

Our mission at Deuk Spine Institute is to fix back, neck and joint pain through a continuum of care philosophy in state-of-the-art facilities with world class Surgeons and Physicians. We want you to have exceptional service and the best medical care available anywhere, and we pledge to put the Patient First.

Enclosed, you will find a map to our offices. We look forward to seeing you!

Please remember...

- ✓ Bring your completed packet to your appointment.
- ✓ Bring your most current insurance card(s), including secondary insurance and a photo ID.
- ✓ Bring films or CDs with reports pertinent to your visit that were done in the last six months. (MRIs, X-Rays, CT Scans.)
- ✓ Bring a current list of medications including dosage.

Please arrive 15 minutes prior to your Scheduled appointment time.

Deuk Spine Institute:

7955 Spyglass Hill Road Suite A, Melbourne, FL 32940

Phone: (321) 255-6670 Fax: (321) 242-2545

Things to Know About Our Office

We collect insurance deductibles, co-pays, and coinsurances upon checking in. Check or Credit Card Only. **No cash, please.**

Office hours are Monday through Friday, 8:00am to 5:00pm.

Directions To Deuk Spine Institute



Start out on I-95.

0.30
miles



Take Exit 191 for Wickham Rd toward Viera/Brevard County 509



Merge onto N Wickham Rd/FL-404/County Hwy-509 heading Eastbound

0.60
miles

Follow signs for Wickham Road E



Turn left onto Murrell Rd.

0.50
miles

- *Murrell Rd is 0.1 miles past Sheriff Dr*

If you are on N Wickham Rd and reach Office Park Pl you've gone about 0.1 miles too far



Turn right onto Spyglass Hill Rd.

0.50
miles

- *Spyglass Hill Rd is 0.2 miles past Hammock Trace Dr*

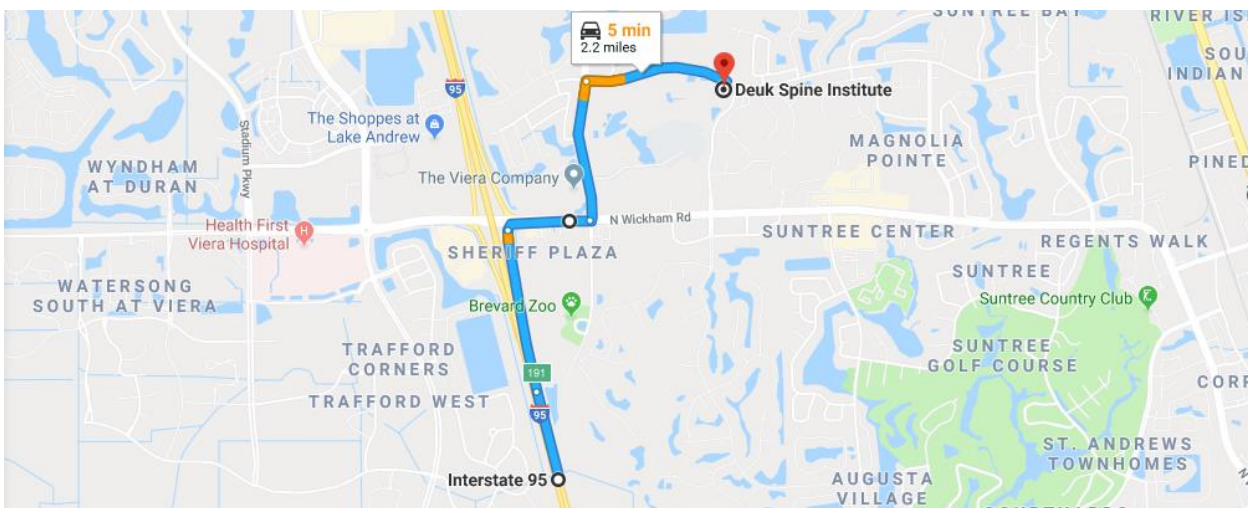
If you reach Crane Creek Blvd you've gone about 0.3 miles too far



7955 Spyglass Hill Rd, FL, 32940-8135, 7955 SPYGLASS HILL RD is on the right.

0.00
miles

- *Your destination is just past Classic Ct*
- *If you reach Baytree Dr you've gone a little too far*



What to expect on your first visit....

During your appointment here at Deuk Spine Institute you will meet a number of staff members.

First you will be greeted by the **Front Office** staff who will take your personal information pertaining to your visit. This may include identification, insurance information, medical records and any x-rays, MRI's, or other diagnostic studies that you might have. Please arrive 15 minutes prior to your first appointment with your packet of new patient forms filled out. The Front Office staff may have a few additional questions or forms for you. It is especially important for you to arrive early if you are the first patient of the day or the first patient after lunch.

You will then be escorted to a room by a **Medical Assistant**. Our Medical Assistants have advanced training above and beyond that usually found in typical clinics. The Medical Assistants, under direct supervision of our physicians, will take your blood pressure, heart rate, weight and record your level of pain at the time of the visit. We have created in-depth questionnaires that the Medical Assistants will go over with you that are an important part in your plan of care. Please cooperate with them as they are trying to provide the physician with the most pertinent information for your care.

Our Medical Assistants will assist Deuk Spine Institute physicians and Physician Assistants in basic parts of the examination including testing strength, balance and coordination. The physician and/or Physician Assistant will test their findings with the patient and perform additional examination as necessary.

Next you may meet the **Physician Assistant** or **Nurse Practitioner** who is licensed by the State of Florida to practice medicine and advanced nursing under the supervision of Deuk Spine Institute physicians. These PAs and NPs assist with surgeries, perform exams, order testing, prescribe medications and collaborate with Deuk Spine Institute physicians on all patients in the practice (clinic and the hospital), and generally serve as 'physician extenders'. WE ABSOLUTELY DO NOT PRESCRIBE NARCOTIC/OPIOD PAIN MEDICATIONS AT THE FIRST VISIT.

Some patients may or may not see the physician at the time of their visit, depending on their needs and whether all necessary diagnostic tests and imaging are available for the physician to review. However, it is our intention each and every patient at each of their visits is seen by the physician, and a physician reviews the work of all staff during clinic. In compliance with state laws, all patients have the right to see the providing physician, and in the event that he is physically unavailable, and the patient does not want to see the PA/NP, we will be happy to reschedule to the next available appointment.

Our physicians establish the plan of care for each patient individually. The doctors and our mid-level providers have close professional and personal relationships and frequently discuss patient needs and issues whether they are in the office, hospital, home, etc. We have developed our office protocols after years of research, experience, and the latest published standards of care for our specialty. Our physicians' visits with you will be focused, in depth, and to the point. In providing the highest quality of care to the patients in our very busy clinic, this approach works very well.

If you are scheduling surgery or a procedure, you will meet the **Surgery Coordinator** or **Procedure Coordinator**. The Coordinator will guide you through all of the steps prior to your surgery date. They will review pre- and post-operative instructions, assist in scheduling your pre-surgical clearance appointment with your Primary Care Physician, Internist, or Cardiologist, and are a resource person for your pre- and post-surgical questions.

The **Clinical Director** is responsible for the day-to-day hands on running of the clinic here. If you should have any questions or comments about process, please contact him/her as he/she works closely with the physicians and the rest of the team to ensure that your experience here is a positive one.

Expect **your initial appointment** to take up to 2 hours. If the surgeon has a complicated medical situation with another patient or an emergency, there may be a wait beyond your appointment time that may be as long as an hour. We work hard to keep wait times to a minimum and will advise you in advance when a wait can be expected.

Some of our new patients come to us because they attended one of our **educational symposiums** or seminars, or they may have been referred by another physician. **All new patients must complete the new patient packet of forms and bring it to their appointment.** Patient forms are available on our website at www.DeukSpine.com under *Patient Services*. **Our mission** at *Deuk Spine Institute* is to fix back, neck and joint pain through a continuum of care philosophy in state-of-the-art facilities with world class surgeons and physicians. We want you to have exceptional service and the best medical care available anywhere, and *we pledge to put the Patient first.*

Pharmacy Information Request Form

Patient Name & Address: _____

Patient Phone Number: _____

Pharmacy Name & Address: _____

Pharmacy Phone Number: _____

Patient Signature

Date

Verified By

Date

Patient Name: _____ DOB: _____

So that we may keep your primary care physician and/or referring physician informed of your progress under our care, please list the name and address of that physician.

Primary Care Physician: _____

Address: _____

Phone: _____ Fax: _____

Referring Physician: _____

Address: _____

Phone: _____ Fax: _____

Patient Signature

Date

Medical Records Release

Patient Name: _____

SSN# XXX-XX-_____ Date of Birth: _____

I hereby authorize _____ to release the following information on my behalf:

- ___ Demographic/Insurance Information
- ___ Entire Medical Record: From: _____ To: _____
- ___ Partial Medical Record: From: _____ To: _____
 - ___ Dictated Notes/Reports
 - ___ Radiology Reports
 - ___ Lab Work

Other: _____

Fees for Copies

For Personal Use: \$1.00 per page up to 25 pages, \$0.25 per page over 25 pages **For Personal Injury:** \$1.00 per page up to 25 pages, \$0.25 per page over 25 pages. **For Work Comp:** \$0.50 per page. **For Continuing Care:** (doctor-to-doctor) No charge

Patient/Legal Representative Signature

Date

Witness Signature

Date

(Validation of legal representative must be in patient chart)

Please send the selected information to one of the following:

No Charges Apply	Charges Apply
<p>___ Our Office (Deuk Spine Institute)</p> <p>___ Fax (if record is no more than 10 pages)</p> <p style="padding-left: 20px;">Fax (321)-751-3305</p> <p>___ Physician Office:</p> <p style="padding-left: 20px;">Mailing Address: _____</p> <p style="padding-left: 20px;">Office Phone: _____</p> <p style="padding-left: 20px;">Office Fax: _____</p>	<p>___ My Home:</p> <p style="padding-left: 20px;">Mailing Address: _____</p> <p style="padding-left: 20px;">_____</p> <p style="padding-left: 20px;">Phone: _____</p> <p>Will Pick Up: _____</p> <p style="padding-left: 20px;"><i>Name of individual if other than the patient</i></p> <p style="padding-left: 20px;"><i>Must provide valid identification</i></p> <p>___ Other: _____</p>

I understand these records may contain information from other health care providers, as well as information which are administrative in nature. This information will be given only to those specified on this form and only through the expiration date stated below. I also understand I have the right to revoke this authorization at any time through written notice and that written notice must include: 1) The patient’s name, social security number, and DOB, 2) reference to this specific authorization and the name of those authorized by this form to receive this information, 3) a statement that the patient wants to revoke this authorization, the effective date of revocation, and the signature of the patient or legal guardian. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal laws or regulations. This authorization will expire six months from the date specified above.

Health History

Please complete this Questionnaire.
It is designed to give us information about your health, which will allow us to better understand and assist you.

Patient Name: _____ DOB: _____ Sex: ___ M ___ F

Weight: _____ lbs Height: ___ ft ___ in Race: _____ Ethnicity: _____

What is the main reason for you visit today? (check all that apply)

- Back Pain Leg Pain Neck Pain Arm Pain Other

How long has this been a problem?

- Less than 2 months 2-6 months 6-12 months greater than one year

Please describe onset or injury of problem (include the date of injury): _____

Is your problem related to: Job injury Date: _____ Right handed Left Handed

Car Accident Date: _____

Other Date: _____

Have you been involved in a motor vehicle accident within the last 10 years? Yes No

Have you had a personal injury/slip and fall accident within the last 10 years? Yes No

Have you been involved in a work related accident within the last 10 years? Yes No

Other Concerns: _____

What are your health goals for the next year? _____

In the past 2 weeks, have you been bothered by: Little interest or pleasure in doing things? No Yes

Feeling down, depressed or hopeless? No Yes

List below the **PREVIOUS PHYSICIANS** (MD, DO, Chiropractor) you have seen for your **Neck/Back** problem

Physician	Specialty	Dates	Treatment

Indicate which **DIAGNOSTIC TESTS** you have had in evaluation of your **Neck/Back** problem (include dates).

Test	Date	Test	Date	Test	Date
Plain X-ray		EMG/NCV/ SSEP		CT Scan	
Bone Scan		Arthrogram		Dexa Scan	
Myelogram		MRI		Discogram	
Other:					

Patient Name: _____ Date of Birth: _____

What treatments have you had for this problem? (check all that apply):

- Nothing Chiropractic Care Acupuncture Injections
 Physical Therapy (Please check all that apply):
 Stretching Strengthening Traction Iontophoresis/Topical Steroid Tens Massage Ultrasound
 Heat/Ice Therapeutic Ball

Medications:

- Muscle Relaxants Pain Medications Anti-inflammatory (prescription) Anti-inflammatory (over the counter)
 Aspirin, Tylenol, etc.

Please check which **TREATMENTS** you have had for your **Neck/Back** problem and indicate whether they were helpful

Treatment	✓	Helpful?	Treatment	✓	Helpful?	Treatment	✓	Helpful?
Electrical stimulation			Massage			Whirlpool		
T.E.N.S.			Pool exercises			Injections		
Ultrasound			Home exercises			Acupuncture		
Hot packs			Manipulation			Cold		
Other:			Medications or Botox			Physical Therapy		

Current problem began?

- Suddenly Gradually Lifting Twisting Fall Bending Pulling
 Other: _____

Non-Operative Treatment **Overall improvement: _____% to date None performed**

<input type="checkbox"/> L-ESI (_____):	<input type="checkbox"/> No Benefit	<input type="checkbox"/> Improved, Non-Durable	<input type="checkbox"/> Improved, Durable
<input type="checkbox"/> L-MBB/FB (_____):	<input type="checkbox"/> No Benefit	<input type="checkbox"/> Improved, Non-Durable	<input type="checkbox"/> Improved, Durable
<input type="checkbox"/> L-Rhiz (_____):	<input type="checkbox"/> No Benefit	<input type="checkbox"/> Improved, Non-Durable	<input type="checkbox"/> Improved, Durable
<input type="checkbox"/> SI injection (_____):	<input type="checkbox"/> No Benefit	<input type="checkbox"/> Improved, Non-Durable	<input type="checkbox"/> Improved, Durable
<input type="checkbox"/> Piriformis Inj. (_____):	<input type="checkbox"/> No Benefit	<input type="checkbox"/> Improved, Non-Durable	<input type="checkbox"/> Improved, Durable
<input type="checkbox"/> TP injection (_____):	<input type="checkbox"/> No Benefit	<input type="checkbox"/> Improved, Non-Durable	<input type="checkbox"/> Improved, Durable
<input type="checkbox"/> Joint injection (_____ joint)	<input type="checkbox"/> No Benefit	<input type="checkbox"/> Improved, Non-Durable	<input type="checkbox"/> Improved, Durable
<input type="checkbox"/> GT Injection (_____ R / L)	<input type="checkbox"/> No Benefit	<input type="checkbox"/> Improved, Non-Durable	<input type="checkbox"/> Improved, Durable
<input type="checkbox"/> Supervised Therapy (_____ weeks)	<input type="checkbox"/> No Benefit	<input type="checkbox"/> Improved, Non-Durable	<input type="checkbox"/> Improved, Durable
<input type="checkbox"/> Home Exercise Therapy (_____ weeks)	<input type="checkbox"/> No Benefit	<input type="checkbox"/> Improved, Non-Durable	<input type="checkbox"/> Improved, Durable
<input type="checkbox"/> NSAIDS (_____ weeks)	<input type="checkbox"/> No Benefit	<input type="checkbox"/> Improved, Non-Durable	<input type="checkbox"/> Improved, Durable

Patient Name: _____ Date of Birth: _____

What position/activity makes the pain worse/better?

	Worse	Better	Comments
Bending			
Bowel Movement			
Coughing			
General Activity			
Home Remedies			
Lying Down			
Sitting			
Standing			
Walking			
Shifting/Changing Positions			

How long can you **STAND** with no or minimal pain _____ minutes.

WALKING DISTANCE with no or minimal pain

0-50 feet 50-200 feet 200-500 feet 500+ feet ½ mile+

Do you need **SUPPORT** to help you walk? Yes No

If yes, what kind of support? _____

Do you wear a back or neck **BRACE**? Yes No

If yes, what kind of brace? _____

Patient Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS: Please mark the box and /or circle any **persistent** symptoms you have had in the **past few months**. Read through every section and check “no problems” if none of the symptoms apply to you. List other concerns above.

General

Unexplained weight loss/
gain

Unexplained fatigue/
weakness

Fall asleep during day when
sitting

Fever, Chills

No Problems

Gastrointestinal

Heartburn / reflux/
indigestion

Blood or change in bowels

Constipation

No Problems

Allergic/Immune

Hay fever/ allergies

Frequent infections

No Problems

Breast

Breast lump/pain/nipple
discharge

No Problems

Respiratory

Cough /wheeze

Loud Snoring/altered breathing during
sleep

Short of breath with exertion

No Problems

Skin

New or change in mole

Rash /itching

No Problems

Genitourinary

Leaking urine

Blood in urine

Nighttime urination or increased
Frequency

Discharge: penis or vagina

Concern with sexual functions

No Problems

Women Only

PMS Symptoms (bloating, cramps,
irritable)

Problem with menstrual periods

Hot flashes / night sweats

No Problems

Hematologic/

Lymphatic

Swollen glands

Easy Bruising

No Problems

Neurological

Headache

Memory loss

Fainting

Dizziness

Numbness/tingling

Unsteady gait

Frequent infections

No Problems

Endocrine

Heat or cold sensitivity

No Problems

Eyes

Change in vision/ eye pain/ redness

No Problems

Psychiatric

Anxiety / stress /irritability

Sleep problem

Lack of concentration

No Problems

Cardiovascular

Chest Pain / discomfort

Palpitations

No Problems

Musculoskeletal

Neck Pain

Back Pain

Muscle /Joint Pain

No Problems

Immunizations: Check off any vaccinations you have had in the past. Add year if known.

Tetanus (Td) ___ With Pertussis (Tdap) ___ Varicella (Chicken Pox) shot or illness ___ Pneumovax (pneumonia) ___
 Influenza (flu shot) ___ Hepatitis A ___ Hepatitis B ___ MMR ___ Meningitis ___ Zostavax (shingles) ___ HPV ___

List ALL current medications:

Medication Name	Dose (milligrams, grams)	How many times per day?	How long?

Drug Allergies:

Drug	Type of Reaction?

Are you allergic to Latex? Yes No

Do you take Blood Thinners? (Coumadin, Plavix, Aggrenox, Ticlid, Pletal) Yes No

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) _____ Date: _____ **Abnormal:** Yes No

Sigmoidoscopy or Colonoscopy _____ Date: _____ **Abnormal:** Yes No

Women Only:

Mammogram _____ Date: _____ **Abnormal:** Yes No

Pap Smear _____ Date: _____ **Abnormal:** Yes No

Bone Density Test _____ Date: _____ **Abnormal:** Yes No

Social History & Status

Occupation: _____ Marital Status: _____ Highest Education: _____

Work Status

Full Duty Light Duty Off Duty (per physician) Unemployed Retired

If you are **not** working full duty, how long have you been off of work? _____

Have you had a work capacity assessment? Yes No Are you disabled through Social Security? Yes No

Alcohol Use

Do you currently consume alcoholic beverages? Yes No

Quantity per day? Beer: ____ Wine: ____ Spirits: ____

Please answer the sidebar questions: → → →

Have you ever been treated for a drug or alcohol addiction? Yes No

1. Have you ever felt you needed to cut down on your drinking? Yes No
2. Have people annoyed you by criticizing your drinking? Yes No
3. Have you ever felt guilty about drinking? Yes No
4. Have you ever felt you needed a drink first thing in the morning to steady your nerves, or to get rid of a hangover? Yes No

Sexual Activity

Currently sexually active? Yes No

Sexual partner(s) is/are/have been: Male Female

Birth control method? None Condom Pill Diaphragm Vasectomy Other: _____

Personal Medical History

Do you currently have, or have you ever had, any of the following conditions?

Condition:	Code:	Current	Past	Comments
Alcohol/ Drug Abuse	305.00/305.90			
Allergy (Hay Fever)	477.9			
Anemia	285.9			
Anxiety	300.00			
Arthritis (Rheumatoid)	714.0			
Arthritis (Osteoarthritis)	715.90			
Asthma	493.90			
Bladder /Kidney Problems				
Blood Clot (Leg)	453.40			
Blood Clot (Lung)	415.11			
Blood Transfusion	V58.2			
Breast Lump (benign)	611.72			
Cancer Breast	174.9			
Cancer Colon	153.9			
Cancer Other Type				
Cancer Ovarian	183.0			
Cancer Prostate	185			
Cataracts	366.9			
Chicken Pox	052.9			
Colon Polyp	211.3			
Coronary Artery Disease	414.00			
Depression	311			
Diabetes (adult onset)	250.00			
Diabetes (childhood onset)	250.01			
Diverticulitis	562.10			
Emphysema	492.8			
Fractures (broken bones)				Where?
Gallbladder Disease	574.20			
GERD	530.81			
Glaucoma	365.9			

Personal Med History Cont.	Code	Current	Past	Comments:
Gout	274.9			
Gynecological Cond. (Endometriosis)	617.9			
Gynecological Cond. (Fibroids)	218.9			
Gynecological Cond. (other)				
Heart Attack	410.90			
Hepatitis A	070.1			
Hepatitis B	070.30			
Hepatitis C	070.51			
Hepatitis Other	070.59			
High Blood Pressure	401.9			
High Cholesterol	272.0			
Hip Fracture	820.8			
Irritable Bowel Syndrome	564.1			
Kidney Disease/ Failure	586			
Kidney Stones	592.0			
Liver Disease	573.9			
Migraine Headaches	346.90			
Osteoporosis	733.00			
Pneumonia	486			
Prostate (enlargement)	600.00			
Prostate (nodules)	600.10			
Seizure / Epilepsy	780.39			
Skin Condition (Eczema)	692.9			
Skin Condition (Psoriasis)	696.1			
Skin Condition (Abn. Moles)	238.2			
Sleep Apnea	780.57			
Stomach Ulcer	531.90			
Stroke	434.91			
Thyroid (Nodule)	241.0			
Thyroid High (Overactive)/ Hyperthyroidism	242.90			
Thyroid Low (Underactive) / Hypothyroidism	244.9			
Other (List)				
Other (List)				

SURGICAL HISTORY

Please check off any procedures or surgeries in your history. List any abnormal finding or complications.

Surgical Procedure	Year	Comments:
Abdominal Surgery		
Appendectomy (appendix removal)		
Back Surgery (lumbar)		
Biopsy (location)		
Breast Biopsy		<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
Breast Surgery		<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
Colonoscopy		
Coronary Bypass		
Coronary Stent's		
EGD (Stomach Endoscopy)		
Cataract		<input type="checkbox"/> Laparoscopic
Gallbladder Removal		
Heart Surgery (other than coronary bypass)		
Hip Surgery		<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
Hysterectomy (total, including ovaries)		<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Vaginal <input type="checkbox"/> Abdominal
Hysterectomy (partial, ovaries left)		<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Vaginal <input type="checkbox"/> Abdominal
Knee Surgery		<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
LEEP (Cervix Surgery)		
Neck Surgery (cervical)		
Ovary Ligation (tubal)		
Ovary Removal		<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
Vasectomy		
Sigmoidscopy		
Sinus Surgery		
Other (list)		

Adopted? Yes No

If yes and you do *not* know your family history, please skip the following section.

Family History

Please indicate which (if any) relatives have had the following diseases. Parents & siblings are most important.

Disease	Mother	Father	Sister(s)	Bother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
No Significant history known										
Alcoholism / Drug abuse										
Alzheimer's										
Asthma										
Autoimmune Disease										

Disease Cont.	Mother	Father	Sister(s)	Bother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Other Type										
Cancer Ovarian										
Cancer Prostate										
Colon Polyp										
Coronary Artery Disease										
Depression, Suicide, Anxiety										
Diabetes (childhood)										
Diabetes (Adult Onset)										
Emphysema (COPD)										
Genetic Disorder (Explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
High Blood Pressure hypertension										
High Cholesterol										
Hip Fracture										
Hypothyroidism/ Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Other (list)										

Patient Name: _____ Date of Birth: _____

The preceding patient information packet has been reviewed and discussed with the patient.

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

Reviewed by: _____ Changes: YES NO Date _____

INFORMED CONSENT AND CONTROLLED SUBSTANCE AGREEMENT

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent to the drug(s) recommended to you by me, as your physician.

CONSENT TO TREATMENT AND/OR DRUG THERAPY voluntarily request Dr. Bharat C. Patel, Dr. Ara J. Deukmedjian, Dr. DeMola, as my physician, and such associates, technical assistants, nurses and other health care providers as it may deem necessary or advisable, to treat my condition which has been explained to me as: chronic pain. I hereby authorize and give my voluntary consent to administer or follow prescribed prescription(s), controlled substance(s), or narcotic medication(s) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) are addictive and may, like other drugs used in the practice of medicine, produce adverse effects or results. (See attached Narcotic Information Sheet.) The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

I understand that I will undergo medical tests and examinations before and during my treatment at Deuk Spine Institute. Those tests include random unannounced urine and/or blood test for drugs and I hereby give permission to perform the tests or my refusal may lead to termination of treatment with controlled substances. Presence of unauthorized substances may result in my discharge from Deuk Spine Institute.

For Female patients only: To the best of my knowledge,

_____ I am pregnant _____ I am not pregnant

If I am not pregnant, I will use appropriate contraception during my course of treatment. I promise to inform my doctor and/or his/her appropriately authorized assistant(s) immediately if I become pregnant during the course of treatment.

If I am pregnant, in addition to the possible risks involved with the long-term use of narcotic(s) and controlled substance(s), I further understand that information on the effects of narcotic(s) and controlled substance(s) on pregnant women and their unborn children is at present inadequate to guarantee that I may not produce significant or serious side effect(s) to my unborn child.

It has been explained to me and I understand that narcotic(s) and controlled substance(s) are transmitted to the unborn child and will cause physical dependence. Thus, if I am pregnant and suddenly stop taking narcotic(s) and controlled substance(s), I or the unborn child may show signs of withdrawal, which may adversely affect my pregnancy or the child. I shall use no other drugs without approval, since these drugs particularly as they might interact with narcotic(s) and controlled substance(s), may harm me or my unborn child.

I shall inform any other doctor who sees me during my present or any future pregnancy or who sees the child after birth, of my current or past participation in a chronic, intractable pain program in order that he may properly care of my child and me.

It has been explained to me that after the birth of my child I should not nurse the baby because narcotic(s) and controlled substance(s) are transmitted through the milk to the baby and this may cause physical dependence on narcotic(s) and controlled substance(s) in the child. I understand that for a brief period following birth, the child may show temporary irritability or other ill effects due to my use of narcotic(s) and controlled substance(s). It is essential for the child's physician to know of my participation in a narcotic(s) and controlled substance(s) treatment program so that he may provide appropriate medical treatment for the child.

Patient Initials _____

All of the above possible effects of narcotic(s) and controlled substance(s) have been fully explained to me and I understand that at present, there have not been enough studies conducted on the long-term use of the drug to assure complete safety to my child. With full knowledge of this, I consent to its use and hold Deuk Spine Institute and its physicians and all staff harmless for injuries to the embryo / fetus / baby.

MOST COMMON SIDE EFFECTS: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention, insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive narcotic(s) for the treatment of my chronic, intractable pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that the goal of taking narcotic(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. An appropriate treatment goal may even mean the eventual withdrawal from the use of all narcotic(s). I realize that the treatment for some will require prolonged or continuous use of controlled medication(s) and that my condition will be evaluated on an individual basis.

I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time, and I will be afforded detoxification under medical supervision.

The drug therapy that my physician may prescribe for me may involve using a drug that the Federal Food and Drug Administration may not have been asked by the manufacturer to review for safety or effectiveness for your condition. Current medical literature shows that such "off label" use may be beneficial to some patients and I understand that recommended dosages for treating intractable pain are often exceeded in order to balance the benefit and risk to the patient.

I understand that no warranty or guarantee has been made to me as to result of any drug therapy or cure of any condition. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

I am aware that certain other medicines such as nalbuphine (Nubain), pantazocine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of these medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low, if I follow the assigned protocol. I am aware that the development of addiction has been rarely noted in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware that physical dependence means that if my pain medicine use is markedly decreased, stopped or reverse by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any of all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

CONTROLLED SUBSTANCES AGREEMENT: This informed consent also contains the following important requirements that I must fulfill in order to participate in the Chronic Pain Treatment Program.

Patient's Initials _____

This agreement relates to my use of any controlled substance(s) (i.e., Narcotics, painkillers, prescription medications) for chronic pain prescribed by Deuk Spine Institute's Doctors and/or any appropriately authorized ancillary personnel at its office(s). I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). The Florida Department of Health has specific requirements for the use of controlled substance(s) for the treatment of chronic pain.

Therefore, controlled substance(s) will only be provided so long as I am actively participating in Deuk Spine Institute Treatment Program and adhere to the rules specified in this Agreement.

My doctor and/or any appropriately authorized ancillary personnel may at any time discontinue the narcotic prescription(s) at his/her discretion. My progress will be periodically reviewed and, if the narcotics are not improving my quality of life, the narcotics will be discontinued. I will disclose to Deuk Spine Institute drugs I take at any time, prescribed by any physician.

In the event that my doctor and/or any appropriately authorized ancillary personnel discontinue my medication and start me on another medication, the discontinued medication will need to be turned into my local police department and a copy of the receipt from the police department will need to be turned into Deuk Spine Institute prior to receiving any new medications.

The therapies necessary to treat my chronic pain have been explained to me and I understand that the therapies will involve my taking daily dosage(s) or narcotic(s), which will help to control my chronic, intractable pain.

I will use the medication(s) exactly as directed by my doctor and/or his appropriately authorized ancillary personnel. I agree not to share, sell or otherwise permit others, including my family and friends, to have access to these medications. I will not participate in the diversion of my medications for illegal use; nor will I give or sell them to anyone else.

All controlled substances must be obtained at the same pharmacy, when possible. Should the need arise to change pharmacies, I agree to inform Deuk Spine Institute I will use only one pharmacy and I will provide my pharmacist a copy of this agreement.

I authorize my doctor, and his/her appropriately authorized ancillary personnel to release my medical records to my pharmacist at his/her discretion. I also authorize any pharmacy that I am receiving medications from to release my medical records to Deuk Spine Institute.

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____ Patient's Initials _____

I understand that my medication(s) will be refilled on a regular basis. **I understand that my prescription(s) and my medication(s) are exactly like money. If either are lost or stolen, they WILL NOT BE REPLACED. I FURTHER UNDERSTAND THAT ANY REPLACEMENT OF LOST OR STOLEN MEDICATIONS IS COMPLETELY AT THE DISCRETION OF MY TREATING PHYSICIAN.** Otherwise, I will need to wait until my next scheduled refill. I will not seek the same or similar medications from any other source, whether professional or otherwise and if I am prescribed them by another practitioner, I will notify the physician here. In the event that I am arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given.

Refill(s) will not be ordered before the scheduled refill date. I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out. I agree that refills of my prescription(s) for pain medicine will be given only at the time of an office visit or during regular office hours. No refills will be available during evening hours and/or weekends. The patient or authorized person must be present in person at the office in order to be able to pick up medication script(s). I am aware of the fact that my physician will not call in any pain medication(s) to the pharmacy by phone and/or fax.

I will receive controlled substance(s) or medication(s) **only** from Deuk Spine Institute Doctors and/or their appropriately authorized ancillary personnel unless it is for an emergency or the controlled substance(s) that are being prescribed by another physician are approved by Deuk Spine Institute Doctors.

Information that I have been receiving medication(s) prescribed by other doctors, that has not been approved previously by Deuk Spine Institute doctors may lead to a discontinuation of medication(s) and treatment.

Patient's Initials _____

Until Deuk Spine Institute and/or their appropriately authorized ancillary personnel have gotten to know me and my medical history well, I understand that prescription(s) for larger quantities of medication(s) to cover me while I am out of town will not be given. Later, depending on my compliance, *Deuk Spine Institute* and/or their appropriately authorized ancillary personnel may modify this, at the sole discretion of the physicians.

If it appears to my doctor and/or his appropriately authorized ancillary personnel that there are no demonstrable benefits to my daily function or quality of life from the controlled substance(s), then my doctor and/or his appropriately authorized ancillary personnel may try alternative medication(s) and/or his appropriately authorized ancillary personnel, may taper me off of all narcotic(s). I will not hold my doctor and/or any other member of Deuk Spine Institute staff liable for problems caused by the discontinuance of controlled substance(s).

I agree to submit to urine and blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), treatment for chronic pain will be terminated and can only be restarted if I am evaluated and treated by an Addictionologist and the Addictionologist recommends continued treatment for chronic pain.

I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, behavioral medicine strategies, and surgery. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program to secure increased function and improved coping with my condition.

I agree that I shall inform any doctor who may treat me for any medical problem that I am enrolled in a narcotic(s) and controlled substance(s) treatment program, since the use of other drug(s) in conjunction with same may cause me harm.

I hereby give my doctor and/or his appropriately authorized assistant(s) permission to communicate with the referring physician(s) and any pharmacist(s) regarding my use of controlled substance(s).

I must take the narcotic medication(s) as instructed by my doctor and/or his appropriately authorized assistant(s) or in smaller doses. Any unauthorized **increase** in the dose of narcotic medication(s) may be viewed as a cause for discontinuation of the treatment with narcotic medication (s).

All opiate medications prescribed must be brought to each visit. This means you must bring your opiate medication bottles with you to each visit in order for the physician to refill your medication. The medication will then be counted by an authorized Deuk Spine Institute staff member in a sterile manner to ensure that medications are being taken as prescribed and will document those finding in your chart.

If I demonstrate unacceptable behavior patterns, my doctor and /or his appropriately authorized assistant(s) may discontinue prescribing the narcotic medication(s) for me.

I must keep all regular follow up appointments as recommended by my doctor and/or his appropriately authorized assistant(s).

I agree to be seen/re-evaluated every month, while receiving controlled substances prescriptions from Deuk Spine Institute.

Evidence of medication hoarding; increasing the amount of medication without communication to my doctor and/or his/her appropriately authorized assistant(s); refilling my prescription too frequently; getting the medication from multiple physicians; increasing the amount of the medication despite significant side effects; altering prescriptions; selling, trading, or giving away medication; un-approved use of other drugs (alcohol, sedatives, or using non-prescription medications inconsistent with drug labeling) during narcotic analgesic treatment; or other unacceptable behavior will result in tapering and discontinuing of narcotic maintenance therapy.

Patient's Initials _____

Failure to comply with any of the foregoing conditions may cause discontinuation of narcotic prescription(s) and/or your discharge from the care and treatment by Deuk Spine Institute. Discharge may be immediate for alleged criminal behavior.

I certify and agree to the following:

I am not currently abusing illicit or prescription drug(s) and I am not undergoing treatment for substance dependence or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

I have never been involved in the sale, illegal possession, diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.). No guarantee or assurance has been made as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that I would otherwise continue to have chronic pain.

I have reviewed the Narcotic Side Effect Information, on pages 1, 2, 3 and 4 that may be used in the treatment of my chronic pain. I fully understand the explanations regarding the benefits and the risks of this method. I agree to the use of narcotic medication(s) in the treatment of my chronic pain.

Patient Signature

Patient Full Name

BHARAT C. PATEL, M.D., FIPP, DABIPP

ARA J. DEUKMEDJIAN, M.D.

PHILIP M. DeMOLA, D.O.

Physician (or Appropriately Authorized Ancillary Personnel) Signature

Patient Name: _____ Date of Birth: _____

Assignment of Insurance Benefits; Appointment of Authorized Representative; Privacy; Payments; Appointments

Assignment of Insurance Benefits -- Appointment as Legal Authorized Representative: I (i) assign all applicable health insurance payments and benefits, and all rights and obligations that I and my dependents have under my health plan to the Deuk Spine Institute, LLC ("Provider"); (ii) authorize payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Provider; and (iii) appoint Provider as my authorized representative ("Authorized Representative") with the power to (i) file medical claims, appeals and grievances with the health plan; (ii) file appeals and grievances with the health plan; (iii) institute any necessary litigation and/or complaints against my health plan ***naming me as plaintiff in such lawsuits and actions if necessary*** (or me as guardian of the patient if the patient is a minor); and (iv) discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan. I also understand that Provider is not responsible for the terms of the contracts which I have with my health benefit plan or insurance companies. I certify that the health insurance and coverage information I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated. I am fully aware that having health insurance and/or Medicare coverage does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that (i) I am responsible for all amounts not covered by my health insurance and/or Medicare, including co-payments, co-insurance, and deductibles; and (ii) with respect to Medigap/Secondary Insurance, should my insurance or not pay all or part of the secondary balance, I am responsible for all remaining allowed charges.

Authorization to Release Information: I authorize my Authorized Representative and any holder of medical or other information about me to (i) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments (including the Social Security Administration or its Medicare Administrative Contractors if I am a Medicare beneficiary); (ii) process insurance and other payment claims generated in the course of examination or treatment; and (iii) allow a photocopy of my signature to be used to process insurance and other payment claims. This authorization will remain in effect until revoked by me in writing. I authorize Provider to discuss my **medical/health care** with the following family members or close friends:

Full Name: _____	Relation: _____	Phone: _____
Full Name: _____	Relation: _____	Phone: _____
Full Name: _____	Relation: _____	Phone: _____

I authorize Provider to discuss my **account finances** with the following family members or close friends:

Full Name: _____	Relation: _____	Phone: _____
Full Name: _____	Relation: _____	Phone: _____
Full Name: _____	Relation: _____	Phone: _____

ERISA Authorization: I designate, authorize, and convey to my Authorized Representative to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (i) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (ii) the right and ability to act as my Authorized Representative to pursue such claim, right or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.503-1(b)(4) with respect to any health care expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. This authorization will remain in effect until revoked by me in writing. A photocopy of this Authorization shall be as effective and valid as the original.

Payment Policy; Out-of-Network Disclosure/Patient Acknowledgment of Responsibility: I understand that (i) Provider accepts most forms of payment including checks, debit cards, credit cards and credit facilities like CareCredit (ii) Provider reserves the right to charge 1.5% interest per month, compounded daily, after 90 days of non-payment on all outstanding balances; (iii) credit cards and other revolving credit programs have chargeback provisions to allow, for example, return of purchased goods, but that such chargeback features are not appropriate at Provider, such that I waive my rights for chargebacks; (iv) if a chargeback occurs, Provider may initiate legal action to recoup those charges and I will be responsible for all resulting legal fees and other appropriate expenses to recoup those charges; and (v) Provider will assess a \$50 fee on all checks that are returned as unpaid. I understand that Provider is an out-of-network provider and that, consequently: (i) I am responsible for the difference between charges and payments made by my health plan and any coinsurance and deductible required by my health plan; and (ii) Provider cannot waive any such patient responsibility.

Notice of Privacy Practices: I have reviewed the posted copy of Provider's Notice of Privacy Practices, which describes how my medical information may be used and disclosed and how I can obtain access to this information, and I understand that a copy for my records is available upon request.

Patient Name: _____

Patient Signature: _____ Date: _____

Cancellation and No Show Policy

At Deuk Spine Institute our goal is to provide quality medical care to you and the rest of our patients. In an attempt to be fair to all patients seeking our care, we have implemented a Cancellation and No Show Policy. We understand that there are times when you may miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If you must cancel an appointment we ask that you please call at least 24 hours prior to the appointment, or earlier if possible.

To cancel an appointment, call Patient Services at 321-751-3389 or 1-800-349-6922 (1-800-FIX-MY-BACK). Each cancellation or “no show” is tracked in our system and you will receive a cancellation number. Excessive cancellations and ‘no shows’ may require us to discharge you from the practice.

**Cancellation Policy/No Show Policy
For Doctor Appointment and Surgery**

1. Cancellation/No Show policy for Doctor Appointment

We understand that there are times when you miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a forty (\$40) dollar fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will either fit you in or give you the option to reschedule the appointment.

3. Cancellation/No Show Policy for Surgery/Procedures

Due to the large block of time needed for surgery, last minute cancellations will not allow time needed to schedule another patient in need of our services.

If surgery/procedure is not cancelled at least 48 hours in advance you will be charged an eighty dollar (\$80) fee; this will not be covered by your insurance company.

4. Account Balances

We will require that patients with no show/cancellation fees pay their account balances to zero (\$0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss the charges, may call the Office Manager and review their account and concerns.

_____ /_____/_____
Print Patient Name Signature Patient Date

Patient Account # _____

Mutual Agreements, Consents and Resolution of Concerns

1. Privacy and Ratings

Deuk Spine Institute agrees not to provide medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Deuk Spine Institute will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Deuk Spine Institute has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about Deuk Spine Institute - our practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Deuk Spine Institute, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Deuk Spine Institute for any written, pictorial, and/or electronic commentary. This assignment shall be effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be for a period of five years from Deuk Spine Institute's last date of service to Patient. Deuk Spine Institute requires all patients in its practice to sign the Mutual Agreement to establish that any anonymous publishing or airing of commentary will be covered by this agreement. Further, this Agreement will survive for a minimum of three years beyond any termination of the Deuk Spine Institute - Patient relationship.

Patient and Deuk Spine Institute acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Deuk Spine Institute agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this provision result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

2. Surgical Consent Modification

We recognize that you have a choice in receiving care. We take great pride in our reputation for providing the highest levels of quality medical care to our patients. However, we realize there are times when some patients might not be satisfied with the outcomes of their treatments.

Every patient has a right to file a complaint with the Division of Medical Quality Assurance, Board of Medicine. But, that right is not unlimited. For example, those who file complaints in bad faith can be subject to civil liability (Florida Statutes § 456.073 (11)). In the context of balancing your rights with those of the physician, I, the patient, agree to the following:

1. If a complaint related to my care is ever filed (by my agent or me) with the Division of Medical Quality Assurance, I will only do so in good faith, addressing matters only related to my health and welfare.
2. In particular, I understand that there are risks inherent to any surgical procedure and these risks have been explained to me prior to the procedure. I have signed that consent voluntarily and with my free will. And I have had an opportunity to ask questions and have them answered to my satisfaction. In that context, a complaint to the Division of Medical Quality Assurance, founded on any such realized risks, unless there is clear and convincing evidence to the contrary, will be construed as bad faith.
3. Next, should a complaint be filed with the Division of Medical Quality Assurance related to standard of care, I, the patient, will explicitly request that the complaint be reviewed by a member of my specialty; that specialty being Neurosurgery, Spinal Surgery, Orthopedic Surgery, Pain Management or Neurology.
4. Finally, should the complaint allege facts that can be disrupted by the clear medical record, I, the patient, will voluntarily withdraw my complaint if that portion of the medical record is drawn to my attention. I will have the right to inspect and review the medical record to correct any perceived error in the medical history. Such corrections must be performed within two weeks of the treatment received

3. Resolution of Concerns

I understand that I am entering into a contractual relationship with Physician(s) of Deuk Spine Institute for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative, agree not to initiate or advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Medical Specialties ("ABMS") board-certified expert medical witness (es) in the same specialty as Physician.

Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the



American Board of Neurosurgery, American Board of Interventional Pain Management, American Academy of Pain Management, American Board of Electrodiagnostic Medicine, American Board of Physical Medicine and Rehabilitation, American Board of Orthopedic Surgery and American Board of Psychiatry and Neurology.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician’s reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

4. Waiver

Article 1, Section 21 of the Florida Constitution reads as follows: Access to court – The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay. The Undersigned patient understands and acknowledges that: I have been advised that signing this waiver releases an important constitutional right; and I have been advised that I may consult with counsel before signing this waiver; and by signing this waiver I agree that if any controversy arises out of or in any way relating to the current, future or past diagnosis, treatment, or care that I have or will receive from Deuk Spine Institute, LLC, it’s physicians, agents or employees or Surgery Center of Viera, LLC, the maximum amount of any non-economic damages that can be awarded in any such action will be \$250,000. This limit applies regardless of the number of claimants or defendants in the proceeding. There is no limit on the amount of economic damages that a jury may award; and I have three (3) business days following execution of this waiver in which to cancel this waiver; and I wish to engage the medical services of Deuk Spine Institute, but I am unable to do so because of the provisions of the constitutional limitation set forth above. In consideration of the physician or group of physicians’ agreements to provide medical services to me and my desire to receive medical services from the physician or group of physicians listed below, I hereby knowingly, willingly, and voluntarily waive the right, in an action in a court of law for any controversy, including any malpractice claim, arising out of or in any way relating to the diagnosis, treatment, or care of the patient by Deuk Spine Institute, including any partners, agents, employees of the physician or Surgery Center of Viera, LLC, to recover non-economic damages in excess of \$250,000; and I have selected Deuk Spine Institute as my physician group of choice in this matter and would not be able to retain their medical services without this waiver; and I expressly state that this waiver is made freely and voluntarily, with full knowledge of its terms, and that all questions have been answered to my satisfaction. I understand that this waiver will remain in effect for one year from the date that I have signed this form.

ACKNOWLEDGEMENT BY PATIENT FOR PRESENTATION TO THE COURT

The undersigned patient hereby acknowledges, under oath, the following:

I have read and understand this entire waiver of my right under the constitutional provision set forth above. I am not under the influence of any substance, drug, or condition (physical, mental, or emotional) that interferes with my understanding of this entire waiver in which I am entering and all the consequences thereof. I have entered into and signed this waiver freely and voluntarily.

I authorize Deuk Spine Institute to present this waiver to the appropriate court, if required. Unless the court requires my attendance at a hearing for that purpose, Deuk Spine Institute is authorized to provide this waiver to the court for its consideration without my presence.

DATED this _____ day of _____, 20____ By: _____
PATIENT

Sworn to and subscribed before me this _____ day of _____, 20____ by _____, who is personally known to me, or has produced the following identification: _____.

Notary Public Signature

My Commission Expires:

Financial Guidelines

Form Of Pay	You are responsible for...	We will...
Medicare	<p>If you have regular Medicare as your primary insurance and also have a secondary insurance or Medigap coverage: No payment is required at the time of the visit. If your secondary insurance does not send payment within 45 days, a bill for the balance will be sent to you.</p> <p>If you have regular Medicare as your primary insurance and no secondary insurance: Be prepared to pay your 20% co-insurance at the time of the visit</p> <p>For any services not covered by Medicare, payment is also requested at the time of the visit.</p>	Accept your co-insurance amount, file the claim on your behalf including any claims to your secondary insurance.
Medicare HMO Fee-For-Service	All applicable co-payments and co-insurance at the time of the visit.	Accept your payment and file a claim to your insurance.
In Network HMO/PPO Plans	If the services you received are covered by your plan: All applicable co-payments and deductibles apply and are due at the time of the visit. If authorization is required by your insurance, you must verify with provider's office before your visit.	Accept your payment and file a claim to your insurance.
Limited Plans	Full payment for services provided at the time of service.	Accept your payment and file a claim to your insurance without accepting assignment.
Commercial Insurance	All applicable co-payments and deductibles at the time of the visit.	Accept your payment and file a claim to your insurance.
Out of Network	Payment in full at the time of service for office visit, injections, and for any other service provided. You may be asked to make a deposit at the time of registration.	Accept your payment and courtesy file a claim to your insurance.
Self Pay	Payment in FULL at time of service is expected. For patients scheduled to see our specialists, the deposit amount is \$250-\$500 (New Patients) and \$150-\$300 (Established Patients) and any additional fees will be settled at time of visit. Credit, debit, check are accepted methods of payment. If you are a NEW patient please come prepared to pay by credit or debit.	Accept your payment.
HSA Plans	You must return to the Registration area to pay with your HSA Debit Card.	Accept your HSA card payment.
Workers Comp or MVA	If an authorization to treat has been obtained from your carrier, no payment will be required at time of visit. If an Authorization is not in place, your appointment will be re-scheduled.	Schedule your appointment after services have been authorized by your carrier.

General Information: You are responsible for providing the correct insurance information prior to your appointment for verification and for us to estimate patient responsibility for your visit. You are responsible for knowing your medical plan benefits. If you do not understand your medical benefits, please contact your insurance carrier by calling the customer service number on your insurance card or your HR department.

Request for form completion including FMLA, Jury Duty Exemption, and other forms will have a charge at the physician/clinic's discretion starting at \$40 per form, varying based on form complexity and length. Our staff will return forms to patient/requestor in a timely manner.

Cancellations & No Shows: Deuk Spine Institute staff will contact you prior to your scheduled appointment. If you cannot make your appointment, please cancel at least 24 hours in advance. Your appointment slot could go to another patient.