ALLAN M. SPIEGEL, M.D., P.A.

Date: ____

Have you been involved in a Car Accident that has not been settled? YES NO

Language Spoken: English Other: ____________________________________

Name: ____

Date of Birth: ________/ _________/ __________ Age: _______________ Sex: ________________

SSN: _________ - __________- _________ E-Mail Address: _____________________________________

Address: ____

City: ________________________ State: ________ Zip Code: __________________

Primary Phone Number _for appointment confirmations:_ cell/home/other: _____________________

Secondary Phone Number: ______________________ Marital Status: ________________

Employer: ____________________________________ Phone: ________________________

Emergency contact: _______________________ Relationship: _________________________

Phone Number: _________________________

Primary Care Doctor: ____________________________ Phone: ________________________

Referring Doctor: _______________________________ Phone: ________________________

Preferred Pharmacy Name: _______________________ Pharmacy Phone: _________________

INSURANCE INFORMATION

Primary Insurance Name: ____

ID # ______________________________________ Group # __________________________

Secondary Insurance Name: ____

ID # ______________________________________ Group # __________________________

I hereby authorize direct payment of medical/surgical benefits to Dr. Allan Spiegel for services rendered by him in personally or under his supervision. I understand that I am financially responsible for any balance not covered by insurance. In the event of payment not received, I agree to pay all collection fees and attorney fees associate with bills.

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize Dr. Spiegel and any other Physician to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

The fee for a missed appointment is $75.00, to avoid please call to cancel 24 hours in advance.

PATIENT SIGNATURE: ___________________________________ DATE: ____

Name: ____ DOB: _________/ _________ / _________
SSN: __________ - _________ - _________

REASON FOR SEEING DR. SPIEGEL TODAY:

IS YOUR INJURY DUE TO AUTO, WORK, OR A SLIP AND FALL? YES NO

FAMILY HISTORY: (PLEASE SELECT)

EPILEPSY	MIGRAINE	MENTAL ILL.	GLAUCOMA
DIABETES	THYROID	HAYFEVER	ASTHMA
ANEMIA	BLEEDING	OSTEOPOROSIS	ARTHRITIS
HEART DISEASE	STROKE	HYPERTENSION	CANCER
ALCOHOLISM	CHOLESTEROL	TREMOR	

HOSPTIAL ADMISSIONS AND OPERATIONS:

MEDICATIONS:

ALLERGIES:

HABITS:

Drink Alcohol: Yes No If yes, how often? ____

Smoke Cigarettes: Yes No If yes, number of packs daily? ____________________________________

Addictive Drugs: Yes No If yes, which ones? ____

And, how long? ____

Right or Left Handed __________

Education:

College: ____________________________ High School: ___________ HEIGHT ___________________

Occupation Now ____________________ Retired _______________ WEIGHT ___________________

Who lives with you ____

IF YOU ARE, OR THINK YOU MAY BE, PREGNANT NOW OR ARE BREAST FEEDING, ADVISE DR. SPIEGEL TODAY

Name: ____ DOB: __________/ _________ / __________
SSN: ___________ - _________ - __________

REVIEW OF SYSTEMS
Any problem with the following (please select).

GENERAL:
Recent fever
Undue tiredness
Unexplained weight loss
Weight gain
If yes, how much?

HEAD:
Tense or frequent headaches
Fainting spells
Hair change

EYES:
Glasses/contacts
Discharge
Pain
Blurred vision
Glaucoma
Cataracts

NOSE:
Drainage
Bleeding
Difficulty breathing
Post nasal drip

MOUTH:
Dentures
If yes, state type:
Upper, lower, partial, bridge, etc.
Sore throat
Hoarseness

EARS:
Hearing loss
Ringing
Discharge
Pain
Hearing aid

NECK:
Goiter
Thyroid trouble
Stiffness
Lumps

BREASTS:
Lumps
Discharge

HEART:
Pain or exertion
Shortness of breath on exertion
More than one pillow
Swelling of the ankles
Heart palpitations
High blood pressure
Heart murmur
Chest tightness

RESPIRATORY:
Cough
If yes, how long?
Sputum (Phelgm)
Cough up blood
Pain upon breathing
Pneumonia

SKIN:
Rashes
Lumps
Easy bruising
Skin cancer

GENITOURINARY:
Pain or burning on passing water?
Frequency
Blood in urine
Trouble starting urine
Up at night to pass water
How many times?
Leakage of urine?
Pain or trouble with sexual intercourse?
If yes, describe

GASTROINTESTINAL:
Loss of appetite
Indigestion
Heartburn
Nausea
Vomiting
Vomiting blood
Diarrhea
Constipation
Blood in stool
Black stools
White stools
Abdominal pain
Food intolerance
What foods?

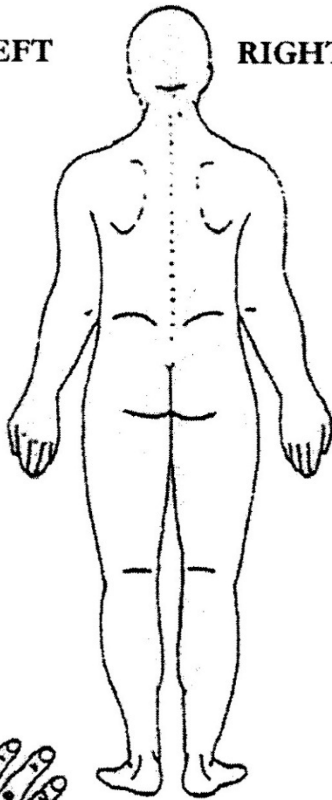
NERVOUS SYSTEM:
Depression
Nervousness
Trouble sleeping
Excessive worry

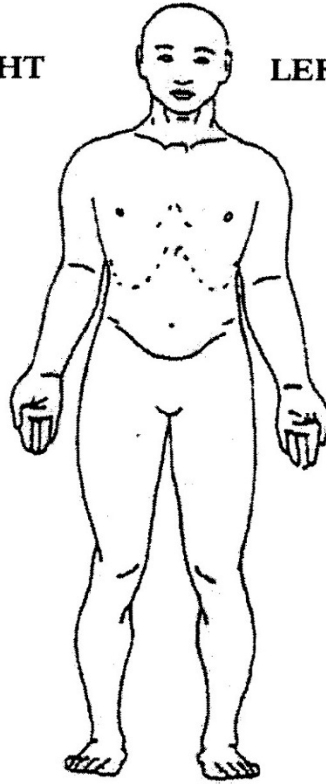
EXTREMITIES:
Joint or pain swelling
Varicose veins
Paralysis
Weakness
Numbness
Pain in walking
Back trouble

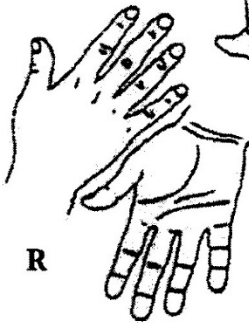
Name: ______________________________ DOB: ________/ ________ / ________
SSN: ________ - ________ - ________

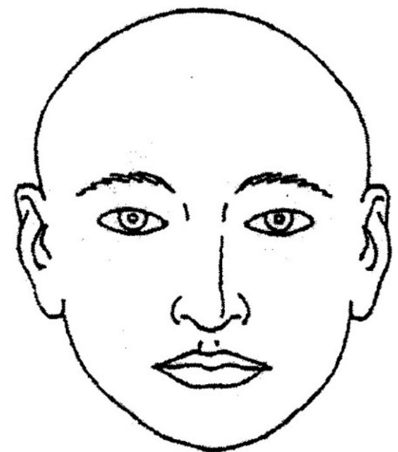
PLEASE NOTE ANY PAIN, NUMBNESS, OR TINGLING

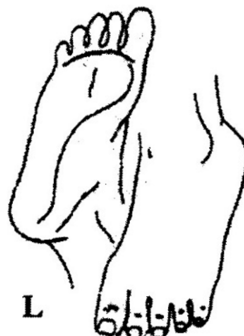
SENSATION ON THE DIAGRAM BELOW











Name: ____ DOB: ________/ ________ / ________
SSN: _________ - ________ - ________

Prescription Drug Policy

The law requires responsible usage of drugs by doctors and patients. If you accept a prescription from Dr. Spiegel, you are also accepting the responsibility to use the drug for yourself and only as prescribed. My responsibility is to prescribe the medications in an appropriate dosage and amounts, with clear instructions, I will also inform you of the reasons I am prescribing the drug, the expected benefits from its use, and the major precautions and side effects. I will answer any questions you have about the drug.

Drugs have potential for abuse and are regulated closely by the state and federal agencies. Certain more closely controlled drugs (narcotic, pain medications and tranquilizers) require even more responsibility on your part. I will accept NO excuses for their loss or theft and will not order replacements. I will not prescribe them if you are using them other than exactly prescribed or receiving them from another source. I expect you to notify my office if you change drug stores, so that the order at the first store may be canceled.

Many drugs are appropriate for short-term use only. If and when I feel it is not in your best interest to continue on a medication I will tell you. If we cannot agree about your continued use of a substance, then I would require additional consultation with other specialists to help decide on the correct course of action.

My office also requires a 24-48 hour call-in policy for the refill of your prescriptions. When your medications are getting low and you feel you will need a refill, please call my office 2448 hours prior so that my office staff will have ample time to ask me to review your chart and call your medication into your pharmacy.

Failure to follow these policies will force my office to terminate our professional relationship and may require me to file a report with the Department of Professional Regulation (DPR) or the local police.

If you are in agreement with all information stated above, please sign on the line below.

____

Patient or Patient Guardian Date

____
Print Name

Name: ____ DOB: _______/ _______ / _______
SSN: ________ - _______ - _______

ALLAN M. SPIEGEL M.D. P.A.
NEUROLOGY

INDIVIDUAL CONSENT

CONSENT TO THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION FOR TREATMENT. PAYMENT AND / OR HEALTH CARE OPERATIONS

I understand that as a part of my health care, Dr. Allan M. Spiegel receives, originates. maintains, discloses, and uses individually identifiable health information, including but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, & treatment, treatment plans, and billing and health insurance information. I understand that Dr. Spiegel and staff may use this information to perform the following tasks.

1. Diagnose my medical/psychiatric/psychological condition.
2. Plan my care and treatment
3. Communicate with other health professionals concerning my care.
4. Document services for payment/reimbursement.
5. Conduct routine health care operations, such as quality assurance (the process of monitoring the necessity for, the appropriateness of. and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel).

I have been made aware of the location of the NOTICE OF INFORMATION PRACTICES that fully explains the uses and disclosures that Dr. Spiegel will make with respect to my individually identifiable health Information. I understand that I have the right to review the Notice before signing this consent. Dr. Spiegel has afforded me sufficient time to review this Notice and has answered any questions that I have to my satisfaction. I also understand that Dr. Spiegel cannot use or disclose my individually identifiable health information other than as specified on the Notice.

I also understand, however that Dr. Spiegel reserves the right to change its notice and the practices detailed therein prospectively (for uses and disclosures occurring after the revision) if it sends a copy of the revised notice to the address that I have provided.

I understand that I do not have to consent to the use or disclosure of my individually identifiable health information for treatment, payment and health care operations, but that if I do not consent. Dr. Spiegel may refuse to provide me health care services unless applicable state or federal law requires Spiegel to provide such services.

I understand that I have the right to request restrictions on the use of disclosure of my individually identifiable health information to carry out treatment, payment or health care operations. I further understand that Dr. Spiegel must honor this request if the method of communication is reasonable. Dr. Spiegel may not ask me why I want the alternate method of communication.

I understand that I have the right to object to the use and/or disclosure of my individually identifiable health information for facility directories and to family members. This request must be in writing to Dr. Spiegel. This will be made a permanent part of my medical chart,

I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that Dr. Spiegel has already taken action in reliance on my earlier effective consent.

I give permission to the following people to speak to Dr. Spiegel about my medical condition.

____ ____________________________

____ ____________________________
Signature of Patient or Legal Representative Date

31608 US 19 NORTH
PALM HARBOR, FL 34684

PHONE: 727-787-7077 FAX: 727-786-6588

ALLAN M. SPIEGEL M.D., P.A.
31608 US Hwy 19 NORTH
PALM HARBOR, FL 34684
727-787-7077

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

PATIENT NAME ________________________________**DATE OF BIRTH** ______________________

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my rights and the practice's legal duties with respect to my protected health information. The notice includes:

A statement that this practice is required by law to maintain the privacy of protected health information.

A statement that this practice is required to abide by the terms of the notice currently in effect.

Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.

A description of uses and disclosures that are prohibited or materially limited by law.

A description of other uses and disclosures that will be made only with my written authorization and that may revoke such authorization.

My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

The right to complain to this practice and to the secretary of HHS if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint.

The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.

The right to receive confidential communications of protected health information.

The right to inspect and copy protected health information.

The right to amend protected health information.

The right to receive an accounting of disclosures of protected health information.

The right to obtain a paper copy of the Notice of Privacy practices from this practice.

I authorize this office to leave a voice mail message on my home telephone, cell telephone or answering machine.

This office reserves the right to change its Notice of Privacy practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practice upon request

Signature ______________________________ Date ______________________________

Relationship to patient ____
(if signed by a personal representative of patient)

First name ________________________________ **Last Name**___________________________

Email Address: ____

How did you hear about our office? (Check all that apply)

Newspaper Ad (name of paper ____)

Yellow Pages

Mailing or letter

Internet search that lead to our website

Insurance website

Referral by a patient (Name of patient: ___________________________________)

Referral by a doctor (Name of doctor: ___________________________________)

What was it that helped you choose our office? (Check all that apply)

Reputation

Friends Recommendation

Inclusion in your insurance plan

Other: ________________________________

Was there any recent event in your life that has caused you to consider our center? YES NO

If YES, please explain:

Do you have any questions or concerns you would like the doctor to address?

If you are seeing the doctor due to PAIN issues, please answer Question 1-3 below.
If you are NOT being seen for pain issues, please skip this section.

1. Please number from 1-4, in order of importance why you are considering one of our pain relief programs.
   _____ My pain is getting worse.
   _____ I've tried other things but still my pain persists.
   _____ I can no longer tolerate the pain.
   _____ I am looking for a new approach to pain relief.
   _____ Other: ________________________________

2. What other procedures have you tried (past or present)? (Check all that apply)
   Over the counter medications (ex. Motrin, Tylenol) Pain relief creams (ex. Ben-Gay, Mineral Ice)
   Physical Therapy Chiropractic Massage Therapy Acupuncture
   Other ____

3. Are you interested in learning about an anti-inflammatory pain and weight control program to help reduce your pain?
   YES NO

________________________________ ________________________________
Signature Date