Felix Linetsky, M.D.

611 Druid Road East, Suite 303 ~ Clearwater, Florida 33756 ~ (727) 787-5555 ~ Fax (727) 789-9176

New Patient Information Form

Patient Name: _____ Today's Date: _____/_____/_____

Is your problem related to: ❒ Job Injury (date) _____ ❒ Car Accident (date) _____ ❒ Other (date) _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ / _____ / _____ Age: _____ Social Security #: _____--_____--_____ Sex: ❒M ❒F (check one)

Home Phone: _____ Work Phone: _____ ext.: _____ Cell Phone: _____

E-Mail Address: _____

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Employer: _____ Occupation: _____

INSURANCE COVERAGE – PRIMARY

Insurance Name: _____ Policy Type: _____ ID #: _____ Group ID #: _____

INSURANCE COVERAGE – SECONDARY

Insurance Name: _____ Policy Type: _____ ID #: _____ Group ID #: _____

INSURANCE POLICY HOLDER ❒ Self

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ / _____ / _____ Age: _____ Social Security #: _____--_____--_____ Sex: ❒ M ❒ F (check one)

Home Phone: _____ Work Phone: _____ ext: _____ Cell Phone: _____

REFERRAL INFORMATION: (Please provide the name of the referring person or source)

❒ Physician: _____ ❒ Website: _____

❒ Friend: _____ ❒ Other (please list): _____

PRIMARY CARE PHYSICIAN / PHARMACY INFORMATION / EMERGENCY CONTACT

Primary Care Physician: _____ Phone: _____

Emergency Contact(s): _____

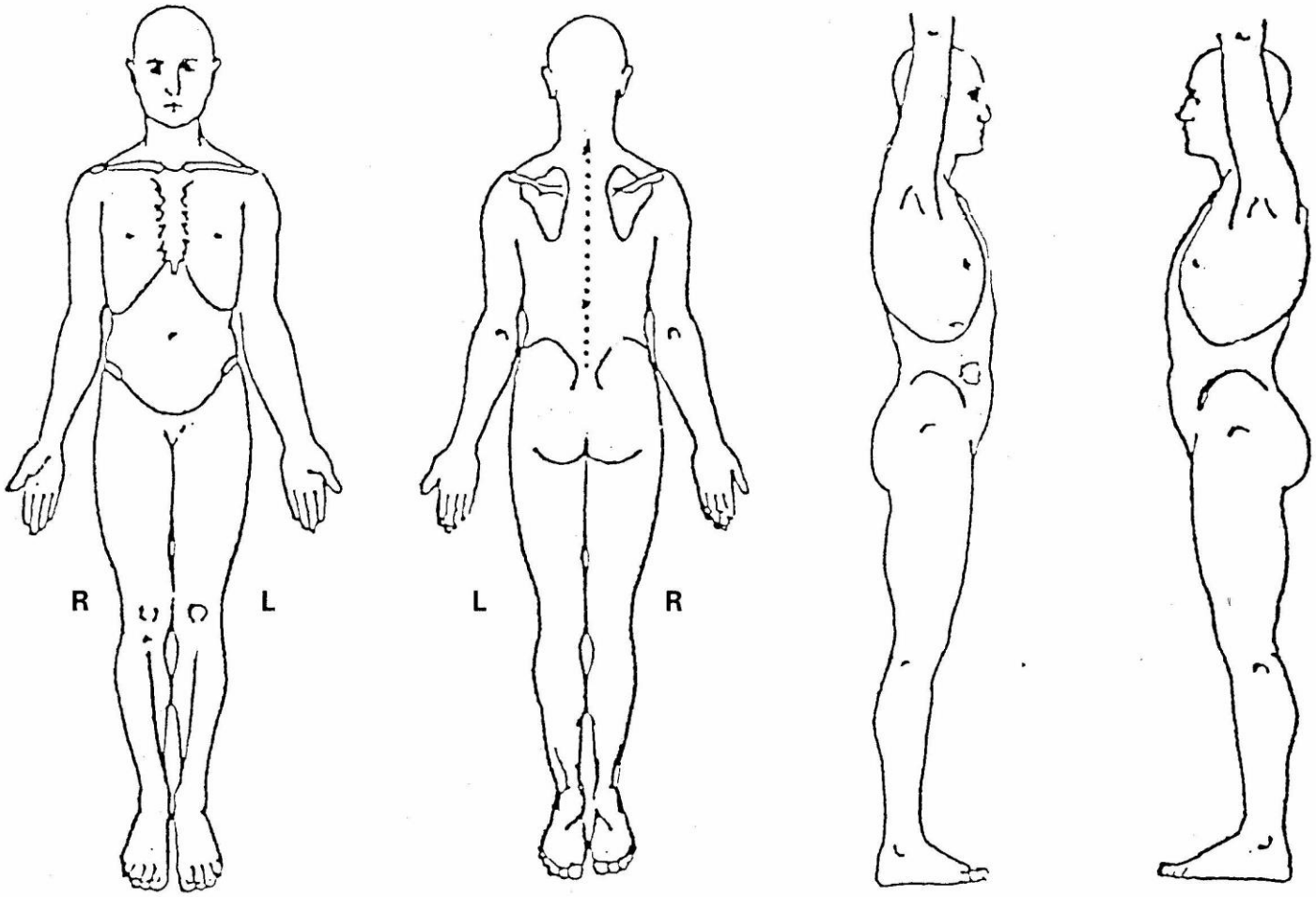
Relationship to patient: _____ Phone Number: _____

Name _____ **Date** _____

Please mark the diagrams below to indicate where on your body you feel sensations using the following symbols:

Pain xxx	**Burning = = =**	**Numbness ooo**
Stabbing /////	**Ache ^ ^ ^**	**Numb-like feeling zzz**

FRONT **BACK** **Right Side** **Left Side**



Please rate your overall pain: least 1 2 3 4 5 6 7 8 9 10 worst

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PATIENT HISTORY

Patient Name: _____ Today's Date: _____/_____/_____

Complaint/What happened:_____

_____

Date problem started: _____ Did the pain begin: ❒ gradually ❒ sudden

Does your pain wake you? ❒ YES ❒ NO The pain is: ❒ Constant ❒ Occasional

What position/activity makes the pain worse/better?

	Better	Worse	Comments
Bending			
Sitting			
General Activity			
Walking			
Lying Down			
Standing			

ACTIVITIES OF DAILY LIVING (Please check if painful)	**Usually**	**Sometimes**	**No**
Walking?	❒	❒	❒
Climbing stairs?	❒	❒	❒
Descending stairs?	❒	❒	❒
Sitting down?	❒	❒	❒
Getting up from chair?	❒	❒	❒
Reaching behind your back?	❒	❒	❒
Bending forward?	❒	❒	❒
Dressing yourself?	❒	❒	❒
Staying asleep due to pain?	❒	❒	❒
Working?	❒	❒	❒
Engaging in leisure time activities?	❒	❒	❒

Have you ever had surgery? List operation & date: _____

Do you have **allergies** to medications or foods? If so, please list: _____

_____

Allergy to Lidocaine: ❒YES ❒NO Allergy to Latex: ❒YES ❒NO

Do you take aspirin, aspirin like products or blood thinners? ❒YES ❒NO Allergy to Epinephrine: ❒YES ❒NO

What is your present state of health? (List health problems/diagnosis) _____

_____

Please list any medications, prescribed and over-the-counter:

Medication:	**Dosage:**	**Frequency:**

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PATIENT NOTICE OF PRIVACY PRACTICES

PLEASE ***INITIAL*** YOUR RESPONSES TO THE FOLLOWING QUESTIONS REGARDING THE PRIVACY OF YOUR MEDICAL INFORMATION.

1. If we refer you to a medical specialist's office, do we have your permission to share your medical information, insurance information and radiographs with their office? _____ Yes _____ No

2. Do we have your permission to share your medical information with your family members? ____ Yes ____ No

3. Do we have your permission to place medical alerts on the outside of your chart i.e. allergies, drug reactions, etc.? _____ Yes _____ No

4. If you seek medical care from another physician, do we have your permission to send them your records and radiographs? _____ Yes _____ No

If you have any other privacy concerns or comments, please write them on the reverse.

In conjunction with these privacy practices you will need to provide us with following information:

Name of any other person(s) we may speak to regarding your health information.

_____

_____

_____
Signature of Patient or Legal Guardian and Relationship to Patient

_____ Date: ____/____/____
Print Name of Patient or Legal Guardian

_____ Date: ____/____/____
Witness Signature

RELEASE OF INFORMATION:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature: _____ Date____ / _____ /_____

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ASSIGNMENT OF BENEFITS

I hereby instruct and direct my insurance carrier to pay by check made out and mailed directly to Felix S Linetsky MD, 611 Druid Rd E Suite 303, Clearwater FL 33756. *Should payment be sent directly to me, I will endorse the benefit check and forward it to Dr. Linetsky within one week of reception.* _____ ***(Please initial)***

I further assign the benefits of any insurance policies for payment of medical and surgical billings, including the right to take appropriate legal action for collection of said benefits, from any insurance company to which I have an interest as if he were proceeding in my stead.

I also authorize the release of any pertinent medical or financial information to any insurance company, adjuster or attorney involved in this case. A photocopy of this Assignment shall be considered as effective and valid as the original.

I fully understand that all charges incurred by me or my dependents for services rendered by Felix S. Linetsky, MD, are *my own financial responsibility*. All court fees, attorney's fees or other fees necessary to collect this account are payable in full by me.

POLICY OF ADDITIONAL CHARGES

The completion of information/insurance forms represents an administrative service to our patients above and beyond the provision of medical care. Recent changes in health care have resulted in the tremendous increase in the volume of information requests to our practice. The time and effort involved in providing this detailed information results in significant costs. The refusal of insurance companies and requesting agencies to cover the costs requires us to institute a policy of charges for the completion of forms as follows:

- $30.00 per forms for completion of the following:
  - Credit care deferment forms
  - Family medical leave act forms
  - Private disability insurance forms
  - School educational disability or limitation forms

- $50.00 for completion of any dictated letter describing medical care and limitations.

- $100.00-$350.00 for any narrative report detailing diagnosis, treatment and future medical care including work capacity statements. (Functional capacity evaluation testing maybe necessary prior to or in addition to the narrative report).

_____ _____

Patient's Signature Date

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MEDICAL MALPRACTICE POLICY

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. **YOUR DOCOTR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE**. This notice is provided pursuant to Florida law.

Wording pursuant to 2001 Florida statutes, Title XXXII 458, section 458.320(5)(f)

Please read and **initial** the following:

_____ I have read the paragraph above and I acknowledge that Dr. Linetsky is not carrying medical malpractice insurance at this time.

_____ I have read and signed the Consent Form, and I understand all the risks involved with the treatment that Dr. Linetsky provides.

_____ I hereby release Dr. Felix Linetsky from all liability that may arise from treatment provided.

_____
Patient Signature

_____ _____
Printed Name Date

_____ _____
Witness Date

CONSENT TO MEDICAL OR SURGICAL CARE AND TREATMENT

NOTE TO PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment.

I authorize **Felix S. Linetsky MD** and such physicians, associates, assistants and other personnel or the hospital or medical facility chosen by him or her to perform the following (IN MEDICAL TERMS KNOWN AS):

REGENERATIVE INJECTION THERAPY ALSO KNOWN AS

PROLOTHERAPY, SCLEROTHERAPY OR RECONSTRUCTIVE THERAPY

(IN COMMON TERMS KNOWN AS):

INJECTION OF AN IRRITATING SOLUTION INTO THE LIGAMENTS ABOUT A JOINT

and/or to do any other procedures that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to remedy conditions discovered during the above procedure.

- **GENERAL RISKS AND COMPLICATIONS.** I am satisfied with my understanding of the more common risks and complications of the treatment or procedure which are described generally on the back of this consent form. These risks include the risk of bleeding, infection, pain, anesthesia risks and death.
- **SPECIFIC RISKS AND COMPLICATIONS.** I am satisfied with my understanding of specific risks of this procedure or treatment including (Doctor to describe specific risks where applicable):

ALLERGY OR ADVERSE REACTION TO ANY COMPONENT OF THE INJECTION; IRRITATION OF SURROUNDING STRUCTURES (INCLUDING POSSIBLE NEURALGIA); ECCEYMOSIS (BRUISING); SWELLING; DIZZINESS; HYPERTENSION; EPIDURAL INFILTRATION; PAIN ABOUT THE INJECTION AREA AND JOINT; HEADACHE; NAUSEA; PNEUMOTHORAX

- **ALTERNATIVE METHODS OF TREATMENT.** I am satisfied with my understanding of alternative procedures or treatments and their possible benefits and risks including (Doctor to describe specific alternative procedures and complications where applicable):

OPEN SURGICAL REPAIR OF LIGAMENTS; CHRONIC MEDICATION FOR THE RELIEF OF PAIN; EXTERNAL AND INTERNAL SUPPORTS (FUSION) OF THE AFFECTED JOINT;

DO NOTHING

- **NO TREATMENT.** I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.
- **SECOND OPINION.** I have been offered the opportunity to seek a second opinion concerning the proposed treatment or procedure.
- **ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT.** I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.
- **OTHER SERVICES.** I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue or member in accordance with customary hospital or medical facility practice.
- **PHOTOGRAPHY.** I consent to the photographing, filming or videotaping of the treatment or procedure for educational or diagnostic use.
- **NO GUARANTEES.** I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.
- **OTHER QUESTIONS.** I am satisfied with my understanding of the nature of the procedure or treatments and all of my additional questions about the treatment or procedure have been answered.

I have read and been given a copy of this form.

DATE: _____ TIME _____ AM/PM

SIGNATURE: _____
(PATIENT, PARENT OR LEGAL GUARDIAN)

TRANSLATED BY (IF APPLICABLE): _____

PHYSICIAN: _____

WITNESS: _____

PLEASE READ THE GENERAL INFORMATION ON BACK.

WHITE-Office Copy CANARY-Patient Copy