

THE SPINE CENTER, LLC.

TODAYS DATE:	ACCOUNT #:
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PATIENT INFORMATION				INSURANCE INFORMATION			
LAST NAME:				PRIMARY INSURANCE COMPANY:			
FIRST NAME:				BILLING ADDRESS:			
STREET:				CITY:		STATE: ZIP:	
CITY:		STATE:		ZIP:		PHONE #:	
HOME PHONE:		MAY WE LEAVE A MESSAGE ?		Y		N	
CELL PHONE:		MAY WE LEAVE A MESSAGE?		Y		N	
E-MAIL:				SECONDARY INSURANCE COMPANY:			
DATE OF BIRTH				BILLING ADDRESS:			
SS#:				CITY:		STATE: ZIP:	
Sex (circle) M F				PHONE #:			
HOW DID YOU HEAR ABOUT US?				ID#:		GROUP:	

PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME:	HOME PHONE#:	WORK PHONE#:
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PATIENTS EMPLOYER:	IF INSURANCE POLICY IS NOT IN PATIENTS NAME PLEASE COMPLETE:
ADDRESS:	NAME OF POLICY HOLDER:
CITY: STATE: ZIP:	DATE OF BIRTH:
WORK PHONE:	SS #:
MAY WE CONTACT YOU AT WORK? Y N	EMPLOYER:
MAY WE LEAVE A MESSAGE AT WORK? Y N	ADDRESS:
	CITY: STATE: ZIP:

REFERRING PHYSICIAN AND PRIMARY CARE PHYSICIAN INFORMATION

REFERRING PHYSICIAN:	PRIMARY CARE PHYSICIAN:
ADDRESS:	ADDRESS:
CITY: STATE: ZIP:	CITY: STATE: ZIP:
PHONE:	PHONE:
FAX:	FAX:

FOR WORKERS COMPENSATION OR LEGAL CLAIM COMPLETE BELOW

COMPANY NAME:	ADJUSTER NAME:
MAILING ADDRESS:	PHONE #: FAX:
CITY: STATE: ZIP:	NURSE CASE MANAGER:
CLAIM #:	PHONE: FAX:
DATE OF INJURY:	INJURY YOU ARE BEING TREATED FOR:



USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

* The educational pamphlet entitled “**Notice of Privacy Practices**” provides information about how The Spine Center may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

* Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy either by mail, or in person.

* You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

*By signing below, you acknowledge receipt of our **Notice of Privacy Practices**.*

RELEASE OF MEDICAL INFORMATION FOR COORDINATION OF CARE

I, hereby authorize The Spine Center, LLC to release medical information to my referring physician, primary care doctor, case manager and any other individual involved in my medical care for the sole purpose of facilitating my treatment. I understand that my medical information is confidential and that I have a choice to request that my physician not share my medical records with any of the above individuals. Should I choose to exercise this right, I will provide in writing to my physician any of the individuals involved in my care whom I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original.

I am aware that I may request that this Release of Medical Information may be revoked at any time by providing the physician’s office with a dated and signed letter. I have read and agree to those terms.

MISSED APPOINTMENT POLICY

Please be aware that by scheduling an initial consultation with our physicians, you are agreeing to abide by the billing policies of our service. To better serve all of our patients, we require a 24 hour notification should you need to cancel or reschedule your appointment. Should you miss, or reschedule your appointment with less than a 24 hour notice, you will be charged \$35.00, and payment will be due at the time of your next appointment. Your insurance company does not cover fees for missed appointments.

AUTHORIZATION TO DISCUSS INFORMATION WITH DESIGNATED PERSON

It is often difficult to reach a patient to discuss appointments, medications and other information pertinent to our patients’ care. In this event with your signed authorization we would discuss such information to a person you designate. Please complete the section below:

I hereby authorize The Spine Center to discuss any information required in the course of my examination or treatment (when I cannot be reached by phone) to the following designated person(s)

Name of Designee: _____
Relationship to Patient: _____

Phone Number: _____

Name of Designee: _____
Relationship to Patient: _____

Phone Number: _____

None

I agree to all of the above

Patient or Legal Guardian Signature

Date

This form shall expire one year from the date of signature



RELEASE OF MEDICAL INFORMATION FOR BILLING PURPOSES

I, hereby authorize The Spine Center, LLC to release medical information to Medicare, my employer's Benefits Department, or my other insurance company for the sole purpose of obtaining payment for my medical care. Although medical information is confidential, many carriers require medical documentation prior to payment for services. I understand that only information pertaining to obtaining payment for my care will be released. I agree that a copy of this release may be used in place of the original.

I am aware that I may request this Release of Medical Information to be revoked at any time by providing the physician's office with a dated and signed letter. I have read and agree to these terms.

NOTICE OF FINANCIAL INTEREST

Federal regulations require that we inform you that the physicians below have a financial interest in The Center for Pain Management, ASC, LLC and/or the ASC Development Company, LLC. An interest in this facility enables them to have a voice in the Administrative and Medical Policy of this healthcare institution. This involvement helps us ensure the finest quality surgical care for their patients.

The Center for Pain Management, LLC Physician Partners
The DECK Pain Management, LLC Physician Partners

PAYMENT FOR MEDICAL SERVICES

I hereby assume financial responsibility for all charges incurred for services rendered. I understand that I will be required to pay co-payments, amounts applied to deductibles, and balances of bills not paid in accordance with the benefits of my current insurance policy. If I am unable to make payment in full for my medical treatment within 30 days, I agree to call the business office and make payment arrangements.

I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy, to be paid directly to The Spine Center, LLC, or designates for services rendered.

I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's office to verify insurance coverage and benefits allowed in accordance with my insurance company's policy.

I understand that it is my full responsibility that any third party which I direct The Spine Center, LLC to bill, in the event of non-payment for whatever reason in accordance with the benefits of my current insurance policy, I will pay immediately. It is further agreed that in the event I fail to pay upon demand, should my account be referred to an outside collection agency and or attorney, I accept full responsibility to pay all collection costs not to exceed 30% and interest of 1.5% per month not to exceed 18% per annum and reasonable court costs.

I agree to all of the above.

Patient or Legal Guardian Signature

Date

This form shall expire one year from the date of signature



Late Arrival Policy and Form

The appointment time you are given is when you are expected to be in the exam room or operating room. We require that new patients come in 30 minutes early, and established patients 15 minutes early to complete paperwork. If you do not arrive 15 minutes early, you may not have enough time to complete the necessary paperwork. Arriving late means, not arriving 15 minutes prior to the appointment time. We are a Surgery Center and not a private physician's office. This is standard protocol for any inpatient or outpatient Surgery Center.

It is the policy of The Spine Center that Patients are to arrive on time. Patients who arrive late for visits or procedures **cannot expect or demand to be seen.** Other Patients who have arrived on time expect to be seen at their allotted appointment time. Many appointments are scheduled only for 15 minutes. Arriving late by even five minutes will affect the schedule. We have a limited number of Exam Rooms and only one Operating Room. Due to this, seeing one late Patient will make the schedule run late for the rest of the day. This is not considerate to the other Patients who have arrived on time.

There are many things that can occur to make a Patient late; i.e. car trouble, traffic, parking etc... We understand that this can happen, but need you to understand we cannot change the schedule for the rest of the day to accommodate any of these reasons.

If you arrive late for any reason, please check in at the front desk. The Practice Manager or Office Manager will check the schedule for the day and if possible, offer you another available time the same day. For example, if another Patient has cancelled or re-scheduled an appointment and there is an unexpected, available slot available, you will be offered the open time slot. If one is not available, an appointment on a different day will be offered to you. Please remind the staff if your medication will run out prior to this new appointment date.

We specifically ask all new Patients to arrive 30 minutes early and follow-up Patients to arrive 15 minutes early. This request is made both verbally when we schedule your appointment and it is on the recording you hear when you are on hold. We also request Patients who will be having a procedure to arrive 30 minutes early if they are having sedation and 15 minutes early if they are having a procedure without sedation. This information is also repeated on the recall slip.

There may be times when we run late. This is due to some unforeseen Patient clinical need that we must accommodate. We respect our patient's time and will do all that we can to be on schedule.

I have read the late arrival policy and understand that if I arrive late I am not guaranteed that I will be seen the same day.

Patient Signature

Date

SEVERITY OF PAIN: In general, over the past month, the intensity of my pain has been:

- Mild
- Moderate
- Moderate- Severe
- Severe

TIMING OF PAIN: How often do you have your pain (please check one)?

- Constantly (100% of the time)
- Nearly constantly (60 to 95% of the time)
- Intermittently (30 to 60% of the time)
- Occasionally (less than 30% of the time)

In general, during the past month, when has your pain been the worst (please check one)

- Morning
- Afternoon
- Evening
- Night
- No typical pattern

PAIN/SYMPTOM QUALITY: How would you describe your pain (please check all that apply; if there is a dominant quality to your pain, please circle the appropriate term):

- burning sharp cutting throbbing
- cramping dull/aching pressure-like
- shooting other (describe) _____

Associated with pain, I feel the following (please check all appropriate terms):

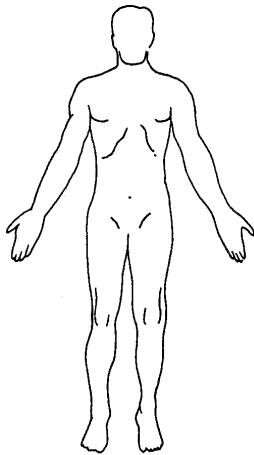
- Numbness I feel these sensations in the Same Different areas than the pain.
- Pins and needles I feel these sensations in the Same Different areas than the pain.

I have had weakness in my:

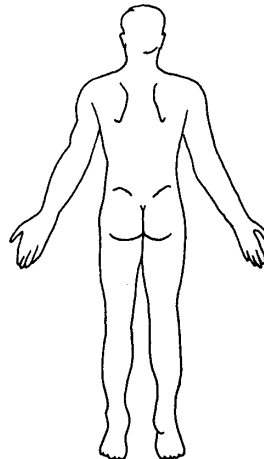
- Upper extremities Yes
- Lower extremities Yes
- Other (please describe) _____

- Dropping objects? Yes
- Falling? Yes

PAIN LOCATION: please mark the location(s) of your pain on the diagrams above with an "X". If whole areas are painful, please shade in these areas.



Front



Back

RELIEVING AND AGGRAVATING FACTORS:

How do the following affect your pain (please check one for each item).

	<u>DECREASE</u>	<u>NO CHANGE</u>	<u>INCREASE</u>
LYING DOWN			
STANDING			
SITTING			
WALKING			
EXERCISE			
RELAXATION			
COUGHING/SNEEZING			
BOWEL MOVEMENTS			

I have ____ **had** - or- ____ **not had** a recent change in bowel or bladder habits.

Please describe recent changes _____

ACTIVITIES AND YOUR PAIN:

How many blocks can you walk? Less than a block ____Blocks (how many?)

How many minutes or hours can you sit? ____Minutes (how many?) ____Hours (how many?)

How many minutes or hours can you stand? ____Minutes (how many?) ____Hours (how many?)

How often during the day do you lie down because of pain?

- Never Seldom Sometimes Often Constantly

To assist walking, I use a: Cane Walker Wheelchair No assistance device-

Are you **NOT** able to perform any of the following activities of daily living? (check all that apply)

- Going to work Performing household chores Doing yard work or shopping
 Socializing with friends Participating in recreational activities Exercising

PAIN TREATMENTS: Please check your response to all the treatments you have tried.

<u>TREATMENT</u>	<u>NO RELIEF</u>	<u>MODERATE RELIEF</u>	<u>EXCELLENT RELIEF</u>
SURGERY			
TRACTION			
NERVE BLOCK/INJECTION			
PHYSICAL THERAPY			
EXERCISE			
TENS			
HEAT TREATMENT			
ICE TREATMENT			
PSYCHOTHERAPY			
ACUPUNCTURE			
HYPNOSIS			
BIOFEEDBACK			
CHIROPRACTIC MANIPULATION			

CURRENT MEDICATIONS FOR PAIN:

<u>NAME</u>	<u>DOSE</u>	<u>FREQUENCY</u>

My pain medications provide relief:

- None of the time
- Some of the time
- Most of the time
- All of the time

Side-effects from these medications include:

- Nausea
- Vomiting
- Constipation
- Stomach Upset
- Sedation
- Other (please specify) _____

CURRENT MEDICATIONS (OTHER THAN ANALGESICS)

<u>NAME</u>	<u>DOSE</u>	<u>FREQUENCY</u>

ALLERGIES: Please indicate the names of any medications to which you are allergic:

What type of reaction did you have ? _____
I am allergic to contrast dye used for X-rays ____ Yes ____ No

REVIEW OF SYSTEMS: please check all items you feel are applicable to you:

- Recent significant gain of weight: ____ pounds over ____ weeks/months/years
- Recent significant loss of weight: ____ pounds over ____ weeks/months/years
- Fever
- Dizziness
- Difficulty swallowing
- Double or blurry vision
- Nausea
- Vomiting
- Constipation
- Diarrhea
- Difficulty initiating urine stream
- Genital pain
- Chest pain
- Heart palpitations
- Shortness of breath
- Wheezing
- Memory loss
- Loss of consciousness
- Seizures
- Easy or excessive bruising
- Easy or excessive bleeding
- Rash
- Diabetes
- Adrenal disease
- Hypothyroidism
- Hyperthyroidism
- Joint stiffness
- Decreased range of motion
- Pain in extremity (specify) _____
- Swelling (specify) _____
- Difficulty walking
- Muscle weakness

SOCIAL HISTORY:

EDUCATION: Your highest education level achieved:

- Graduate or professional training
- College graduate
- Partial college training
- High school graduate
- GED or trade-technical school graduate
- Partial high school (10th grade through partial 12th)
- Partial junior high school (7th grade through 9th grade)
- Elementary school

EMPLOYMENT: Your current or most recent occupation:

- Semi-skilled or unskilled (eg. Waitress, assembler)
- Skilled trade or clerical (eg. Carpenter, electrician, truck driver, secretary)
- Business executive or Managerial
- Professional (eg. Lawyer, teacher, nurse, physician, psychologist)
- Homemaker
- Other: please specify _____

CURRENT EMPLOYMENT STATUS: Please check one:

- Employed full-time
- Employed part-time
- Unemployed
- Retired
- Student
- Homemaker

If you are unemployed or employed part-time, is this due to your present pain condition? Yes No

If you are currently unemployed, indicate how long you have been off work: _____

LEGAL ISSUES: Please indicate any of the following claims you have filed related to your pain problem:

- Worker's compensation
- Personal Injury/Liability
- Social Security Disability Insurance (SSDI)
- Other insurance

SLEEP DISTURBANCE:

- Do you have difficulty falling asleep? Yes No
- Do you have difficulty remaining asleep? Yes No
- Are you ever awakened by pain? Yes No

If you use any sleep-aids, please specify _____

FAMILY LIFE: please specify living arrangements:

- Living alone
- Living with spouse/partner
- Living with spouse/partner and children
- Living with children
- Living with friends
- Living with other

PSYCHOLOGICAL TREATMENT:

Have you ever had psychiatric, psychological, or social work evaluation or treatments for any problem, including your current pain?

- Yes
- No

For what diagnosis were you treated? _____

When? _____

Please list your current or last therapists _____

- Have you ever considered suicide? Yes No When? _____
- Have you ever planned suicide? Yes No When? _____
- Have you ever attempted suicide? Yes No When? _____

SUBSTANCE ABUSE:

- Have you ever been a smoker? Yes-Current Yes- In past No-Never
- If you smoke, how many packs per day? _____ Packs per day
- For how many years did you smoke? _____ Years

- Do you have a history of alcoholism? Yes No Current problem
- Have you abused prescription analgesics? Yes No Current problem
- Cocaine or intravenous substance abuse? Yes No Current problem

How many years has it been since you abused alcohol or drugs _____ years

If you have a history of alcoholism, have you ever been enrolled in Alcoholics Anonymous?
 Yes No When? _____

If you have a history of substance abuse, have you ever been in a detoxification program?
 Yes No When? _____

FAMILY HISTORY: Please specify any medical or psychiatric conditions common in your family and who suffers with these ailments:

- Condition: _____ Specific family member(s): _____
- Condition: _____ Specific family member(s): _____
- Condition: _____ Specific family member(s): _____
- Condition: _____ Specific family member(s): _____

PHYSICAL EXAMINATION

How much do you weigh? _____ pounds
How tall are you? _____ feet _____ inches

***TO BE COMPLETED BY THE SPINE CENTER STAFF ***

BP _____ HR _____

Notes:

Physical examination:

- HEENT: Head: Atraumatic Normocephalic Other: _____
- Pupils: Equal, Round, Reactive and able accommodate Other _____
- Neck: Supple without masses Other _____
- Thyroid: Not enlarged Enlarged Mass detected
- Heart: Regular Rate & Rhythm S1 S2 present Other _____
- Lungs: Clear to auscultation bilaterally Wheezes Other _____
- Abdomen: Soft, non-tender, non-distended with normal active bowel sounds Other _____
- Neuro: Gait Normal Antalgic
- Higher intelligence: Intact CN II-XII grossly intact Other: _____
- Motor Intact Other: _____
- Sensory Intact to touch and pinprick Other: _____
- Reflexes Normal Reduced Hyper Specify _____

Imaging:

Differential:

Plan: