

Welcome to Gervin Neurosurgery and Avoid the Knife! We are committed to providing you with the ultimate in modern medical care, delivered promptly and pleasantly.

Please read and complete this packet. Make sure to bring ALL of the following with you on your first visit:

- Health History Questionnaire (this document, completed and signed)**
- Health Insurance Card**
- Auto Insurance Card (if involved in a motor vehicle accident)**
Please bring any billing information pertaining to the liable party. This typically includes your insurance company name, claim #, adjuster name, and phone number. If you have retained an attorney you must bring the attorney's name, address, and phone number. If any of this information is missing, we will have no choice but to reschedule your appointment.
- Referral (if applicable)**
Referrals must originate from your primary care doctor. If you are unclear whether a referral is required by your health plan, please call the customer service number on the back of your health insurance card for clarification. If your primary doctor has committed to fax your referral to our attention, please call our office prior to your first visit to verify that it was received.
- Co-payments**
Co-payment will be collected at the start of your first appointment. The co-payment amount may typically be identified as the number following the "S" on the front of your insurance card (S for specialist). If you are unclear as to your specialist co-payment responsibility, please call the customer service number on the back of your health insurance card for clarification. For your convenience, we accept all major credit cards (Visa, AMEX, Discover, Master Card), and debit cards.
- Films/Medical Records**
Please bring all films related to your injury or condition, in the form of either a hard copy or computer disc. In addition, bring any relevant medical records as these will help accelerate our understanding of your condition, and expedite your appointment.

Your care and attention to these items will help ensure that your first appointment proceeds smoothly and efficiently. Please be sure to bring ALL of items listed above (where applicable), as well as this original signed Health History Questionnaire. Failure to do so may result in your appointment being rescheduled. Should you have any questions, please do not hesitate to call us.

Once again, welcome to our office. We look forward to meeting you and providing you with the highest quality of medical care.

Locations

Broward County

Pembroke Pines
2301 N. University Dr., Ste. 210
Pembroke Pines, FL 33024
Ph: 954-961-3365
Fax: 954-961-5629

Palm Beach County

Boca Raton
7025 Beracasa Way, Suite 204
Boca Raton, FL 33433
Ph: 561-300-3750

Miami-Dade County:

Aventura
21150 Biscayne Blvd., Ste. 208
Aventura, FL 33180
Ph: 305-682-9944

Doral
8323 NW 12th St., Ste. 202
Doral, FL 33126
Ph: 786-517-6600

On the Web

info@drgerwin.com
www.avoidtheknife.com
www.drgerwin.com

35

YEARS

**35 Years of
Surgical and
Non-Surgical
Care in
South Florida**

RECEIPT OF NOTICE OF HIPAA PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, was provided with the Notice of Privacy Practices of
(Patient's Name)

Stephen Z.Gervin, MD, Neurological Surgery, PA to read/review. By signing below, I attest that I am aware and understand the Privacy policies, procedures, and my patient rights as related to HIPAA Laws that are listed in the lobby on the wall, as well as, in paperback form on the table.

Name of Patient

Signature of Patient

Date

Patient Name: _____

PATIENT INFORMATION/UPDATE FORM

Date: _____

Name: _____	Soc. Security No#: _____
Mailing Address: _____	Apt: _____ Cel#: _____
City: _____	Zip: _____ Home#: _____
DOB: _____ Age: _____	Sex: _____ Work#: _____

Emergency Contact Person: _____	Contact #: _____
Next of Kin (if different than Emergency Contact): _____	Contact #: _____
Primary Doctor: _____	Ph#: _____ Fax#: _____

How did you learn about us? (Check all that apply - you can check more than one):

<input type="checkbox"/> Doctor	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Internet (check):	<input type="checkbox"/> Patient Referral
Name: _____	(check): ☆ Miami Herald	☆ Google	Name: _____
Specialty: _____	☆ Sun Sentinel	☆ Yahoo	
Phone#: _____	☆ El Nuevo Herald	☆ AvoidTheKnife.com	
	☆ Radio	☆ DrGervin.com	

What form of payment will you use to pay your copay/deductible/visit: Debit Credit Card Check Cash

YOUR INSURANCE CARD WILL BE COPIED AND ATTACHED FOR BILLING INFORMATION:

Please list who is the primary insured on this policy (if other than yourself) _____

Must include their SSN# _____ DOB: _____

Dr. Stephen Gervin has decided not to carry medical malpractice insurance. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law. We are required to give you a copy of this notice to sign, acknowledge its receipt and keep in your patient file.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services. I recognize that I am responsible for all services not covered by my insurance company. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. I understand co-payments are due at the time of service.

Please sign below and continue on the next 3 pages.

_____ Signature	_____ Date
_____ Parent (if Minor)	_____ Date

Patient Name: _____

HEALTH HISTORY QUESTIONNAIRE (please fill out completely)

Name: _____ Age: _____ Height: _____ Weight: _____ Right or Left handed

Chief Complaint	Reason for your visit : _____ Describe details or history of your present illness including onset, treatment, doctors and/or clinics and dates: _____ _____ Is this problem a result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Accident: _____ ☆ Car ☆ Work ☆ Other _____ Case still open/pending? ☆ Yes ☆ No, if closed or settled, provide date: _____ Did you miss any time from work, if yes how much? _____ Is there any another accident(s) before/after this one? ☆ No ☆ Yes – if yes, provide dates and treatments given: _____
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Past History	Date and list any prior major illness/injury including doctors you have seen: _____ _____ Surgeries/Hospitalizations include year, reason and any complications: _____ _____ List all current Medications include any Herbal Supplements - Dose: _____ Frequency: _____ _____ _____ ALLERGIES TO MEDICATIONS: _____ any prior problems with anesthesia? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Family History	<table border="0"> <tr> <td>Family History</td> <td>Alive</td> <td>Deceased</td> <td>Age</td> <td>Health status or cause of death</td> </tr> <tr> <td>Father</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Mother</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Sister/Brother</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Sister/Brother</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> <td>_____</td> </tr> </table>	Family History	Alive	Deceased	Age	Health status or cause of death	Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
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Social History	<table border="0"> <tr> <td> Employment: <input type="checkbox"/> Yes-My occupation is: _____ <input type="checkbox"/> Not employed, last worked date and the reason(s) you are not working now _____ <input type="checkbox"/> Disabled, provide date of disability and the reason(s) for your disability _____ </td> <td> Education (highest level): _____ Military service : <input type="checkbox"/> Yes type of discharge _____ <input type="checkbox"/> No Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Do you have children? <input type="checkbox"/> Yes How many? _____ <input type="checkbox"/> No </td> <td> Do you smoke? <input type="checkbox"/> Yes. How much per day _____ For how long _____ <input type="checkbox"/> No, I quit _____ years ago <input type="checkbox"/> No never Do you drink alcohol? <input type="checkbox"/> No, never <input type="checkbox"/> No, but I used to <input type="checkbox"/> Yes How much and how often? _____ Any history of drug abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain: _____ </td> </tr> </table>	Employment: <input type="checkbox"/> Yes-My occupation is: _____ <input type="checkbox"/> Not employed, last worked date and the reason(s) you are not working now _____ <input type="checkbox"/> Disabled, provide date of disability and the reason(s) for your disability _____	Education (highest level): _____ Military service : <input type="checkbox"/> Yes type of discharge _____ <input type="checkbox"/> No Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Do you have children? <input type="checkbox"/> Yes How many? _____ <input type="checkbox"/> No	Do you smoke? <input type="checkbox"/> Yes. How much per day _____ For how long _____ <input type="checkbox"/> No, I quit _____ years ago <input type="checkbox"/> No never Do you drink alcohol? <input type="checkbox"/> No, never <input type="checkbox"/> No, but I used to <input type="checkbox"/> Yes How much and how often? _____ Any history of drug abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain: _____
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Patient Name: _____

Review of Systems: (Check symptoms in the past year)

Constitutional:

- NONE
- Fever
- Weight Loss
- Excessive Fatigue
- Night Sweats/Chills
- Headache
- Loss of sleep
- Fainting
- Depression
- Forgetfulness

Cardiovascular:

Date of last EKG:

- NONE
- Chest Pain or Angina
- High Blood Pressure
- Irregular Pulse
- Leg Pain While Walking
- Heart Murmur
- High Cholesterol
- Swelling in Feet or Hands

Gastrointestinal:

- NONE
- Blood in Your Urine
- Incontinence
- Kidney Stones
- Prostate Cancer
- Difficulty Starting or Stopping Stream
- Endometriosis (females)
- Uterine or Cervical Cancer (females)
- Urinary Tract Infections/Painful Urination

Neurological:

- NONE
- Disorientation
- Fainting Spell or "Black Outs"
- Memory Problems
- Speech Difficulty
- Coordination in Arm
- Seizures
- Inability to Concentrate
- Double/Blurred Vision
- Face Weakness and/or Legs

Eyes:

Date of Last Exam:

- NONE
- Infections/Injuries
- Glaucoma
- Cataracts
- Double vision
- Blurred vision

Respiratory:

Date of last Chest X-ray:

- NONE
- Asthma
- Chronic Cough
- Emphysema
- Shortness of Breath
- Lung Cancer
- Bloody Sputum
- Pneumonia
- Bronchitis

Musculoskeletal:

Broken Bones - List::

- NONE
- Arm or Leg Weakness
- Back Pain
- Arm or Leg Pain
- Joint Pain or Swelling
- Arthritis

Psychiatric:

- NONE
- Anxiety
- Depression
- Other Psychiatric Disorder/Treatment:

E.N.T. and Mouth:

Date of last hearing exam:

- NONE
- Hearing Loss
- Ear Pain
- Ringing in Ears:
Side: R L Both
- Nasal Congestion
- Sore Throats
- Nosebleeds
- Sinus Headaches
- Inability to Smell
- Balance Disturbance (e.g., Vertigo, Spinning)
- Sinus problems
- Nasal
- Mouth Sores

Gastrointestinal:

- NONE
- Nausea/Vomiting
- Blood in your Vomit
- Liver Disease
- Jaundice
- Colon Cancer
- Abdominal Pain
- Ulcers/ Gastritis
- Indigestion/Pain With Eating
- Change in Your Bowel Habits

Integumentary:

Date and Result of Last Mammogram (female's):

- NONE
- Skin Disease
- Skin Cancer
- Breast Pain, Tenderness or Swelling
- Nipple Discharge (females)

Endocrine:

- NONE
- Diabetes
- Thyroid Disease
- Increased Appetite
- Excessive Thirst or Urination
- Hormone Problems

Allergic/Immunologic:

- NONE
- Food Allergies
- Inhalant (nasal) Allergies
- Immunologic Disorders
- Latex

Hematologic/Lymphatic:

- NONE
- Anemia
- Hemophilia
- Bleeding Tendencies
- Persistent Swollen Glands or Lymph Nodes
- Blood Transfusion If yes, when?

Patient Name: _____

All office visits are audio recorded, transcribed and filed electronically for accuracy and mutual protection. My signature below shows that I agree with the above stipulation of my visit and that the information is accurate to the best of my knowledge.

LIFETIME SIGNATURE AUTHORIZATION

I request that payment of authorized insurance benefits be made on my behalf for any services and/or supplies furnished to me by Stephen Z. Gervin, M.D. I authorize any holder of medical or other information to release any information needed to determine these benefits for related services or payment.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Stephen Z. Gervin, M.D. to release any information acquired in the course of my examination or treatment to my insurance company and/or other physicians involved in my about care.

PLEASE NOTE: THIS INCLUDES THE RIGHT TO FAX INFORMATION.

Please be aware that in view of the HIPAA regulations we will honor your patient's right to privacy and confidentiality as per the Notice of Privacy Practices effective 4/14/03.

Patient Signature

Date

I have reviewed the above information with the patient.

Stephen Z. Gervin, MD, FACS (signature)

Date

Patient Name: _____

PLEASE READ CAREFULLY

PATIENT – DOCTOR ARBITRATION AGREEMENT

This Agreement is made between Stephen Z. Gervin, M.D., Stephen Z. Gervin, M.D., F.A.C.S, Neurological Surgery PA., and their employees, agents, and servants (hereinafter collectively referred to as “Doctor”) and _____ (hereinafter referred to as “Patient”). It is the intention of the parties to this agreement to bind not, only themselves but also their, heirs, personal representative, guardians or any persons deriving their claims through or on behalf to the Patient.

It is understood by the Patient that he or she is not required to use Doctor Gervin for neurosurgical services, for ambulatory medical facilities or for other neurological or medical services of facilities (“Services”). The Patient also understand that there are numerous other physicians and facilities in this area who are qualified to render quality Services and the Doctor is willing to refer the Patient to another physician or facility in the area of those Services if the Patient requests. Both the Doctor and the Patient agree that arbitration is a preferable method to solving any disputes they may have in connection with Services, and wish to avoid the expense and inconvenience of litigation, whether by judge alone or by jury.

It is mutually agreed that any controversy, dispute or claim arising out of or relating to the Services of any kind, including the medical care rendered or payment of medical or surgical fees, or an other matter whatsoever, including the interpretation, hereof, shall be settled by arbitration accordance with the Florida Arbitration Code. The controversy of claim, shall be submitted to single arbitrator (who must be a physician licensed in Florida) mutually agreed upon by the parties within thirty (30) days of notice of an intent to arbitrate any matter hereunder. If the parties cannot agree upon an arbitrator within such thirty (30) day period such an arbitrator shall be selected in accordance with the Florida Arbitration Code through a court, which has a situs in Miami-Dade County, Florida. The arbitration of such dispute will be held in Miami-Dade County, Florida. Within thirty (30) days after completing of discovery. The award of the arbitrator will be final and binding on all parties to the arbitration and judgment may be entered upon it in accordance with law in any court of competent jurisdiction. In the event of arbitration the parties hereto specifically agree that discovery shall be allowed in the form of written interrogatories, depositions of witnesses, production, inspection and copying of documents to the same extent as is provided under the Florida Rules of Civil Procedure. Provided, however, the time for responding to requests for written interrogatories, production and inspection and copying of documents shall be reduced to ten (10) days.

Any disagreement between the parties to the dispute as to the scope and extent of and compliance with the discovery will be referred to the arbitrator and his or her determination shall be final. The parties further agree that such discovery procedures shall both be extended said time for discovery. All expenses of the arbitrator and arbitration (exclusive of each party’s attorney’s fees, if any) shall be borne equally between the Patient and the Doctor. The parties hereto agree that should any non-economic damages be awarded, in no event shall the amount to economic damages awarded exceed the limits set forth in Florida Statute sec. 7660118(2) (generally \$500,000.00, with greater amounts allowed under limited exceptions). The definition of non-economic damages and the calculation there of shall be consistent with the use of said

Patient Name: _____

term and the calculation of non-economic damages under Florida Statutes (2003) sec 766.202(8) and 766.118(2). Provided, further, the parties hereto agree that no punitive damages may be awarded.

Should any part of the provision of this Agreement be held unenforceable or in conflict with law, the validity of the remaining parts or provisions shall not be effected by such holding.

This agreement shall remain in effect for all treatment, services and surgery provided to the patient presently and any future dates. I (we) have set our hands this ____ day of _____, _____

DOCTOR:

PATIENT:

WITNESS:

By: _____

By: _____

By: _____

Stephen Z. Gervin MD, FACS,

Patient (Guardian if patient is a minor)

Neurological Surgery PA

Patient Name: _____