CENTER FOR
BRAIN & SPINE

Today's Date: _____/_____/_____

PATIENT NAME:

LAST_____ **First**_____**MI**____

Date of Birth: _____/_____/_____ Male ❑ Female ❑

Social Security Number _____

Marital Status: Single ❑ Married ❑ Widowed ❑ Separated ❑ Partnered ❑

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

PHONE: **Home #** (_____)_____ **Cell #** (_____)_____

Work # (_____)_____ **Preference of Contact** ❑ Home ❑ Cell ❑ Work

EMAIL:_____

PRIMARY INSURANCE

Ins. Company:_____

Policy Holder:_____ **DOB:** _____/_____/_____

Relationship to patient: _____

ID#:_____ Group#_____

Secondary Insurance

Ins. Company:_____

Policy Holder:_____ **DOB:** _____/_____/_____

Relationship to patient: _____

ID#:_____ Group#_____

Thank you for choosing the Center for Brain & Spine. We are honored to be your choice in partnering towards your health and are committed to providing you with the highest quality care. Listed below are our financial policies and we ask that you read carefully and sign below.

I understand that:

- The patient (or guardian, if a minor) is ultimately responsible for all services provided.
- Center for Brain & Spine will bill my insurance(s), but I am responsible to provide the most current insurance information, and for providing any changes or updates to my insurance as soon as they occur.
- I understand that failure to provide accurate insurance information will result in any charges or services not covered becoming my responsibility.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and the fees for any services/medical equipment not covered by my insurance.
- I understand that copays are due at the time of my appointments.
- I understand that it is my responsibility to obtain any referrals that are needed before my appointment(s). Failing to obtain a needed referral could result in my appointment being rescheduled.
- I understand that I will be charged **$50.00** for any missed appointments or cancellation that are not received **within 24 hours of the appointment**.
- I understand that Center for Brain & Spine charges a **$35.00** fee for checks returned for insufficient funds.
- I understand that I am responsible for paying or making a payment arrangements for outstanding balances on my account. Failure of non-payment may result in my dismissal from the practice.
- I understand that extensive phone consultations and/or after hours phone calls may result in additional fees.
- I understand that the Center for Brain & Spine may share or access my health information via CRISP.

Medical Records & Forms Completion

Center for Brain & Spine charges for the completion of forms and the processing of medical records.

1. Medical Records Fee(s): .76 cents per page Postage & Handling $4.00 - $10.00
   **There is no charge for picking up records from our office.*
2. Completion of Forms: $35.00 1st page & $5.00 for each additional page. Fees must be paid in advance.

   Please allow 5-7 business days for processing.

Financial Authorization

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Center for Brain & Spine for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

By signing below, I acknowledge, understand and agree to the policies as stated above. I also confirm that all information provided by me is correct and up to date.

Signature **Date**

CENTER FOR
BRAIN & SPINE

Health Insurance Portability and Protection Act

Patient Acknowledgement and Consent Form

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent. I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Center for Brain & Spine, LLC for any services furnished to me by my physician. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits for related services. I agree to provide all reference and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements. ***You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.***

Center for Brain & Spine, "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office's Notice of Privacy Practices by initialing:

_____ **Patient's Initials**

Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, we will post them in our office and you will receive a hard copy of them at your next visit.

_____ **Patient's Initials**

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.

_____ **Patient's Initials**

Signature **Date**

Printed Full Name

Please list below any person(s) that you authorize us to speak to or release medical information to.

Name:_____ Relation:_____ Phone #:_____

Name:_____ Relation:_____ Phone #:_____

CENTER FOR
BRAIN & SPINE

Health Insurance Portability and Protection Act

Patient Acknowledgement and Consent Form

"CONTINUED"

Section II: CONSENT FOR USE AND DISCLOSURE OF INFORMATION

Center for Brain & Spine's physicians and healthcare staff & Business Associates routinely contact patients during normal business hours as well as after hours and may sometimes need to leave messages. On these occasions our office leaves messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule we must obtain your authorization to continue this mode of communication.

Protected Health care Information that we may possibly disclose on your home, cell phone or email would include, but is not limited to: prescription/pharmacy information, appointment instructions for visits and procedures, surgical posting/scheduling information as well as financial information regarding your account.

_____ **(Initial) Yes, I agree to allow Center for Brain & Spine's physicians and healthcare staff to leave messages that include Protected Healthcare Information on all three communication devices: home, cell phone & email.**

_____ **(Initial) I agree to allow Center for Brain & Spine's physicians and healthcare staff to leave messages that include Protected Healthcare Information on the following:**

Please initial next to the applicable communication devices:

_____ **Home number** _____**Cell number** _____**Email**

_____ **(Initial) No, I do not agree to allow Center for Brain & Spine's physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work and cell phone.**

_____ **(Initial) I understand that I may revoke this authorization at any time by completing/updating this form.**

CENTER FOR
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☐ **Check this box if your symptoms are related to a workers comp or personal injury claim**

Name: _____ DOB: _____ Age: _____

Address: _____ Phones (give all): _____

Primary Care Physician Info			**Referring Physician Info**		
Name:			Name:		
Telephone:	**Fax:**		Telephone:	**Fax:**	
Address:			Address:		
City:	State:	Zip Code:	City:	State:	Zip Code:

History of Present Illness:

Physician Notes

What is the reason for your visit? Headache / Back pain / Neck pain / Arm pain / Leg pain
Right side / left side / both sides (circle one) Others:.....

When did this problem start?

How would you best describe the pain? *Check all that apply.*

☐ Sharp ☐ Burning Sensation ☐ Numbness
☐ Dull ☐ Shooting pain ☐ _____

Please rate your pain by checking the number that best correlates to your pain level.

No Pain ***Least Pain*** ***Moderate Pain*** ***Most Severe Pain***

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What makes it worse?

☐ Nothing makes the symptoms worse ☐ Movement of any kind ☐ Sitting
☐ Standing ☐ Walking ☐ Lifting
☐ _____ ☐ _____ ☐ _____

What helps?

☐ Nothing helps the symptoms ☐ Steroid injections ☐ Sitting
☐ Standing ☐ Walking ☐ Laying still
☐ Pain medication ☐ Physical therapy ☐ _____

Is it worse at certain times of the day or night?

☐ Day ☐ Night ☐ Neither

Do you have any other related symptoms?

☐ Bowel incontinence ☐ Urine incontinence
☐ Weakness of arms or legs (please specify) _____

What treatments have been attempted in the past to alleviate your symptoms?

☐ Physical Therapy ☐ Steroid Injections ☐ Prior Surgery
☐ Occupational Therapy ☐ Pain management ☐ _____

Please check only those items, which apply to your personal medical history. (PMH)

☐ High Blood Pressure ☐ Cancer ☐ Lung problems / Asthma
☐ Diabetes ☐ High Cholesterol ☐ Headache
☐ Peptic Ulcers ☐ Hepatitis ☐ Accidents /broken bones
☐ Heart attack ☐ HIV ☐ Back pain
☐ Chest pain/Tightness ☐ Stroke ☐ Neck Pain
☐ Stroke ☐ Seizure ☐ Other _____

CENTER FOR BRAIN & SPINE

Previous Hospitalizations/Surgeries: (not including pregnancy)

Illness/Surgery	Date	Surgery	Date

Current Medications: (including vitamins and over the counter medications)

Medication	Dosage	Frequency	Reason for taking medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Please Lists All Allergies:

☐ No known drug allergies	☐ Penicillin	☐ Iodine	☐ Contrast Dye
☐	☐	☐	☐

Please check if you are experiencing any of the following symptoms: (ROS)

☐ Chest pain	☐ Shortness of breath	☐ Seizures	☐ Urinary Incontinence	☐ Fever
☐ Palpitations	☐ Nausea	☐ Weakness	☐ Bowel Incontinence	☐ Swollen Legs
☐ Chest tightness	☐ Vomiting	☐ Headache	☐ Easy bruising	☐ Muscle Spasms
☐ Fainting Spells	☐ Dizziness	☐ Blurred Vision	☐ Easy Bleeding	☐ Neck Pain
☐ Heat Intolerance	☐ Depression	☐ Double Vision	☐ Difficulty Speaking	☐ Back pain
☐ Cold Intolerance	☐ Anxiety	☐ Loss of Vision	☐ Difficulty Swallowing	☐ Numbness

Social History: Check any of the following if they pertain to your current social situation.

Marital Status:
☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ In a relationship

Employment:
☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired
Occupation: _____

How many children do you have?
0-1-2-3-4-5-more ____

Tobacco Use:
Cigarettes ☐ Never ☐ Quit Date _____ ☐ Current smoker: packs/day _____ number of years _____
Other Tobacco ☐ Pipe ☐ Chew ☐ Cigar ☐ Snuff

Alcohol Use:
☐ Do you drink alcohol? ☐ Yes ☐ No Number of drinks per week _____

Drug Use:
Do you use any recreational drugs? ☐ Yes ☐ No Pain killer / Marijuana / Cocaine / others

Family History: Check only the condition if a blood relative has suffered.

☐ Epilepsy	☐ Stroke	☐ Alcoholism	☐ Brain Tumors	☐ Osteoporosis
☐ Migraine	☐ Sickle Cell	☐ Bleeding Disorder	☐ Mental Illness	☐ Arthritis
☐ High Blood Pressure	☐ Cancer	☐ Multiple Sclerosis		

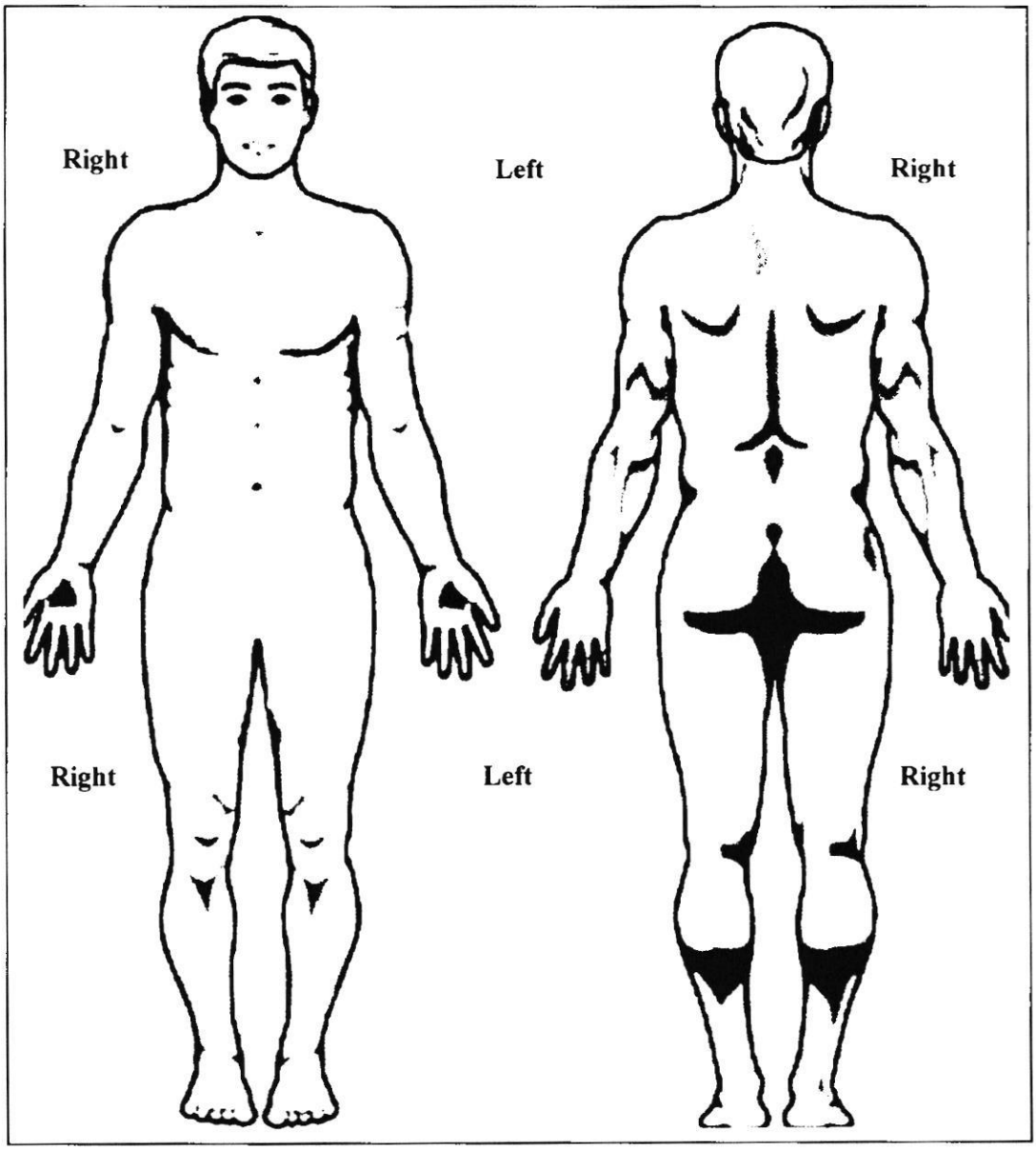
Patient Signature: _____ **Date:** _____

CENTER FOR BRAIN & SPINE

Patient Name _____ **DOB** _____ **Date** _____

Please use the following descriptive symbols on the body outlines below to describe the location of your symptoms.

Pain	Numbness	Pins & Needles	Burning	Weakness
XXXX	0000	.....	BBBB	+ + + +



Front **Back**

Patient Name: _____ **DOB:** _____ **Date:** _____

CENTER FOR
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INFORMATION UPDATE:

In an effort to keep your providers informed, we ask that you please provide or update your physician information for our records. Thank you!

Patient's Name: _____ ***Date of Birth:*** _____

I VERIFY THAT I DO NOT HAVE ANY DOCTORS TO LIST ON THIS FORM. _____ ***Date:*** _____

Primary Care Doctor: _____ Phone Number: _____

Address: _____

Referring Doctor: _____ Phone Number: _____

Address: _____

Neurologist: _____ Phone Number: _____

Address: _____

Orthopedic Doctor: _____ Phone Number: _____

Address: _____

Pain Specialist: _____ Phone Number: _____

Address: _____

Rheumatologist: _____ Phone Number: _____

Address: _____

Oncology/Hematology Doctor: _____ Phone Number: _____

Address: _____

Physical Therapist: _____ Phone Number: _____

Address: _____

Cardiologist: _____ Phone Number: _____

Address: _____

Radiation Oncology: _____ Phone Number: _____

Address: _____

Other Doctor: _____ Phone Number: _____

Address: _____