***In Room New Patient Questionnaire***

|  |  |
| --- | --- |
| **Patient Name**: |  |
|  |  |

What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where is your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What caused your pain? Have you had any treatment for this pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past history of this pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous injury or motor vehicle accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 0-10 what is your pain level?\_\_\_\_\_ On a scale of 0-10 what is your worst pain?\_\_\_\_\_

Is the pain: (Circle all that apply)

Shooting Tingling Numbness Aching Burning Deep Dull Sharp Stabbing Throbbing

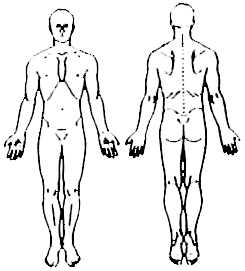
What makes the pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications you are currently taking for pain or need refills on.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please use the key ↓below to indicate what you feel.**

**Key:**

****X = PAIN (dolor)

O = NUMBNESS (adormecimiento)

/ = ACHING (adolorido(a)) **\*** = PINS/NEEDLES (cosquilleo)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ SS# \_\_\_\_\_\_\_/\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ (required)

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: M F Married Widow Single Divorced/Separated Minor

Patient Employer/School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Physician** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance please give receptionist your photo ID and insurance cards**

**Do you have Health Insurance? YES / NO (If yes, please provide information and card)**

Insured Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address if different then above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health or Auto (PIP) Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Accident or Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_

Do you have secondary Insurance? Yes No Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance or Workers Compensation**

Claim Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance or WC Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address for Claims \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse Case Manager \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*If Attorney: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize USA Spine or insurance company to release any information required to process my claims.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Legal Guardian Signature Date

**PATIENT CONSENT FORM**

Welcome to USA SPINE. We will strive to help restore and improve your health but there are no guarantees or promises of improvement or complete recovery.

Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability, religious or political beliefs; these quality healthcare services will be delivered with dignity and concern.

Your signature on this document fully authorizes our doctor and staff to perform any examination, diagnostic tests and/or treatments as well as we may consider medically necessary & to release all information pertinent to your health, insurance, or benefits to any & all applicable parties on your behalf.

Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document confirms that you have read, understand and agree to comply with all terms & conditions regarding your responsibilities to USA SPINE and that you grant the physician and staff to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern USA SPINE operations and responsibilities.

As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in a while.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**FINANCIAL POLICY-COMMERCIAL, MEDICARE & SELFPAY**

**FINANCIAL POLICY-COMMERCIAL, MEDICARE & SELFPAY**

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility and staff are NOT responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligation or arrangements between you and your attorney, insurance company, liable or third party payer are between you and said person or party.

1. Our facility will file initial insurance claims for you. Secondary claims submissions and/or additional reports and/or documents sent on your behalf may result in an additional filing and/or medical report charges, which you will be responsible for paying. (These fees and payments will be discussed prior to so that proper payment can be made prior to any further services being rendered).
2. Co-pays, Deductibles and all Non-Covered Services charges will be due at the time of service. Due to our office being a multi-disciplinary practice all providers are subject to separate co-pays. For your convenience this office accepts: **Cash/Check/Debit/Credit Cards.**
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. A service charge is computed by a “periodic rate” of 1 ½% per month. 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collections related expenses, attorney fees, court & filing fees.
5. Returned checks, debit and credit charges made payable to the facility for insufficient funds, stop payments or other expenses of non-payment will be assessed a $30.00 charge.

MEDICARE PATIENTS/MEDICARE REPLACEMENT POLICIES

Patients who qualify for Medicare and those Medicare replacement policies will be limited to the services that are covered under their healthcare insurance. We try to do our very best to notify these types of patients in advance by having you sign an ABN form (Advance Beneficiary Notice). This form outlines the services that ARE and are NOT covered in our office. Please be sure and inquire with our front desk if you have NOT received one of these forms.

**MEDICARE PATIENT CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I certify that the information given to me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or related Medicare claim(s). I request that payment of authorized benefits be made on my behalf; I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

ASSIGNMENT OF BENEFITS

I hereby assign rights and benefits of any applicable insurance policy directly to USA Spine accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician’s regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay. It is further agreed that any credit or balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician by the insured or his/her family.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: Date:

What is the main reason you are here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History (Check all that apply)**

\_\_ Diabetes \_\_High Blood Pressure \_\_Heart Disease \_\_Heart Attack

\_\_ Asthma \_\_Bronchitis or Emphysema \_\_Pneumonia \_\_Ulcers

\_\_Hypo/Hyper Thyroid \_\_Rheumatoid Arthritis \_\_History of Cancer \_\_Blood Clots

\_\_High Cholesterol \_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_ type: \_\_\_\_\_\_\_\_\_ \_\_HIV/Hepatitis C

**Past Surgical History**

\_\_Appendix (Appendectomy) \_\_Breast Surgery \_\_Tonsillectomy

\_\_Gall Bladder (Cholecystectomy) \_\_ Back Surgery \_\_Hysterectomy

\_\_Heart Bypass \_\_Total Joint Replacement \_\_Arthroscopy

\_\_Prostate \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical History**

Has anyone in your immediate family died of heart disease: YES NO

Has anyone in your family had an adverse reaction to anesthesia: YES NO

Has anyone in your family had an adverse reaction to Latex: YES NO

List any medical illnesses that run in your family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Who do you live with now: By yourself Spouse Other family Friends Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke tobacco? YES NO How much? \_\_\_\_\_\_\_\_ packs per day How long? \_\_\_\_\_\_ years

Do you drink alcohol? YES NO How much? \_\_\_\_\_\_\_ drinks per day How long? \_\_\_\_\_\_\_ years

Are you currently working? YES NO If yes, where do you work?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING? Please circle if yes

**Constitutional Symptoms Eyes Allergic Ear/Nose/Throat Genitourinary**

Fever Blurred vision Hay Fever Ear Infection Urine Retention

Chills Double Vision Drug Allergies Sore Throat Painful Urination

Headache Pain Other\_\_\_\_\_\_\_\_ Sinus Problems Urinary Frequency

**Neurological Endocrine Gastrointestinal Respiratory Hematologic/Lymphatic**

Tremors Excessive Thirst Abdominal Pain Frequent Cough Swollen Glands

Dizzy Spells Too hot/ cold Nausea/Vomiting Short of Breath Blood Clots

Numbness/Tingling Tired/sluggish Rectal bleeding Wheezing Bleeding Problems

**Cardiovascular** **Integumentary** **Musculoskeletal** **Psychological**

Chest Pain Skin Rash Joint Pain History of depression

Varicose Veins Boils Neck Pain History of bipolar disorder

High BP Persistent Itch Back pain History of schizophrenia

Other Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Height\_\_\_\_\_\_\_\_Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications: YES NO If so what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please specify any prior tests you have undergone for this problem.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Test** | **Date** | **Test** | **Date** | **Test** | **Date** |
| Plain X-ray |  | Nuclear Bone Scan |  | Myelogram |  |
| MRI |  | NCS/EMG |  | Arthrogram |  |
| CT scan |  | Dexa scan |  | Discogram |  |
| Other |  |  |  |  |  |
|  |  |  |  |  |  |

Please mark any prior treatments that you have had for this problem and the number of times you have had each

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Treatment** | **X** | **Helpful Yes/No** | **# of injections** | **Dates of each** |
| Epidural steroid injection |  |  |  |  |
| Facet injection |  |  |  |  |
| Sacroiliac injection |  |  |  |  |
| Hip injection |  |  |  |  |
| Radiofrequency ablation |  |  |  |  |
| Discectomy |  |  |  |  |
| Vertebroplasty |  |  |  |  |
| Trigger Points |  |  |  |  |
| Nerve blocks |  |  |  |  |

Please list any other PHYSICIANS (MD, DO, CHIROPRACTIC) you have or are currently seeing for this problem

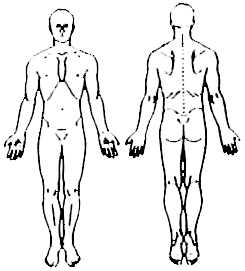
|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Physician** | **Specialty** | **Treatment/Testing** | **Phone Number** | **Date of Last Visit** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

CURRENT MEDICATIONS (List all medications. Use back of this sheet if you need more room)

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICATION** | **DOSAGE** | **#PER DAY/FREQUENCY** | **REASON FOR TAKING** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please use the key below to indicate the location(s) of pain.



Key:

X= PAIN

O= NUMBNESS

/= ACHING

\*= PINS/NEEDLES

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Activities of daily living:**

**Please mark the items which are difficult to perform or you are unable to perform since the injury. Please only mark if you were previously performing the activity.**

Difficult Unable To Perform

Laundry \_\_\_\_\_\_ \_\_\_\_\_\_

Vacuum \_\_\_\_\_\_ \_\_\_\_\_\_

Dishes \_\_\_\_\_\_ \_\_\_\_\_\_

Mop Floors \_\_\_\_\_\_ \_\_\_\_\_\_

Sweep Floors \_\_\_\_\_\_ \_\_\_\_\_\_

Dust \_\_\_\_\_\_ \_\_\_\_\_\_

Make Bed \_\_\_\_\_\_ \_\_\_\_\_\_

Cook Meals \_\_\_\_\_\_ \_\_\_\_\_\_

Drive Car \_\_\_\_\_\_ \_\_\_\_\_\_

Put On Clothes \_\_\_\_\_\_ \_\_\_\_\_\_

Get Into/Out of Bath or Shower \_\_\_\_\_\_ \_\_\_\_\_\_

Walk From House to Get Mail \_\_\_\_\_\_ \_\_\_\_\_\_

Brush Hair \_\_\_\_\_\_ \_\_\_\_\_\_

Shave \_\_\_\_\_\_ \_\_\_\_\_\_

Other \_\_\_\_\_\_ \_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Records Release Authorization**

**In order to avoid a delay this form must be completed in its entirety. PLEASE PRINT CLEARLY**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B. **(Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** SS# **(Required)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission is hereby granted to Colleen Maxcy, MD and USA SPINE to release medical information to the individual / organization as noted below or to have records released to Colleen Maxcy, MD and USA SPINE:

Mail to: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax to another medical entity Call when ready for pick up Person picking up records

(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check information to be released:

All records, excluding records from other physicians. Office Notes only

Surgical Records X-ray/MRI films

Therapy reports X-ray/MRI reports

Diagnostic test results Patient information

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization will be valid for two years after the date of the patient’s signature as it appears below, or by whichever comes sooner.

I understand I have the right to refuse this authorization, in writing, Dr Colleen Maxcy, MD and USA SPINE is released from all legal liability that may arise from the released information requested.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient/Legal Guardian Date

**Notice of Privacy Practice**

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review carefully.

At USA Spine we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act require us to continue to maintain your privacy, to give you this notice and follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we will want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your medical records to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copies, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice.

Patient Name (Printed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain Management Agreement

The purpose of this agreement is to prevent misunderstanding about certain medicine(s) you will be taking for the control of your pain. This is also to help you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that if I break this agreement which is essential to the trust and confidence necessary in a doctor/patient relationship, based on this agreement, the doctor has the right to discharge me as a patient of the practice.

I understand that if I break this agreement, my doctor will stop prescribing these pain control medicines. In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment program will be recommended.

I have communicated, and will continue to communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve the pain.

I will not use illegal controlled substances, including marijuana, cocaine etc. at any time.

I will inform Dr. Maxcy/Dr.Panagakos of all the medications I am presently taking, including all remaining refills. I will not attempt to obtain any controlled medicines which include controlled opium pain medicines and refills, controlled stimulants or anti-anxiety medicines from any other doctor.

I will not share, sell or trade my medication with anyone.

I will safeguard my pain medicine(s) from loss or theft. Lost or stolen medicines will not be replaced.

I understand that Dr. Maxcy reserves the right to terminate my care and treatment if such is the case at anytime.

Medication refill requests should be made at a minimum of 48 hours in advance. By law, some medications require a written prescription or a follow up appointment for refills. Prescriptions will not be called in on the weekends or after hours. If there is an emergency please go to the nearest emergency room.

I agree to use the pharmacy listed below to fill my pain medicine(s).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name Location Phone #

I have read, understand and agree with ALL of the above mentioned

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Patient Name (Print) Patient Signature Date

NO SHOW AND CANCELLATION POLICY

\_\_\_ Initials: Your time is very important to us, to be respectful of the medical needs of our Patients, please be courteous and call promptly if you are unable to attend an appointment/Procedure. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment/Procedure, we require that you call 48Hours in advance. Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care.

If you show up more than 15 minutes after your scheduled appointment/Procedure time, you will be considered a "No Show" and will need to reschedule your appointment.

To cancel an appointment/Procedure, please contact our office at (813)-855-8400; if you’re unable to reach someone please leave a detailed message stating your Name, Date, and time of the appointment.

Any cancellations within 48 hours or no-shows will be considered as " No Show" and will be subjected to a $75.00 cancellation fee.

GUARENTEE OF PAYMENT

\_\_\_ Initials: For value received, including, but not limited to the services rendered, I agree to pay USA Spine all charges and expenses incurred in my treatment. This would include those expenses not covered by my insurance policy, any co-payment and/ or deductible. Unless specifically agreed in writing, all charges shall be paid at discharge, time of visit or upon presentation of any bills by USA Spine.

Patients/Guarantor (Print Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guarantor (Signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_