ATLANTA SPINE

Demographic Information			
Date of Birth:			
Patient Name:			
Previous Name (If any):			
Mailing Address:	City:	State:	Zip Code:
Home Phone:	Consent to Call: ☐ Yes	☐ No	
Cell Phone:	Consent to Text: ☐ Yes	☐ No	
Work Phone:			
Patient Email:			
Spouse's Name:	Spouse's Phone Number:		
Do you authorize your spouse to receive medical information on your behalf? ☐ Yes ☐ No			
Primary Care DOCTOR:			
Pharmacy Name:	Phone Number:		
Pharmacy Address:			
Pharmacy City:	State:	Zip Code:	
Race: ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Black ☐ White ☐ Hispanic ☐ Other			
Language Spoken:			
Sex: ☐ Male ☐ Female ☐ Transgender **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino			
****Emergency Contact Information/ Release of Information other than Spouse****			
Emergency Contact Name:			
Phone Number:			
Address:			
Relationship to Patient:	☐ Medical information may be released		
Secondary Contact Name:			
Phone Number:			
Relationship to Patient:	☐ Medical information may be released		
****Guarantor/ Responsible Party (if other than self) ****			
Guarantor Name:			
Guarantor Phone Number:			
Guarantor Date of Birth:			
****Additional Information****			
Do you have an Advanced Directive? ☐ Yes ☐ No Can you provide us with a copy? ☐ Yes ☐ No			
Power of Attorney for medical decisions ☐ Yes ☐ No IF YES Who:			

* Atlanta Spine includes Atlanta Spine Surgery Center, LLC and its affiliates and subsidiaries.

Primary Insurance	
Insurance:	
Insured's Name:	Insured's Date of Birth:
Subscriber ID Number:	
Subscriber Address:	
Group Number:	
Insured's Relationship to Patient:	
Secondary Insurance	
Insurance:	
Insured's Name:	Insured's Date of Birth:
Subscriber ID Number:	
Subscriber Address:	
Group Number:	
Insured's Relationship to Patient:	
Additional Billing Information	
Is this a Workers Compensation Case? ☐ Yes ☐ No Date of Injury:	
- Workers Compensation Company/Employer:	
Is this a Motor Vehicle Accident Case? ☐ Yes ☐ No Date of Injury:	
Please provide Attorney Information:	

I attest that the information provided is correct and I hereby authorize the release of information necessary for my insurance company to process my claim. The above information is correct to the best of my knowledge. I hereby allow the clinical staff of Atlanta Spine to view my medication history from external sources.

✖_____ **Date:** _____

Patient or legally authorized individual signature, **please sign for permission to treat**

*** Who were you referred by?** _____

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Past Medical History

- ☐AIDS/HIV
- ☐Acid Reflux
- ☐Anemia
- ☐Anxiety/Depression
- ☐Arthritis
- ☐Asthma
- ☐Bleeding Disorder
- ☐Bleeding Ulcer
- ☐Blood Clot
- ☐Blood Transfusion
- ☐COPD
- ☐Cancer
- ☐Coronary Artery Disease
- ☐Diabetes (TYPE:_____)
- ☐Fibromyalgia
- ☐Gout
- ☐Heart Attack (MI)
- ☐Heart Problems(Explain:_____)
- ☐Hepatitis
- ☐Hernia
- ☐High Cholesterol
- ☐High Blood
- ☐Pressure/Hypertension
- ☐Kidney Disease
- ☐Liver Disease
- ☐Migraines
- ☐Orthotics
- ☐Osteoporosis
- ☐Pacemaker
- ☐Peripheral Vascular Disease
- ☐Psychiatric Disorder
- ☐Pulmonary Embolism
- ☐Rheumatoid Arthritis
- ☐Seizures/Epilepsy
- ☐Sleep Apnea/ CPAP Machine
- ☐Stroke: CVA/ TIA
- ☐Tuberculosis
- ☐Ulcers
- ☐bladder problems
- ☐chest pain on exertion
- ☐dental abnormalities/ disorder
- ☐irregular heartbeat
- ☐Adverse reaction to anesthesia
- ☐Significant Memory Loss
- ☐Alzheimer's
- ☐Atrial fibrillation
- ☐Emphysema
- ☐Congestive heart failure
- ☐Hemophilia/ Bleeding Disorder
- ☐Home Oxygen___ liters/minute
- ☐Infections: _____
- ☐MRSA:
- ☐Osteoarthritis
- ☐Pneumonia
- ☐Sickle cell

*** Menopause: If post -Menopausal, age of menopause? _____**

SURGERY HISTORY

	Yes	Date		Yes	Date
Appendectomy			**Knee Surgery**		
Gall Bladder Removal			**Hip Surgery**		
Tonsil/adenoid removal			**Gastric Bypass**		
Hysterectomy			**Other:**		
Kidney Surgery					
Heart Surgery (Specify)					
Neck Surgery (Specify)					
Back Surgery (Specify)					

Circle the pain intensity with a "0" representing no pain and "10" the most severe pain imaginable.

What is your current pain level? 0 1 2 3 4 5 6 7 8 9 10

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ALLERGIES

☐NKDA

NAME	REACTION TO MEDICATION (rash, facial swelling, hives)

MEDICATION LIST

Please include prescription, over the counter, vitamins or herbal medications that you are currently taking.

** PLEASE REMEMBER TO LIST ANY BLOOD THINNERS YOU ARE CURRENTLY TAKING INCLUDING ASPIRIN, COUMADIN, WARFARIN, PLAVIX, EFFIENT, PLETAL, AGGRENOX, GOODY'S POWDER, LOVENOX, AND PRADAXA **

DRUG NAME	DOSE (ex: 5mg)	Times per Day	Why are you taking it

PREVIOUS DIAGNOSTIC STUDIES – Please indicate approximate date and locations, if known.

Type	Date	Location
MRI		
CT- Scan		
X-rays		
EMG/NCS		

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FAMILY HISTORY

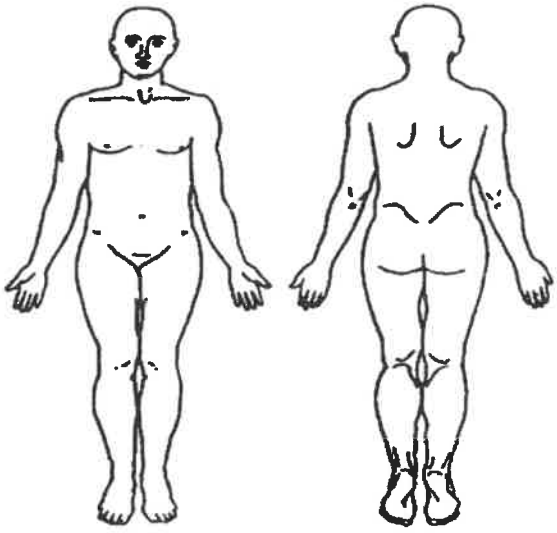
	ALIVE	DECEASED	DIABETES	HYPERTENTION	HEART ATTACK	STROKE	MENTAL ILLNESS	CANCER	OTHER
MOTHER									
FATHER									
SISTER									
BROTHER									

SOCIAL HISTORY

Tobacco Smoker: Yes ☐ No☐ If yes: 2 pack/day, 1 pack/day, ½ pack/day, _____ What age did you start using Tobacco? _____
Marital Status:☐M ☐S ☐D ☐W
Have you ever served in the Armed Forces? ☐ Yes ☐ No
Are you currently employed? If what is your Occupation:
Are you able to care for yourself? ☐Yes ☐No
Chewing tobacco: ☐Yes ☐No
Alcohol Use:☐Yes ☐No If yes how often:
Recreational Drug Use: ☐Yes ☐No If yes:
DEAF or Difficulty hearing:

PAIN LOCATION

Please mark/shade the locations of your pain on the diagrams below.



Briefly describe when and how your current pain started.

_____

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Review of Systems

Has your family or medical history changed since your last visit? _____YES _____ NO
Have your medications changed since your last appointment? _____ YES _____ NO

Please check any of the following systems in the past 30 days?

Constitutional
___ Fever
___ Night Sweats
___ Significant Weight Gain
___Significant Weight Loss
___ Exercise Intolerance
___ Malaise

Cardiovascular
___ Chest Pain
___Arm Pain on Exertion
___Shortness of breath when walking
___Shortness of breath when lying down
___Palpitations
___Known heart murmur
___Ankle Swelling

Genitourinary
___Incontinence
___Difficulty Urinating
___Hematuria
___Increased Urinating Frequency

Respiratory
___ Cough
___ Wheezing
___Shortness of Breath
___ Coughing up Blood
___Sleep Apnea

Gastrointestinal
___ Abdominal Pain
___ Nausea
___ Vomiting
___ Constipation
___ Abnormal Appetite
___ Diarrhea
___ Vomiting Blood
___ Dyspepsia
___ GERD

Musculoskeletal
___ Muscle Aches
___ Muscle Weakness
___ Arthralgias/Joint Pain
___ Back Pain
___ Swelling in Extremities
___ Neck Pain
___ Difficulty Walking
___ Cramps
___ Osteoporosis
___ Fractures

Integumentary
___ Abnormal Mole
___ Jaundice
___ Rashes
___ Laceration
___ Non-Healing Areas
___ Changes in Hair/Nails
___ Psoriasis
___ Change in Skin Color
___ Breast Lump

Neurologic
___ Loss of Consciousness
___ Weakness
___ Numbness
___ Seizures
___ Dizziness
___ Migraines
___ Headaches
___ Tremor
___ Gait Dysfunction
___ Paralysis

Psychiatric
___ Depression
___ Sleep Disturbance
___ Feeling Unsafe in a relationship
___ Alcohol Abuse
___ Anxiety
___ Hallucinations
___ Suicidal Thoughts
___ Mood Swings
___ Memory Loss
___ Agitation
___ Dementia
___ Delirium

Endocrine
___Fatigue

Hematologic/ Lymphatic
___ Swollen Glands
___ Bruising
___ Excessive Bleeding
___ Anemia

SIGNATURE: _____

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ATLANTA SPINE

Financial Policy for Patient Care Services an Assignment of Benefits

We are happy that you have selected Atlanta Spine* for your healthcare needs and we look forward in managing your care. At Atlanta Spine*, we are committed to meeting your healthcare needs. Our goal is to make your insurance or other financial arrangements as simple as possible.

Patients are responsible for co-payments, coinsurances and deductibles as dictated by their insurance plans at the time of service. We ask that you provide your current insurance information to allow us to file your visit to your insurance carrier. If you do not have active insurance, you will be considered a "Self Pay" patient. Our "Self Pay" financial policy is based on very reasonable rates.

In the event that you are not able to maintain your scheduled appointment/procedure, we ask you to provide us with 24 hour notice. We have numerous patients waiting for an appointment/procedure and this will allow us to fill a vacancy for those patients. If we have not received a 24 hour notice prior to your appointment/procedure, a **No Show Fee** will be charged to the patient and be the patient's responsibility. **No show Fees will not be billed to your attorney, WC or Insurance as this is due from the patient.**

We have a dedicated team at Atlanta Spine that will work with you on your financial responsibilities while ensuring your healthcare needs are being met. In the rare occasion that your insurance places financial responsibility on you, a member of our team will contact you prior to your appointment or procedure.

By signing this form, you are acknowledging you have read and understand that you are assigning and transferring to Atlanta Spine all of the benefits due to you under, Medicare, Medicaid or any insurance policy or health plan providing benefits for the services being rendered. You authorize Atlanta Spine to receive payment, file an appeal, and determine medical coverage from your health plan. You understand you are responsible for charges that are not covered by your health plan or that your health plan has assigned to you.

****

I have read and understand the above statements. I certify that this form applies to all visits and procedures at all Atlanta Spine, PC and Atlanta Spine Surgery Center, LLC locations.

_____ _____

Patient or Legally Authorized Individual Signature **Date**

*Atlanta Spine includes Atlanta Spine Surgery Center, LLC its affiliates and subsidiaries

Atlanta Spine Notice of Privacy Practices Acknowledgement Form

Patient Acknowledgement of Understanding of Atlanta Spine Notice of Privacy Practices

I understand that Atlanta Spine* may use and disclose my personal health information to help provide healthcare, to manage billing and payment, to take care of other healthcare operations and for other purposes described in the "Notices of Privacy Practices" document. This document contains more information about the policies and practices protecting the patient's privacy. This document is available online and in the practice. I have the right to request a copy and read the "Notice of Privacy Practices" before signing this acknowledgement if I choose.

Atlanta Spine* may update this acknowledgement and "Notice of Privacy Practices". At my request, Atlanta Spine* will provide me with the most current version.

Within this Notice of Privacy Practices, it contains a complete description of my privacy/confidentiality rights. These rights include but are not limited to access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law and requesting communication by specified methods of communications or alternative location.

Atlanta Spine* has established procedures that help meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements, authorizations, charges for copies, reasonable timeframes for requesting information, and etc. I will assist Atlanta Spine* by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

****

My signature below indicates that I have read and understand this acknowledgement.

_____ _____

Patient or Legally Authorized Individual Signature **Date**

I give my permission to the following person(s) for appointment reminders and other requested medical information:

_____

_____

_____

*Atlanta Spine includes Atlanta Spine Surgery Center, LLC, its affiliates and subsidiaries.

Main: (678)-369-6934 Fax: (770)-679-5556

Authorization to Release Health Information

Patient Information:

Name of Patient:_____ DOB:_____

Address:_____

Phone:_____

At my request, Atlanta Spine may release the following information:

- ☐ Entire Record
- ☐ Office visit notes
- ☐ X-Ray, Diagnostic Studies, Lab results
- ☐ Other (please specify)
- ☐ Financial Records
- ☐ Medical records from _____ to _____

Facility or person who will receive the information:

Name:_____

Address:_____

Phone:_____ Fax:_____

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is completed.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____ _____

Signature of Patient or Personal Representative Date

ATLANTA SPINE

Main:(678)-369-6934 Fax: (770)-679-5556

Authorization to Release Health Information

Patient Information:

Name of Patient:_____ DOB:_____

Address:_____

Phone:_____

At my request, _____ may release the following information:

Phone Number:_____Fax number:_____

- ☐ Entire Record
- ☐ Office Visit Notes
- ☐ X-ray, Diagnostic Studies, Lab results
- ☐ Other (please specify)
- ☐ Financial Records
- ☐ Medical records from _____ to _____

Facility or person who will receive the information:
Name: Atlanta Spine
Address: 1288 Wellbrook Circle Suite A Conyers, Ga 30012
Phone: 678-369-6934 Fax: 770-679-5556

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is completed.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____ _____

Signature of Patient or Personal Representative Date

ATLANTA SPINE

Narcotic Contract and Prescription Refill Policy

1. I agree to allow three business days for prescription refills.
2. I understand that prescription refills requested after 4:00pm will not be received until the next business day.
3. I understand that a follow up visit may be required from my provider in order to obtain a refill.
4. I agree to take all medication exactly as instructed. I am NOT allowed to change the dosage amounts or alter the time schedule of taking the medication without first speaking to my provider.
5. I understand that narcotics and non-narcotic medications will not be sent to the pharmacy after hours or on the weekends.
6. Patients may be terminated from the practice within a 30 days notice for noncompliance in taking their medication. In order to ensure compliance, Atlanta Spine reserves the right to perform random drug screen monitoring on patients who require prescription narcotic medications over an extended period, as required by law. Refusal to cooperate with a drug screen will constitute a basis for termination from the practice. I certify that I will voluntarily provide a fresh, unadulterated saliva or urine specimen for testing.
7. Atlanta Spine will NOT refill prescriptions that have been lost or misplaced.
8. I will keep all appointments as recommended.
9. I will not give, trade or sell medications.
10. The following are specific (but not exclusive) grounds for immediate termination from the practice:
    A. Obtaining narcotics from any other physician while under Atlanta Spine care.
    B. Altering or forging of a prescription. This is a felony and will be reported.
11. I am aware that most of the manufacturers of drugs used to treat chronic pain management are against the operations of heavy equipment, which includes driving a motor vehicle. I am aware if I choose to drive a vehicle I could be charged with a DUI.
12. I will not combine any narcotic medications with the consumption of alcohol.
13. I understand that only one pharmacy will be used for filling and refilling my medications. I agree to update my records at Atlanta spine if my pharmacy information changes.

I have read, understand and agree to the policies above.

My Pharmacy's name and location is:_____

Pharmacy's phone number:_____

Print Name:_____

Signature:_____ **Date:**_____