CENTER FOR
BRAIN & SPINE

Date: _____/_____/_____

Patient Name:

Last:_____ **First:**_____ **M**_____

DOB: _____/_____/_____ **Male** □ **Female** □

SSN: _____

Marital Status: **Single** □ **Married** □ **Widowed** □ **Divorced** □ **Other** □

Address: _____

City: _____ **State:** _____ **Zipcode:** _____

Phone: Cell (_____**)** _____-_____ **Home (**_____**)** _____-_____ **Work (**_____**)** _____-_____

Preference: **Cell** □ **Home** □ **Work** □

Email: _____

Emergency Contact:

Name: _____ **Phone: (**_____**)** _____-_____ **Relationship:** _____

Primary Insurance

Company:_____

ID #: _____ **Group #:** _____

Policy Holder:_____ **DOB:** _____ **Relationship:** _____

Secondary Insurance

Company:_____

ID #: _____ **Group #:** _____

Policy Holder:_____ **DOB:** _____ **Relationship:** _____

Patient Acknowledgement and Consent Forms

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 necessary referrals 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 cancellations 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 payment arrangements for outstanding balances on my account. Failure to make 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.

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

Patient Acknowledgement and Consent Forms

Health Insurance Portability and Accountability Act

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

Patient Acknowledgement and Consent Forms

Health Insurance Portability and Accountability Act

"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.

Please Initial only ONE

_____ (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.

OR

_____ (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

OR

_____ (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 Below

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

CENTER FOR
BRAIN & SPINE

Patient Acknowledgement and Consent Forms

"CONTINUED"

Section III: DEEPSCRIBE PATIENT CONSENT FOR RECORDINGS

Center for Brain and Spine uses DeepScribe, a state-of-the-art AI medical scribe technology to prepare medical notes for your clinical visit. DeepScribe is 100% HIPAA compliant. To ensure your data is as secure as possible, we have implemented multi-factor authentication, data encryption, de-identification of all patient data, and extensively limited access to your information.

By signing below, you consent to be audio recorded during your medical visit. You consent to using DeepScribe's medical scribe services to use these recordings and personal information collected during the recordings, including health information, for the following services, which includes but is not limited to, medical documentation, medical transcription, quality assurance, training, software improvement, and voice analytics purposes.

I understand that any or all of the information provided by me or my care team during the recordings may be used and disclosed for the above-indicated purposes, including personal and health information about myself.

Signature **Date**

CENTER FOR
BRAIN & SPINE

☐ Check box if your symptoms are related to a workers compensation or personal injury claim

Name:_____ **DOB:** _____ **Age:** _____

Primary Care Doctor		Referring Doctor	
Name:		**Name:**	
Phone:	**Fax:**	**Phone:**	**Fax:**
Address:		**Address:**	

PHYSICIAN NOTES

History of Illness:

Reason for Visit
☐ Head ☐ Back ☐ Neck ☐ Arm ☐ Leg
☐ Left ☐ Right ☐ Both

When did this problem start?

How would you describe the pain?
☐ Sharp ☐ Burning
☐ Dull ☐ Shooting
☐ Numbness ☐ _____

Please rate your pain by checking the number that best correlates to your pain level.
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What makes it worse? ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Movment ☐ Lifting

What helps?
☐ Nothing ☐ Steroid Injections ☐ Sitting
☐ Standing ☐ Walking ☐ Laying Still
☐ Medication ☐ Physical Therapy ☐ _____

When is it worse?
☐ Day ☐ Night ☐ Neither

Do you have any other related symptoms?
☐ Bowel Incontinence ☐ Urinary Incontinence ☐ Weakness of arms/legs?_____

What treatments have you tried to alleviate your symptoms?
☐ Physical Therapy ☐ Occupational Therapy ☐ Steroid Injections ☐ Prior Surgery
☐ Pain Management ☐ _____

Personal Medical History:

☐ High Blood Pressure (HTN)	☐ Cancer	☐ Headache
☐ Diabetes (DM)	☐ High Cholesterol	☐ Accidents
☐ Peptic ulcer	☐ Hepatitis	☐ Broken Bones
☐ Heart Attack	☐ HIV	☐ Back Pain
☐ Chest Tightness/Pain	☐ Seizure	☐ Neck Pain
☐ Stroke	☐ Asthma	☐ Other_____
	☐ Lung Problems	

Previous Hospitalizations/Surgeries :	
Surgery/Illness	**Date**

Current Medications: Include vitamins & over-the-counter			
Medication	**Dosage**	**Frequency**	**Reason**

Allergies:

☐ No known Allergies ☐ Penicilin ☐ Iodine ☐ Contrast Dye ☐ other:

Review of Systems: Please check if you are experiencing any of the following symptoms

☐ **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:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ In a relationship | **Children:** 0-1-2-3-4-5-5<

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

Tobacco: ☐ Never ☐ Previous Use (quite date)_____ ☐ Current ☐ Occassional ☐ Other: _____

Alcohol: ☐ None ☐ Daily ☐ Weekly ☐ Socially ☐ Rarely |**Amount:** _____

Drug Use: ☐ None ☐ Marijuana ☐ Cocaine ☐ Narcotics ☐ Pain Killers ☐ PCP ☐ Methamphetamine

Family History:

☐ **Epilepsy** ☐ **Migraine** ☐ **High Blood Pressure** ☐ **Parkinson's Disease** ☐ **Stroke** ☐ **Sickle Cell** ☐ **Cancer**

☐ **Diabetes** ☐ **Heart Disease** ☐ **Bleeding Disorders** ☐ **Multiple Sclerosis** ☐ **High Cholesterol**

☐ **Thyroid Disorder** ☐ **Mental Illness** ☐ **Asthma** ☐ **Alcoholism** ☐ **Anemia** ☐ **Brain Tumors** ☐ **Osteoporosis**

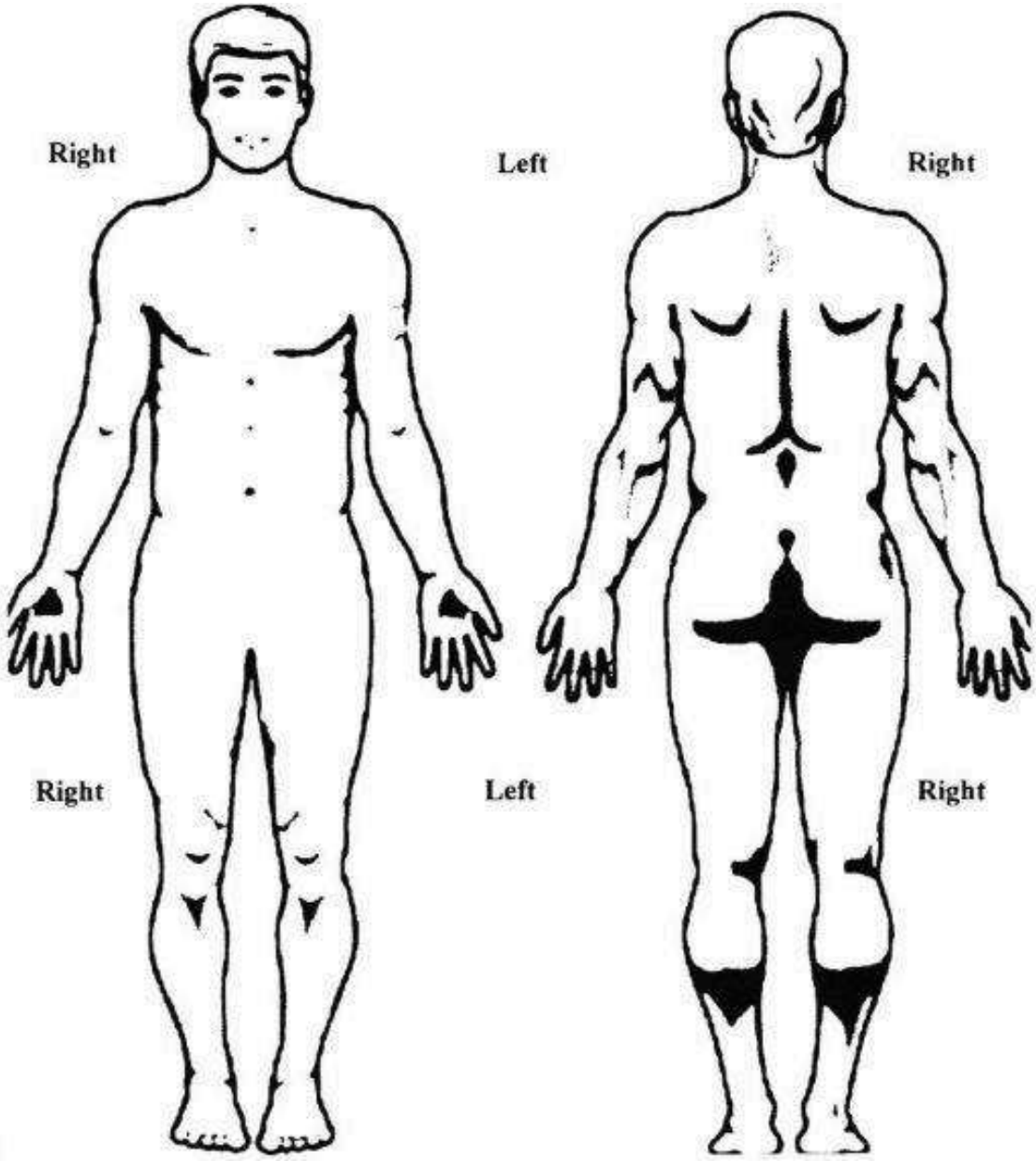
☐ **Arthritis** ☐ **Other:** _____

Signature:_____**Date:**_____

CENTER FOR
BRAIN & SPINE

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	oooo	.....	BBBB	++++



Name:_____ **DOB:**___/___/____ **Date:**___/___/____

CENTER FOR
BRAIN & SPINE

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 Name: _____ DOB:_____

Specialty	Physician Name	Phone number	Address
Primary			
Referring			
Neurologist			
Orthopedic			
Pain Management			
Rheumatologist			
Oncologist			
Hematologist			
Physical Therapy			
Cardiologist			
Radiation Oncologist			

Or

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

Signature: _____ Date:_____