

PATIENT INFORMATION—SPINE

Current pain levels

Please indicate your current pain level by placing an x on the line
 "0" = no pain & "10" = worst pain imaginable

Example 0 X | _____ 10

How bad is your pain now?

Pain on average 0 _____ | _____ 10
Pain at its worst 0 _____ | _____ 10
Pain at its best 0 _____ | _____ 10

Current pain profile (Which of the following activities change the nature of your pain?)

- | | | | |
|-----------------|--|--|----------------------------------|
| Sitting | <input type="checkbox"/> Aggravates pain | <input type="checkbox"/> Relieves pain | <input type="checkbox"/> Neither |
| Standing | <input type="checkbox"/> Aggravates pain | <input type="checkbox"/> Relieves pain | <input type="checkbox"/> Neither |
| Walking | <input type="checkbox"/> Aggravates pain | <input type="checkbox"/> Relieves pain | <input type="checkbox"/> Neither |
| Long car rides | <input type="checkbox"/> Aggravates pain | <input type="checkbox"/> Relieves pain | <input type="checkbox"/> Neither |
| Bending forward | <input type="checkbox"/> Aggravates pain | <input type="checkbox"/> Relieves pain | <input type="checkbox"/> Neither |

Family history (Please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> No significant family history | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Spine disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Bleeding problems | |

Tests & treatment (Any previous tests, examinations or treatments for your current condition?)

Yes No

Medications

- | | | | |
|---------------------------|---|---|------------------------------------|
| Anti-inflammatories _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |
| Muscle relaxants _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |
| Pain medications _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |
| Other(s) _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |

Therapies

- | | | | |
|-------------------------|---|---|------------------------------------|
| Chiropractic care _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |
| Physical therapy _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |
| Other(s) _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |

Injections

(i.e. epidural steroid injections, nerve-root blocks)

- | | | | | |
|------------|----------------------|---|---|------------------------------------|
| Date _____ | Injection type _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |
| Date _____ | Injection type _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |

Are you under a doctor's care for any other medical condition? Yes No

If yes, please explain _____

Spine imaging history

Please indicate whether you have had any of the following studies and write when & where the most recent was

- | | | | | |
|------------------------------|-----------------------------|------------------------|------------|-------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Regular x-ray of spine | When _____ | Where _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | CT scan of spine | When _____ | Where _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | EMG | When _____ | Where _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone scan | When _____ | Where _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Myelogram | When _____ | Where _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Discogram | When _____ | Where _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | MRI of spine | When _____ | Where _____ |

Medical history (Please check all current & past medical conditions)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Abnormal heart rhythm | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Lung disease (COPD) | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Seen a psychiatrist |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> CVA/Stroke | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Asthma/bronchitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Blood clots/DVT | <input type="checkbox"/> Sleep apnea (use CPAP? Y or N) |

Surgical history (Please check all spinal surgeries you have had)

- | | | |
|---|-----------------------|---------------|
| <input type="checkbox"/> Spine-neck | Type of surgery _____ | Date(s) _____ |
| <input type="checkbox"/> Spine-lower back | Type of surgery _____ | Date(s) _____ |
| <input type="checkbox"/> Other: _____ | Type of surgery _____ | Date(s) _____ |

PATIENT INFORMATION—SPINE

Current medications (may attach a list)		
Medication Name	Dose	# per day (SIG)

Allergies (may attach a list)		<input type="checkbox"/> No known medical allergies
Substance	Reaction	

Review of systems (Please check all that apply)

No significant history

General

- Unexplained weight loss
- Appetite change
- Fevers or chills
- Night sweats
- Marked fatigue
- Difficulty sleeping

Cardiovascular

- Heart or chest pain
- Abnormal heartbeat
- Poor heart function

Digestive

- Nausea or vomiting
- Stomach pain or ulcers
- Heartburn/acid stomach
- Frequent diarrhea
- Frequent constipation
- Uncontrolled loss of stool
- Blood in stool

Lung

- Morning cough
- Shortness of breath
- Productive cough or sputum

Neurological

- Seizures
- Blackouts/fainting
- Tremor
- Headaches/migraines
- Chronic pain syndrome
- Fibromyalgia
- Chronic fatigue syndrome
- Reflex sympathetic dystrophy
- Loss of balance
- Increased clumsiness
- Difficulty buttoning shirt
- Dropping things

Genitourinary

- Burning on urination
- Difficulty starting urination
- Incontinence
- Pelvic pain
- Urinate at night more than once
- Unable to completely empty bladder

Psychiatric

- Depression
- Nervous exhaustion
- Anxiety
- Paranoia
- Obsessive/compulsive behavior
- History of sexual abuse
- History of physical abuse

Skin

- Easy bruising
- Swollen ankles

Musculoskeletal

- Joint pain/swelling
- Back pain
- Neck pain
- Muscle aches

Social history

- Married
- Divorced
- Significant other
- Single
- Widow/Widower

Number of children _____

Highest educational level attained Grade school High school College Post graduate

- Do you drink? Yes No
- Frequency* Heavy Moderate Occasionally Never
- Do you smoke? Yes No Cigar Pipe
- Type* Cigarettes No Cigar Pipe
- Do you exercise? Yes No Cigar Pipe
- I quit (when? _____) Frequency _____*

Employment : Full time Part time Student Disabled Retired Unemployed

Occupation: _____ Describe duties: _____

How much weight do you lift? _____ pounds



Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This office is required by a federal regulation, known as the HIPAA Privacy Rule, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This office will not use or disclose your health information except as described in this Notice.

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information (PHI) is the information we create and obtain in providing our services to you. The health information about you is documented in a medical record and on a computer. (Examples of use of your PHI would be a nurse obtaining treatment information about you and recording it in your chart, a bill submitted to your insurance company for services rendered and/or when an outside medical transcription service is utilized by our practice in order to complete your medical chart.)

Your Health Information Rights

The health and billing records we maintain are the physical property of the doctor's office. The information in it, however, belongs to you. You have a right to:

- ❖ Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office – we are not required to grant the request but we will comply with any request granted.
- ❖ Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office.
- ❖ Request that you be allowed to inspect and copy your medical record and billing record – you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request.
- ❖ Appeal a denial of access to your protected health information except in certain circumstances.
- ❖ Request that your medical record be amended to correct incomplete or incorrect information by delivering a written request, including a reason to support it, to our office using the form we provide to you upon request. (We are not required to make such amendments)
- ❖ File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
- ❖ Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. We may charge a cost-based fee for more than one accounting in a 12-month period.
- ❖ Request that confidential communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we provide to you upon request.
- ❖ Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact a staff member of Spine and Orthopedic Specialists at (480) 353-0446 during normal business hours, or in writing to P.O. Box 19060, Fountain Hills, AZ 85269-9060. Our staff will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

This office is required to:

Maintain the privacy of your health information as required by law; provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you; abide by the terms of this Notice; notify you if we cannot accommodate a requested restriction or request; and accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, want to report a problem regarding the handling of your information; or if you believe your privacy rights have been violated and wish to file a written complaint with our office, please contact a staff member at Spine and Orthopedic Specialists at (480) 353-0446, P.O. Box 19060, Fountain Hills, AZ 85269-9060. You may also file a complaint by mailing it or e-mailing is to the Secretary of Health and Human Services.

Other Disclosures and Uses We Can Make Without Your Written Authorization

- ❖ Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.
- ❖ We may disclose your health information to funeral directors, medical examiners, or coroners consistent with applicable law to allow them to carry out their duties.
- ❖ If you are seeking compensation through Workers' Compensation, we may disclose your health information to the extent necessary to comply with laws relating to Workers' Compensation.
- ❖ As required by law, we may disclose your health information to public health authorities or law enforcement agencies.
- ❖ We may use and disclose your health information by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
- ❖ We may disclose your health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.
- ❖ We may provide your employer with your health status regarding your ability to return to work and/or any work restrictions you may have during your treatment.
- ❖ We work with physician and physician assistant training programs and from time to time a medical student will have access to your health information as part of their training.
- ❖ Other uses and disclosures of your health information besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided in the Notice.
- ❖ This Notice will be on our website at www.spineandorthodocs.com.

WHAT TO BRING TO APPOINTMENT:

___ NEW PATIENT REGISTRATION AND MEDICAL HISTORY FORMS

___ MEDICATION LIST / DRUG ALLERGIES

Make list of any medications you are currently taking, including dosages and frequency. Include a list of any drug allergies that you have.

___ INSURANCE COMPANY INFORMATION

Please have your insurance card and insurance company information, including the group number and address where claims should be sent.

___ WORKERS COMPENSATION INFORMATION

Bring the claim number, insurance carrier, claims address, contact person (claim's adjustor) and phone number if you are covered by workers compensation. *Your claim will have to be verified and authorized with your adjustor prior to your appointment.*

___ CO-PAY - If your insurance has a co-payment, you must pay this amount at the time services are rendered (i.e. office visit).

___ INSURANCE AUTHORIZATION / PHYSICIAN REFERRAL

We are on most insurance plans, but be sure your visit with us has been authorized by your insurance company - if this is required. We will not see you if we don't have a required referral and/or authorization. Any questions you may have should be directed to your primary care provider. This is your responsibility. Have your authorization number when you make your appointment with us.

___ X-RAYS, MRI SCAN, CT SCAN, OTHER STUDIES

Please make certain you bring any x-rays, MRI scans, CT scans, etc., as well as any radiology reports. Bring all pertinent studies that have been done.

___ IF YOU REQUIRE DISABILITY FORMS -

We will fill out forms required by the government such as those from the State of Arizona or the Social Security Administration - free of charge. However, if you require disability forms completed for privately-held policies such as those that protect your car, wages, home, or credit cards - *we charge a minimum of \$35 and a maximum of \$50/form(s)*. Your insurance plan will not reimburse you for the preparation of these forms, nor will it reimburse Spine & Orthopedic Specialists; therefore, we require payment before completing the forms. Upon receipt of payment in full and your signature, which acknowledges your understanding of our policy, we will complete your forms.

Authorization for release of information

I authorize SPINE & ORTHOPEDIC SPECIALISTS to release any medical information necessary for purposes of administration, review, investigation, or evaluation of claim coverage and utilization of services.

Assignment of benefits

I authorize the assignment of benefits payable to SPINE & ORTHOPEDIC SPECIALISTS and/or its designee for physician services and supplies by government and/or other private third party payer. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles, and non-covered services.

Authorization for additional fees

In the event any lawsuit or action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all costs, not limited to attorney's fees, court costs, collection fees, interest, and any additional costs that this action may incur.

Authorization for treatment

I agree to any examination, treatment, and procedures that may be performed during office visits, including emergency treatment considered necessary by the physician and/or his/her providers.

Acknowledgement of Receipt of Privacy Notice

By signing below I agree I that have received a copy of the **Notice of Privacy Practices for Protected Health Information**.

X _____ | _____
SIGNATURE (Patient or Responsible Party) DATE