

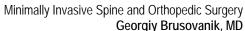


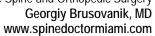
Georgiy Brusovanik, MD www.spinedoctormiami.com

Phone: 305-467-5678 Fax: 305-821-6782

PATIENT INTAKE AND INFORMATION PACKET

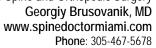
First Name:	Las	t Name:			Middle Init	ial.
Tirst Name.	Las	t Name.			Wilder IIII	iai
Date of Birth:/_	/	Social	Security#: _			
Sex:MF	Age:	Marital Statu [Circle one]:	ıs : Single	Married	Divorced	Widow
Address:				Apartr	ment: #	
City:		State:	Z	ip Code: _		
Home Telephone #:		Mobil	le/Cellular:			
Insurance Company:		r Insurance Company nan				
Group #:		. ,	••			
Policy Holder's Name:	LAST		FIRST		INITIA	NL
Insured's Date of Birth:	/	/	Insur	ed's Sex: _	M _	F
Employer Name:						
Work Address:	STREET		APARTMENT	CITY	STATE	ZIP CODE
Work Telephone:		Posi	tion:			





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PATIENT NAME:		DATE OF BIRTH: //		
REFERRAL: Were you referred by a Doctor or Patient? If so, who? AGE:				
CHIEF COMPLAINT: Main reason	for your visit today?			
ACCIDENT: Is your injury the result	t of an Accident? YES NO I	DATE OF ACCIDENT://		
MEDICINES: What Medications, V	itamins or Supplements do you take?			
	, ,			
ALLED CIEC D	· , M 1· · · ·			
ALLERGIES: Do you have any Alle	rgies to Medicines?			
SOCIAL HISTORY:				
O Do you Smoke?		ttes/packs per day?		
O Do you Drink Alcohol?	YES NO If so, how much per w			
O Do you use any Illicit Drugs?	YES NO If so, what kind and ho	ow often?		
SURGICAL HISTORY: Type of sur	rgery & dates?			
71	8 7			
	FAMILY HISTORY:			
What illnesses or health of	conditions did your MOTHER, FATI	HER and/or SIBLINGS suffer from?		
□Anemia	☐Enzyme Deficiencies	Osteoporosis		
□Arthritis	☐Heart Disease/CAD	□Prostate Disease		
□Asthma	□Hepatitis	□Stomach Ulcer/Reflux		
□Blood Clots/DVT	☐High Blood Pressure	Stroke/Seizures		
□Cancer	☐ High Cholesterol	☐Thyroid Disease		
□COPD/Lung Disease	□HIV/AIDS	☐ Vascular Disease		
Depression	□Irregular Heartbeat			
□Diabetes	☐ Liver Disease			
☐ Ehlers Danlos Syndrome	☐Marfan Syndrome			





PATIENT MEDICAL HISTORY:			
☐ Alzheimer	□ Diphtheria	□Insomnia/Sleep Disorder	☐ Prostate Enlargement/Benign Prostatic Hypertrophy (BPH)
☐ Anaphylaxis	□Diskitis	□Irregular Heartbeats/ Arrhythmia	□Pulmonary Embolism
☐ Anemia	☐ Diverticulitis or Diverticulosis	☐ Irritable Bowel Syndrome (IBS)	☐ Pulmonary Hypertension
☐ Anesthesia Problems	□Eczema	☐ Jaundice	☐ Psychiatric Care
☐ Anxiety	□Emphysema (COPD)	☐ Joint Replacement	☐Renal Dialysis
☐ Arthritis	□Epilepsy/Seizures	☐Kidney Disease	☐ Renal (Kidney) Insufficiency/Failure
☐ Artificial Heart Valve	□Fibromyalgia	☐ Kidney Stone	☐Rheumatic Fever
☐ Asthma	☐GERD/Heartburn	□Leukemia or Myeloma	☐ Rheumatoid Arthritis
☐ Atrial Fibrillation	□Glaucoma	☐ Liver Disease/Cirrhosis	☐ Seasonal Allergies
☐ Back Problems	□Gout	☐Low Blood Pressure	☐ Sexually Transmitted Diseases
☐ Bladder Infections	☐ Heart Attack	☐ Lung Disease	□Shingles
☐ Bleeding Disorder	☐ Heart Disease/Coronary Artery Disease (CAD)	□Lupus	☐ Sickle Cell Disease
☐ Blood Clots/DVT	☐ Heart Murmur	□Malaria	☐ Sleep Apnea
☐ Blood Transfusions	☐ Heart Palpitation	☐Migraine Headaches	□Smallpox
☐ Bronchitis (COPD)	☐ Heart Valve Disease	☐ Mitral Valve Prolapse (MVP)	□ Spina Bifida
☐ Cancer	□Hemorrhoids	□Neurological Disease	☐ Stroke or Transient Ischemic Attack (TIA)
☐ Cardiac Stents	□Hemophilia	□Neuropathy	☐ Thyroid Disease: Hypothyroidism or Hyperthyroidism
☐ Cataracts	Hepatitis A B C D E	☐ Osteoporosis or Osteopenia	Tuberculosis
☐ Chemotherapy or Radiation	☐Herpes Zoster	□Pacemaker	☐Tumor or Growth
☐ Congenital Deformities	☐ High Blood Pressure	□Pancreatitis	☐ Ulcerative Colitis
☐ Congestive Heart Failure	☐ High Cholesterol	□ Parkinson's	□Vertigo
☐ Crohn's Disease	☐ History of Falls	□Peptic (Stomach) Ulcer	
☐ Dementia	☐HIV or AIDS	☐Peripheral Vascular Disease	
☐ Depression		□Pneumonia	

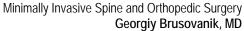


Minimally Invasive Spine and Orthopedic Surgery

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☐ Diabetes	☐ Infectious Mononucleosis	□Polio	
	(MONO)		



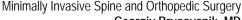
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SPEC	CIAL	IST	s I	
GEORGIY				

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REVIEW OF SYSTEMS:				
Constitutional	☐ Unexplained Weight Loss ☐ Change in Appetite ☐ Fever	□ Fatigue □ Night Sweats		
Eyes	☐ Changes in Vision ☐ Blurry Vision	□Double Vision		
Ears	☐ Hearing Difficulty ☐ Hearing Aids	☐Ringing in Ears		
Nose/Throat	□ Nosebleed □ Difficulty Swallowing	□ Dentures □ Bleeding Gums		
Respiratory	☐ Chronic Cough ☐ Shortness of Breath	□ Difficulty Breathing □ Snoring		
Cardiovascular	☐ Fainting ☐ Chest Pain with Exercise ☐ Chest Pain at Rest ☐ Abnormal Chest X-ray	□ Abnormal EKG □ Palpitations □ Foot/Ankle Swelling		
Gastrointestinal	☐ Stomach Pain ☐ Blood in Stools ☐ Nausea/Vomiting	□Diarrhea □Blood in Urine □Constipation		
Musculoskeletal	□ Joint Swelling □ Muscle Weakness	☐ Joint Pain		
Neurological	☐ Headaches ☐ Loss of Consciousness ☐ Numbness/Tingling of Hands ☐ Numbness/Tingling of Feet	□ Dizziness □ Memory Loss □ Speech Difficulties		
Endocrine	☐ Excessive Thirst ☐ Heat Intolerance	☐ Cold Intolerance		
Hematological	☐ Bruise Easily ☐ Bleed Easily	□Skin Sores □Skin Rashes		
Spine	□ Neck Pain □ Groin Numbness □ Balance Problems □ Pain shooting to Legs □ Pain shooting to Arms/Shoulders	□ Back Pain □ Incontinence □ Difficulty Walking □ Swollen Lymph Nodes		

HIPAA Information, Notice of Privacy Practices & Consent Form



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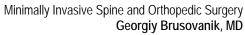
The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. What is HIPAA all about? Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Dept. of Health & Human Services at: www.hhs.gov

We have adopted the following policies:

- 1. Patient's information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. The normal course of providing care means that patient records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
- 2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. Additionally, we may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
- 3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
- 4. You understand and agree to inspections of the office and review of documents, which may include PHI, by government agencies or insurance payers in normal performance of their duties.
- 5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
- 6. Your PHI will not be used for the purposes of marketing or advertising of products, goods or services.
- 7. We agree to provide patients with access to their records in accordance with state and federal laws.
- 8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
- 9. You have the right to request restrictions in the use of your PHI and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

l,	_, ON THIS _	DAY OF		, 20	_ DO HEREBY
Patient Name	_	Date	Month	Year	
CONSENT AND ACKNOLWEDGE MY AGREEME	NT TO THE T	ERMS SET FOR	TH IN THIS HIP	AA Information	N, NOTICE OF
PRIVACY PRACTICES & CONSENT FORM AND ANY S	UBSEQUENT	CHANGES IN C	OFFICE POLICY.	I UNDERSTAND	THAT THIS
CONSENT SHALL REMAIN IN FORCE FROM THI	S TIME FOR\	WARD.			

PATIENT CARE AGREEMENT



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I,, in exchange for receiving trea MD (including all of his employees), hereby acknowledge and accept t	
(Initials). Notice of No Medical Malpractice Insurance: Under Frequired to carry medical malpractice insurance or otherwise demonst potential claims for medical malpractice. DR. GEORGIY BRUSOVANIK, Back & Neck Specialists HAVE DECIDED NOT TO CARRY MEDICAL Mermitted under Florida law subject to certain conditions. Florida law i physicians who fail to satisfy adverse judgments arising from claims of provided pursuant to Florida law. I, as a patient of this office and Dr. Bracknowledge the information provided above. Nevertheless, I have decorded pursovanik, MD.	rate financial responsibility to cover M.D. & GVB MD, LLC d/b/a Miami MALPRACTICE INSURANCE. This is mposes penalties against noninsured medical malpractice. This notice is rusovanik, fully understand and
(Initials). Consent for Treatment: I voluntarily consent to the readministration of anesthetics, injections, performance of diagnostic and that I am under the care & supervision of Dr. Brusovanik and it is the reinstructions.	d/or surgical procedures. I understand
(Initials). Assignment of Medical Benefits & Authorization for Thereby assign payment directly to Dr. Brusovanik, or any other provide & Neck Specialists (a d/b/a owned by GVB MD, LLC) accepting this assigned otherwise payable to me but not to exceed the physician's regular of financially responsible for my health insurance deductible, my coassignment, and/or for any and all charges that the insurance carrithat any credit balance, resulting from payment of insurance or other seaccounts owed to said physician(s) by the insured.	er offering services through Miami Back gnment of medical benefits applicable charges. I understand that I am pay, the charges not covered by this rier declines to pay. It is further agreed
(Initials). Release of Information: The physician(s) may disclosure any person or corporation which is or may be liable under a contract to family member or employer of the patient for all or part of the physicia to, insurance companies, workers compensation carriers, welfare funds	the physician(s) or the patient or to the n(s)' charges, including but not limited
(Initials). Limitation on Damages, Arbitration, Attorneys' fees: action, I agree to resolve any and all claims or controversies, whether in and treatment received from Dr. Georgiy Brusovanik, including but not exclusively by binding arbitration. Such arbitration will be governed by Arbitration Association, and any court of competent jurisdiction may enjudgment. I further agree that the damages, including economic and not a claim or controversy arising from the care and treatment received from exceed \$100,000.00 under any circumstances; and that I am not entitle claim or controversy. I agree that each party shall bear their own attorproceeding.	n tort or contract, arising from the care limited to claims for medical malpractice, the then current rules of the American nter the arbitrator's decision as a final on-economic damages recoverable in such om Dr. Georgiy Brusovanik should not d to recover punitive damages in any such
Print Name of Patient/Insured:	
Signature of Patient/Insured:	Date: