Brevard Orthopaedic Spine and Pain Clinic, Inc.
THE B.A.C.K. CENTER

Pt. Name: _____ Pt. DOB: _____

No Show Policy

Effective January 1, 2018

APPOINTMENT NO SHOW: Effective January 1, 2017 we implemented a **no show policy**. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit if necessary. We ask that if you must change an appointment, please give us at least 1 business days' notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

In the event that you "no show" or cancel with less than 1 business days' notice for a scheduled appointment, the following fees will be applied:

Office Visit No Show Fee- $35.00

Procedure Visit No Show Fee- $75.00

THIS FEE IS NOT COVERED BY YOUR INSURANCE & MUST BE PAID PRIOR TO SCHEDULING YOUR NEXT APPOINTMENT.

For your convenience, payments for these fees can be made in person at our office or by phone where we accept cash, checks (in office) and all major credit cards. After 3 no-shows, it will be at the physician's discretion to refer you to an outside provider.

By signing this statement, I am acknowledging I have been informed/provided the No Show Policy information.

Patient Signature: _____ Date: _____

Brevard Orthopaedic Spine and Pain Clinic, Inc.
THE B.A.C.K. CENTER

Pt. Name: _____ Pt. DOB: _____

Authorization for treatment and Assignment of Benefits
Health Information Release and Privacy Practice Notice

I, _____ herby authorize THE B.A.C.K. Center or any of its physicians/providers
(Patient/Guarantor Name)
to evaluate and treat me for conditions requiring medical, surgical and pain management treatment. I authorize THE B.A.C.K. Center to furnish my insurance company(ies) or representative with any and all information that may be contained in my medical records. I also acknowledge that I have the right to restrict health information shared with my health insurance company(ies) if I pay cash or out of pocket in full for my visit.

It is my responsibility to notify THE B.A.C.K. Center and sign an Assignment of Benefits form for each visit that I do not want billed to my insurance company(ies). I further acknowledge that my health insurance company(ies) may not pay for future visits, procedures, or surgeries as a result without release of previous PHI in where my insurance company was not billed.

I further authorize payments to THE B.A.C.K. Center for provider benefits otherwise payable to me, but not to exceed the regular charges for this period of treatment. I understand that I am financially responsible to THE B.A.C.K. Center for charges/benefits not covered by this assignment. I also understand THE B.A.C.K. Center is not responsible for the terms of the contract(s) which I have with my insurance company(ies) and that in certain circumstances my insurance company(ies) may determine to pay all, some, or none of the charges resulting from my medical care provided by THE B.A.C.K. Center.

I authorize the person(s) listed below to have access to any and all of my health information including HIV, drug and alcohol abuse, and psychiatric records. THE B.A.C.K. Center is permitted to share any medical information with them, including but not limited to test results and information disclosed during office visits.

Authorized Person(s) Full Name: _____

You may notify me of test results, appointment reminders and other information regarding my health information as follows, please initial what applies below

_____ Detailed Message via - Please Circle which below:
Email Cell Home Work
_____ Okay to send Text for appointment reminders

_____ I do **NOT** wish to have any detailed messages left on any machine regarding health information

*To ensure confidentiality and privacy, the use of any type of recording device by a patient while in any of our offices is strictly prohibited. This includes the use of cameras, audio recording devices and camera phones. Using these devices breaches the confidentiality rights of patients and infringes on the privacy rights of our employees. **Initial: _____**
By signing this document, I acknowledge, understand, and direct that this authorization will remain in effect until revoked by me in writing.

I, _____ acknowledge that I have received and understand THE B.A.C.K. Center Notice of Privacy Practices.

_____ _____ _____
Printed Name Signature Patient/Guarantor Date

Brevard Orthopaedic Spine and Pain Clinic, Inc.
THE B.A.C.K. CENTER

Pt. Name: _____ Pt. DOB: _____

Annual Update Demographic Information

_____,_____

Patient Last Name | Patient First Name | Patient Middle Initial

_____ Male _____ Female _____ _____-_____-_____

Patient DOB | Gender | Social Security #

_____

Race | Ethnicity | Preferred Language | Martial Status

Gender Identity: _____ or Choose not to disclose

Assigned sex at Birth: _____ or Choose not to disclose

_____

Patient Address | City/State/Zip Code | Cell # | Home #

_____

Patient Email Address | Emergency Contact Name | Cell Number | Other # | Relationship

Patient Insurance Information

Insurance # 1 (other than auto)

Name of Insurance Carrier: _____ Policy/ID #: _____

Phone # on Card: _____ Group #:_____

Insurance # 2 (if applicable)

Name of Insurance Carrier: _____ Policy/ID #: _____

Phone # on Card: _____ Group #:_____

I Certify the Above Information is Correct (circle) Yes No

Patient or Guarantor Signature _____ Print Name: _____

Who May We Thank for Your Referral to Our Office?

Name: _____ Phone # / Relationship: _____/_____

Please tell us why you are here

Chief Complaint(s): _____

_____

Is this a work related injury? Yes _____ No_____ **If Yes, Please fill out Worker Compensation Section**

Is this an Auto Related injury? Yes _____ No_____ **If Yes, Please fill out Auto Section**

Is there litigation or a legal issue pending? Yes _____ No_____

If none of the above, please indicate type of injury: (please circle) Slip & Fall Lifting Accident

Other: _____

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Pt. Name: _____ Pt. DOB: _____

Authorization to Obtain Protected Health Information

Patient Name: _____ Date of Birth: _____

_____

_____State: _____Zip: _____

Telephone No. _____ Patient Acct. # _____

I hereby authorize the B.A.C.K. Center to obtain Protected Health Information of the above-named patient from:

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

Information authorized to release: ☐ Medical Records ☐ Billing Records ☐ Imaging

Information authorized to release for services rendered during the period from _____ to _____, to include any Federal and State protected information under the Florida Statue 394.459 (9) Psychiatric information, Florida Statue 397.053 and Florida statue 396.112, Drug and/or Alcohol Abuse information and Florida Statue 381.609 (2) Human Immunodeficiency Virus test results (AIDS and related conditions). I understand that authorizing the disclosure of this protected health information is voluntary.

I understand and direct that this authorization remain in effect for six (6) months or until I revoke it in writing. I hereby release your office or facility and its employees from any and all liability that may arise from the release of this information as I have directed.

_____ _____
*Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient. Signature of Witness

Please send the above information to:

The B.A.C.K. Center
2222 S. Harbor City Blvd, Ste 610
Melbourne, Fl. 32901
(321) 723-7716

Attention: B.A.C.K. Center Physician: _____

B.A.C.K.™ Back Authority for Contemporary Knowledge