐ Auto Accident/Accidente de Auto ☐ Worker's Compensation Claim/Accidente de Trabajo ☐ Other/Otro

HEALTH INSURANCE INFORMATION / INFORMACIÓN SEGUROS MEDICOS:

NAME OF PRIMARY INSURANCE/NOMBRE DEL SEGURO PRIMARIO ____________________

Contract Policy ID # / Número de Contrato: ________________ Group #/ Grupo #: __________

Insurance Address/ Dirección del Seguro: ____________________

Name of Subscriber/Nombre del Asegurado : ____________________

Relation to Patient/ Relación con el Paciente: ____________________

Subscriber Date of Birth/ Fecha de Nacimiento Asegurado: ____________________

NAME OF SECONDARY INSURANCE/ NOMBRE DEL SEGURO SECUNDARIO: ____________________

Contract Policy ID # / Número de Contrato: ________________ Group #/ Grupo #: __________

Insurance Address/ Dirección del Seguro: ____________________

Name of Subscriber/Nombre del Asegurado : ____________________

Relation to Patient/ Relación con el Paciente: ____________________

Subscriber Date of Birth/ Fecha de Nacimiento Asegurado: ____________________

WORKERS COMPENSATION INFORMATION / INFORMACIÓN DE ACCIDENTE DE TRABAJO:

EMPLOYERS NAME / NOMBRE DEL EMPLEADOR: ____________________

Address/ Dirección: ____________________
Street/ Calle **Apartment #**

City/ Ciudad: ____________ State/ Estado: ________ Zip Code: ________

Adjustor's Name / Nombre del Ajustador: ____________ Claim #/ # Reclamo: __________

Insurance Company / Nombre del Seguro: ____________ Phone #/ Teléfono #: __________

Date of Accident/Fecha del Accidente: ____________

Explain/Explique: ____________________

AUTO INSURANCE INFORMATION / INFORMACIÓN DE ACCIDENTE DE AUTO:

AUTO INSURANCE CARRIER / COMPAÑÍA DE SEGURO DE AUTO: ____________________

Phone #/ Teléfono #: ____________ Date of Accident/Fecha del Accidente: ________

Auto Accident Claim # / # de Reclamación: __________ Date of Accident/Fecha del Accidente:

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Policy Holders Name/ Nombre de Asegurado : ______________________________

Policy Holder Date of Birth/ Fecha de Nacimento de Asegurado: ______________________________

Are you represented by an attorney/ Está representado por un abogado? ☐ Yes/Sí ☐ No

Attorney's Name/Nombre del Abogado: ______________________ Phone#/ Teléfono #: ______________

ADDITIONAL INFORMATION / INFORMACIÓN ADICIONAL

RESPONSIBLE PARTY OR SPOUSE/ PERSONA RESPONSABLE O ESPOSO(A) : ______________________________

Address/ Dirección: ______________________________

EMERGENCY CONTACT/CONTACTO DE EMERGENCIA:
Name/Nombre: ______________________________

PHONE #/# Teléfono: ______________________________

EMPLOYED BY/ EMPLEADOR: ______________________ Phone/ Teléfono: ______________

Address/ Dirección: ______________________________

Occupation/ Ocupación : ______________________________

REFERRED BY/ REFERIDO POR*:* ______________________________

PRIMARY CARE PHYSICIAN/ MÉDICO PRIMARIO: ______________________________

PCP Phone/PCP Teléfono: ______________________________

REFERRING PHYSICIAN/ Médico que lo Refirio: ______________________________

Referrer Phone #/ Teléfono del Médico: ______________________________

PHYSICIAN RELEASE

I hereby authorize payment of all medical insurance benefits directly to Orthopaedic and Spinal Associates of South Florida, P.A. *(Yo autorizo el pago de todos los beneficios de seguro médico directamente a Orthopaedic and Spinal Associates of South Florida, P.A.)*

I authorize the release of any medical information required by my insurance carrier. A copy of this authorization may be used in lieu of the original. *(Yo autorizo la entrega de cualquier información médica requerida por mi compañía de seguros. Una copia de esta autorización puede ser utilizada en lugar de la original.)*

I understand that I am responsible for charges not covered by this authorization or my insurance coverage. I further understand and agree that should my account be referred to an agency or attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs. *(Yo entiendo que soy responsable de los gastos no cubiertos por la autorización o mi cobertura de seguro. Además, entiendo y estoy de acuerdo que si mi cuenta se refiere a una agencia o*

un abogado para su cobro, que será responsable de todos los costos de cobranza, honorarios de abogados y costos judiciales.)

PATIENT'S SIGNATURE/FIRMA ______________________________ **DATE/FECHA:** ____________________

OFFICE POLICIES

Financial Policy

We are pleased to have you as our patient, and we are committed to providing you with our best professional care. Your understanding of our Financial Policy is important to our relationship. Please feel free to ask us any questions you may have.

Appointment Cancellation Policy

Repeated late cancellations or no shows are disruptive to the optimal delivery of care to you and our other patients. Therefore, we ask that you show us consideration by calling at least 24 hours prior to your appointment if you are unable to attend. Failing to do so will result in a '**NO SHOW APPOINTMENT FEE'** of **$25.00**. This fee cannot be billed to your insurance and will be your direct responsibility.

Insurance

Due to all the various insurance plans now in effect, we require that you check with your insurance carrier(s) regarding our participation in your specific network. There are instances when even though we are contracted with a carrier, the carrier has networks in which we do not participate. If our office does not participate in your network, you will be responsible for a large portion of or the entire bill. The carrier contact information is located on the back of your insurance card. It is your responsibility to update us with any new card that you receive from your carrier.
Some insurance plans require authorization for services in our office. It is your responsibility to acquire the appropriate paperwork, if the visit is not authorized, you will be responsible for the cost of services.
We will send your insurance carrier(s) a claim for all services provided. You will be billed for any balance due after the carrier settles your claim.

All copays are required to be paid at the time of your visit.

Insurance Assignment and Release

I certify that I have insurance coverage with above listed company(ies) and assign directly to South Florida Spine Institute, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of signature on all insurance submissions. The above named doctor/medical group may use my health care information and may disclose such information to the above-mentioned insurance company(ies) and their agents for the purpose of coordinating care, obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Billing and Collections

If necessary, the patient and/or guarantor will be held liable for any late fees, interests, collection fees, and/or reasonable attorneys' fees for the prosecution and/or collection of the patient amount owed. It is the patient's and/or guarantor's responsibility to provide South Florida Spine Institute with the updated billing and insurance information on each and every visit.

Payment Expectations

If you are not covered by insurance, you will be required to pay for your services on the date the service is received. You will receive a statement from our office after your insurance has settled your claim if there is any balance due.

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Payments are expected within 10 days of receipt of the statement. Our office accepts Cash, Checks, American express, Discover, MasterCard, Visa and Debit cards. **There will be a $35.00 charge for any returned check.**

I acknowledge that the information provided is complete and accurate. I understand South Florida Spine Institute's Financial Policy.

____ ____

Patient/Designated Representative Signature **Printed Name** **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES/ CONOCIMIENTO DE AVISO DE PRÁCTICAS DE PRIVACIDAD

I, acknowledge that I have received a copy of South Florida Spine Institute Notice of Privacy Practices. *(Yo, acepto que he recibido una copia del Aviso de Prácticas de Privacidad de South Florida Spine Institute.)*

____

Patient or legally authorized individual signature Date
Firma del paciente o persona legalmente autorizada *Fecha*

____

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal Representative, etc.)
Escriba su nombre si firmo por el paciente Relación (padre, tutor legal, representante personal, etc)

I authorize and agree that South Florida Spine Institute may disclose my protected health information to the following persons, each of who is directly involved in my care *(Yo autorizo y estoy de acuerdo que South Florida Spine Institute puede revelar mi información protegida de salud a las siguientes personas, cada uno de los que están directamente involucrados en mi atención medica):*

1.____ 2.____

3.____ 4.____

I acknowledge and agree that South Florida Spine Institute may disclose my protected health information to the persons set forth in this form unless and until I object to such disclosures, which must be provided in writing to South Florida Spine Institute. (Reconozco y acepto que South Florida Spine Institute puede revelar mi información protegida de salud a las personas establecidas en este formulario a menos que y hasta que yo indique lo contrario, que deberá ser proporcionada en escrito a South Florida Spine Institute.):

____

Patient or legally authorized individual signature Date
Firma del paciente o persona legalmente autorizada *Fecha*

____

Printed Name if signed on behalf of the patient Escriba su nombre si firmo por el paciente	Relationship (parent, legal guardian, personal Representative,,etc.) *Relación (padre, tutor legal, representante personal, etc)*

For office use only / Para uso de la oficina

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because (please specify):

____

____