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

Pt. Name: ____ Pt. DOB: ____________________

ATTENTION

All New Patients and IME Patients

You **MUST** bring with you to your appointment ALL prior X-rays, MRI's, CT Scans, Myelograms and any other films pertaining to your injury.

WITHOUT these films the surgeons cannot do a complete evaluation and you will **NOT** be seen.

The surgeons at **The B.A.C.K. Center** proudly serve on the hospital trauma teams throughout Brevard County. These units were established to respond to severe medical emergencies and when these emergencies present, the physicians and surgeons who are a part of these units must respond.

During these rare cases when we are called upon to assist, we ask your patience and understanding for the inconvenience of having your appointment rescheduled.

We thank you in advance for your understanding and cooperation.

Warmest Regards,

Richard A. Hynes, MD, FACS

Devin K. Datta, MD

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

Pt. Name: _______________________________________ Pt. DOB: ____________________

Dear ____ Date: _____________________

Welcome to THE B.A.C.K. CENTER
We have received your paperwork and are happy you chose us for your orthopedic needs

Appointment Date: _________________ Time: __________________ with ________________________

X-Rays Appointment Date: ____________________ Time: _________ Located: **5th Floor X-Ray Department**

Please note –x- ray appointments may be added to schedule at a later time
You will be notified of this change via telephone

2222 S. Harbor City Blvd
6th Floor, Suite 610
Melbourne, FL 32901

650 S Courtenay
Parkway Suite 100
Merritt Island, FL 32952

Enclosed you will find your NEW PATIENT PAPERWORK. It is important that you complete this paperwork in its entirety and bring it with you for your appointment.

Your primary care physician or the physician that referred you should have faxed your medical records to our office. If they have not, you will need to contact them to do so.

If your insurance plan requires authorization or referral from your primary care physician to be seen by a specialist, it is necessary that you **contact your PCP for the authorization**. Our office must receive authorization before you are seen for your appointment.

YOU MUST BRING any previous X-Rays, MRI's, CT/Myelograms or other films with you to your appointment. It is necessary to hand carry the actual films themselves or discs with film on them and **not just the reports**. We are unable to see you without them; and your appointment may be rescheduled.

If you have had any previous testing such as bone density studies, NCV/EMG or bone scans; please bring the reports only to the visit. We will also need a current list of medications (including dosage and directions), allergies to medications and past surgical and medical history.

THIS IS A FRAGRANCE-FREE OFFICE Please help us to accommodate our patients who are chemically sensitive to fragrances and other scented products.

Thank you for not wearing perfume, aftershave, scented hand lotion, fragranced hair products and/or similar products.

If you have any questions, please feel free to contact our office: 321-541-1570
We look forward to seeing you and participating in your care

Thank you again for choosing THE B.A.C.K. Center.

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

Pt. Name: ____ Pt. DOB: ____________________

Patient Advocate

Because we are committed to providing you with clinically superior,
patient centric care,

Brevard Orthopaedic Spine & Pain Clinic, Inc. (The B.A.C.K. Center) has a Patient Advocate on staff that is dedicated to ensuring that your care experience is always a positive one.

Should you have a complaint, problem or concern or require assistance in resolving any issue; or if you are simply interested in learning more about your patient rights and responsibilities, our Patient Advocate stands ready to serve you and your family in a safe, confidential setting.

Our Patient Advocate is:

Patricia Vargas

Phone: (321) 501-3732

Email: helpme@thebackcenter.net

Hours: Monday – Friday, 8:00am to 5:00pm

Please keep this page for your reference

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

Pt. Name: ____ Pt. DOB: ____________________

Worker Compensation Information

Please complete entire form

Date of Workers Comp Report: _____/_____/_____

____

Employer name   Employer Address   City/State/Zip code

____

Employer Phone #   Injury Verified By   Contact Info

____

Name of Worker Compensation Carrier   Address   City/State/Zip code

____

Adjuster Name   Phone #

Injury Information

____AM/PM_______________________________________

Date of Injury   Time: Place of Injury

____

Accident reported: employer name   Name of person reported to

Please give a full description of how the accident happened:

____

____

____

Have you lost time from work: Yes / No How Much time? ________________________________

Are you seeing other doctors for this injury? Yes / No Doctor(s) Name: ______________________

Diagnosis: ____

X-Rays? Yes / No If Yes, Where: ____

Other Tests? Yes / No If Yes, Please tell us where, by whom and the results

____

I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment in the event that the claims for Worker Compensation benefits are denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges

_________________________________ ____ _____

Printed Name   Signature   Date

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

Pt. Name: ____ Pt. DOB: ____________________

Auto Information

Date of Accident: _____/_____/_____

Name of Auto Insurance: ____

Auto Policy ID #: ____

Auto Claim #: ____

I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment in the event that my claims for my Auto Benefits are denied. I understand that filing for Auto benefits does not relieve me from my responsibility for the payment of all charges.

*******Please bring your auto insurance card with you to your first visit*******

_________________________________ ____ Printed
Name Signature Patient/Guarantor Date

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: _____________________

Authorization for treatment and Assignment of Benefits

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

Pt. Name: _______________________________________ Pt. DOB: ____________________

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: ____________________

New Patient 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: ____

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

Pt. Name: ____ Pt. DOB: ____________________

Medical History

Check all conditions that apply to you or immediate family

Cardiovascular

You Family
_____ _____ Peripheral Vascular Disease
_____ _____ Heart Attack
_____ _____ Hypertension
_____ _____ Stroke
_____ _____ Atrial Fib
_____ _____ Coronary Artery Disease
_____ _____ Congestive Heart Failure
_____ _____ High Cholesterol
_____ _____ Valvular Disorders

Hematologic

You Family
_____ _____ Anemia
_____ _____ Blood Clots
_____ _____ Bleeding disorders

Respiratory

You Family
_____ _____ Emphysema
_____ _____ Asthma
_____ _____ Sleep Apnea
_____ _____ COPD

Musculoskeletal

You Family
_____ _____ Osteoarthritis
_____ _____ Rheum. Arthritis
_____ _____ Osteoporosis
_____ _____ Gout

Psychiatric

You Family
_____ _____ Anxiety
_____ _____ Depression
_____ _____ Schizophrenia

Endocrine

You Family
_____ _____ Diabetes
_____ _____ Thyroid Disease Hypo / Hyper
_____ _____ Extreme Wgt. Gain
_____ _____ Extreme Wgt. Loss

Gastrointestinal

You Family
_____ _____Colitis
_____ _____Gallstones
_____ _____Crohns Disease
_____ _____Gastric Reflux
_____ _____Gastric Bypass Surgery

Neurological

You Family
_____ _____ Migraines
_____ _____ Seizures
_____ _____ Multiple Sclerosis
_____ _____ Peripheral Neuropathy
_____ _____ Transient Ischemic Attack
_____ _____ Fibromyalgia
_____ _____ Alzheimer's
_____ _____ Parkinson's
_____ _____ Dementia
_____ _____ Head Injury

Infectious Disease

You Family
_____ _____ Aids/HIV
_____ _____ Hep A, B, C (specify) _______
_____ _____ Tuberculosis
_____ _____ MRSA/Post-Operative Infection

Renal

You Family
_____ _____ Kidney Stones
_____ _____ Chronic Kidney Disease
_____ _____ Frequent Urinary Tract Infections

Cancer – Type________________________ Year Diagnosed____________with Chemotherapy______Radiation______
Cancer – Type________________________ Year Diagnosed____________with Chemotherapy______Radiation______

FEMALES

Are you pregnant: Yes No Last Menstrual Period Date: ________ If applicable, Age at Menopause: _________
Birth control method: ____________________ Bilateral Tubal Ligation: Yes No If Yes, Date: ______________
Hysterectomy: Yes No If Yes, (circle) Partial or Full Date: ________________

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

Pt. Name: ____ Pt. DOB: _____________________

Medications

To better serve you before your visit,
Please list ALL current Medications/Vitamins/Herbal Supplements with dosages, frequency taken and start date
It's very important to complete ALL fields. Bring your medication with you to your appointment

	Name	Dose: (ex.: 1 application or 125 mcg) mg/mcg/units/ topical application	Frequency (QD, BID, 1x)	Start Date
1)	____________________________	________________________________	_________	_____/_____/_____
2)	____________________________	________________________________	_________	_____/_____/_____
3)	____________________________	________________________________	_________	_____/_____/_____
4)	____________________________	________________________________	_________	_____/_____/_____
5)	____________________________	________________________________	_________	_____/_____/_____
6)	____________________________	________________________________	_________	_____/_____/_____
7)	____________________________	________________________________	_________	_____/_____/_____
8)	____________________________	________________________________	_________	_____/_____/_____
9)	____________________________	________________________________	_________	_____/_____/_____
10)	____________________________	________________________________	_________	_____/_____/_____

Allergy/Reaction

Please list ALL Types of Allergies and Reactions including: Medication, Dye or Contrast, Environmental and Other (ie: Latex)

1____________________________ 2________________________________ 3________________________________

4____________________________ 5________________________________ 6________________________________

7____________________________ 8 ________________________________ 9________________________________

10____________________________ 11________________________________ 12________________________________

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

Pt. Name: ____ Pt. DOB: ____________________

Prior Surgeries and date(s):

____

____

Social History

Do you use tobacco products? Yes _____ No_____ If Yes, No. of cigarettes per day: _____ No. of years: _____

Do you drink Alcohol? Yes _____ No_____ Liquor / Beer / Wine/Other_____________ (circle which pertain to you)

How often? Daily, No. of drinks _____ Weekly, No. of drinks ______ Monthly, No. of drinks _____
Socially, No. of drinks/frequency _______/_______

Do you participate in recreational or IV Drug use? Yes _____ No_____

Do you smoke marijuana? Yes _____ No_____ Rarely _____

Do you consume caffeine? Yes _____ No_____ If Yes, How frequently __________ (1X day, 2x day, 3x day)

What is your dominant hand? Right ____ Left ____ Both ____

What is your primary language? ____

What country were you born in? ____

Are you employed? Yes _____ No_____

Have you ever been in the military? Yes _____ No_____If Yes, what Branch? ________________________________

Do you have children? Yes _____ No_____

Do you have animals in your home? Yes _____ No_____If yes, what kinds? ___________________________________

Do you wear your seatbelt in the car? Yes _____ No_____

Do you agree to a blood transfusion if necessary? Yes _____ No_____

Do you have a living will? Yes _____ No_____

Do you have a Do Not Resuscitate in order? Yes _____ No_____

Do you have a Do Not place on life support in order? Yes _____ No_____

Do you have a Power of Attorney? Yes _____ No _____ If Yes who, ______________________________________

Do you have a Health Care Proxy? Yes _____ No _____ If Yes who, ______________________________________

I certify the above information is correct Yes _____ No_____

________________________________ ____ ________________

Printed Name **Signature Patient/Guarantor/Legal Authorized Rep** **Date**

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

Pt. Name: ____ Pt. DOB: _____________________

Review of Systems

Do You CURRENTLY experience any of the below? If yes, please check off what pertains to you

General
____ Major weakness
____ Fever
____ Increased Weight Gain
____ Decreased Weight Loss

Skin
____ Nail Changes
____ New Lesions
____ Rash
____ Skin Color Changes

HEENT
____ Blurred Vision
____ Decreased Hearing
____ Dry Mouth
____ Ear Ringing
____ Nose Bleeds
____ Oral Ulcers
____ Sore Throat
____ Swollen Glands
____ Head Injury

Respiratory
____ Coughing up blood
____ Wheezing
____ Chronic Cough

Cardiovascular
____ Chest Pain
____ Shortness of Breath
____ Leg Swelling
____ Palpitations

Urogenital
____ Painful Urination
____ Menstrual Irregularities
____ Increased Urination
____ Nighttime Urination
____ Blood in Urine
____ Testicular mass
____ Testicular Pain
____ Impotence

Musculoskeletal
____ Joint Pain
____ Joint Redness
____ Joint Swelling
____ Joint Stiffness
____ Muscle Weakness
____ Muscle Aches/Pains

Gastrointestinal
____ Abdominal Pain
____ Change in Bowel Habits
____ Constipation
____ Diarrhea
____ Nausea
____ Vomiting
____ Rectal Bleeding
____ Trouble Swallowing

Hematology
____ Easy Bruising
____ Enlarged Lymph Nodes
____ Prolonged Bleeding

Neurological
____ Loss of Bowel Control
____ Dizziness
____ Headaches
____ Tingling/Numbness in arms or legs
____ Passing out
____ Seizures
____ Tremors

Psychiatric
____ Anxiety
____ Change in Sleep Pattern
____ Depression
____ Hallucinations
____ Suicidal Thoughts

Endocrine
____ Appetite increase/decrease
____ Cold Intolerance
____ Increased Thirst
____ Hair Changes/Loss
____ Sexual Dysfunction

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

Pt. Name: ____ Pt. DOB: ____________________

OSTEOPOROSIS RISK FACTOR SURVEY

Please circle below:

Race: Asian Caucasian African American Hispanic Native American Other

Have you ever broken any bones? Yes _____ No _____

If yes, which ones? ____ Wrist ____ Elbow ____ Shoulder ____ Hip ____ Compression Fracture Back

____ Other ____

Are you postmenopausal? Yes _____ No _____ If yes, when did you start menopause? _________________________

Have you ever had a Dexa Bone Density Scan? Yes _____ No _____

If yes, when? ___________________________ results _____ Normal _____ Osteoporosis _____ Osteopenia

Have you ever taken any of the following medications for MORE THAN ONE MONTH?

Thyroid replacement medicine	Yes _____	No _____
Steroids including inhalers for asthma	Yes _____	No _____
Estrogen/Testosterone replacement	Yes _____	No _____
Bisphosphonates (Fosamax, Actonel)	Yes _____	No _____
Anticonvulsants (Neurontin, Topamax, Dilantin, etc.)	Yes _____	No_____
Heparin	Yes _____	No _____
Chemotherapy	Yes _____	No _____
Lithium	Yes _____	No _____
Methotrexate	Yes_____	No _____
Antacids (Maalox, Gaviscon, Mylanta)	Yes _____	No _____
Cholestyramine (Questran)	Yes _____	No _____

I certify the above information is correct Yes _____ No _____

________________________________ ____ ________________

Printed Name **Signature Patient/Guarantor** **Date**

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

Pt. Name: ____ Pt. DOB: ____________________

Complete this form ONLY for BACK and/or LEG PAIN **Not applicable ____**

Have you been treated in this office before? Yes ____ No ____
If Yes, when/by whom? _________________/____

Have you had a treatment for this problem prior to this accident/injury? Yes ____ No ____
If Yes, when and by what provider? _________________/___________________________________

How long have you had this problem? ____

I feel my pain is (circle all that apply)

Sharp Burning Tingling Tearing Dull Cramping Weakness Aching

Mild Stiff Discomfort Tightness Severe Numbness Other _____________

Over the last few days, my average pain is:

Use the scales below:

1) **(Please Circle Number)**

0 1 2 3 4 5 6 7 8 9 10

No Pain - Moderate Pain- - - - - - - - - - - - - - - - - - Worst Pain Possible

2)

My Pain is:	**Better**	**Worse**	**No Change**
In the Morning	_______	______	______
Bending Forward	_______	______	______
Sitting in the car	_______	______	______
Night time Pain	_______	______	______
Lying on my stomach	_______	______	______
Coughing/Sneezing	_______	______	______
Prolonged sitting	_______	______	______
Prolonged standing	_______	______	______
Prolonged walking	_______	______	______
Riding Bike	_______	______	______
Exercise	_______	______	______

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

Pt. Name: ____ Pt. DOB: ____________________

Complete this form ONLY for NECK and/or ARM Pain **Not applicable ____**

Have you been treated in this office before? Yes ____ No ____

If Yes, when/by whom? ______________________________/______________________________

Have you had a treatment for this problem prior to this accident/injury? Yes ____ No ____

If Yes, when and by what provider? __________________________/_________________________

How long have you had this problem? ____

I feel my pain is (circle all that apply)

Sharp Burning Tingling Tearing Dull Cramping Weakness Aching

Mild Stiff Discomfort Tightness Severe Numbness Other _____________

Over the last few days, my average pain is:

Use the below scales:

1) **(Please Circle Number)**

0 1 2 3 4 5 6 7 8 9 10

No Pain - Moderate Pain- - - - - - - - - - - - - - - -- - Worst Pain Possible

2)

My Pain is:	**Better**	**Worse**	**No Change**
In the Morning	______	_____	_____
Bending Forward	______	_____	_____
Sitting in the car	______	_____	_____
Night time Pain	______	_____	_____
Lying on my stomach	______	_____	_____
Coughing/Sneezing	______	_____	_____
Prolonged sitting	______	_____	_____
Prolonged standing	______	_____	_____
Prolonged walking	______	_____	_____
Riding Bike	______	_____	_____
Exercise	______	_____	_____

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

Pt. Name: ____ Pt. DOB: ____________________

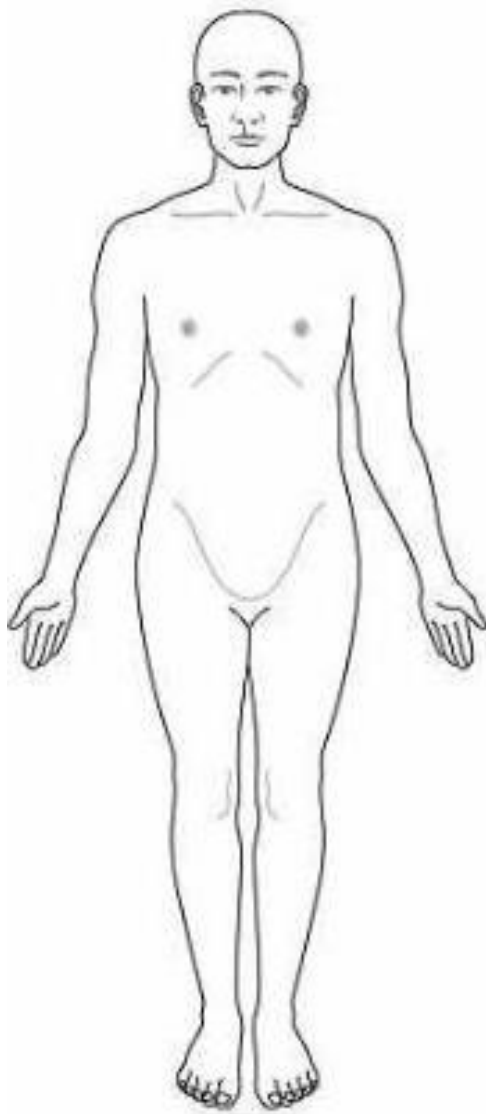
Please indicate areas of pain on the model below:

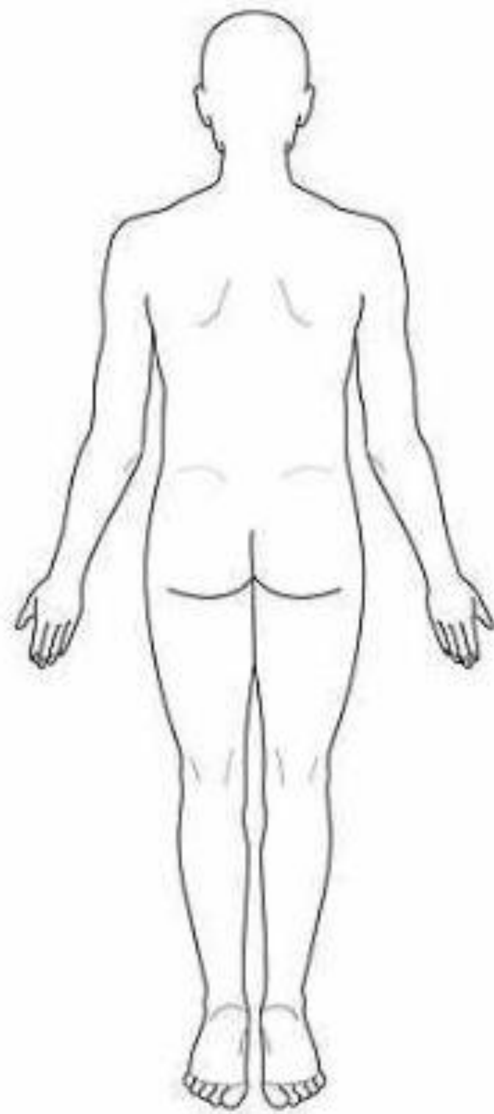
Mark areas with the following

Tingling (0000)

Pain (xxxx)

Numbness (IIII)





Right Left Left Right

 TBC From Version 3.0 Update 2/2019AM

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

Pt. Name: ____ Pt. DOB: ____________________

Authorization to Obtain Protected Health Information

Patient Name: ______________________ Date of Birth: ____________

Address: ____

City: __________________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