ATLANTA SPINE & ORTHOPAEDICS

New Patient Packet

Patient Name: ______________________ DOB: __________

Mailing Address: ______________________ City: __________ ST: ____ Zip: ______

Home Phone: ______________________ Consent to Call: ☐ Yes ☐ No

Cell Phone: ______________________ Consent to Call: ☐ Yes ☐ No

Work Phone: ______________________ Email: ______________________

Spouse's Name: ______________________

Do you authorize your spouse to receive medical information on your behalf? ☐ Yes ☐ No

****Care Team****

Primary Care Provider: ______________________ Phone Number: __________

Cardiologist: ______________________ Phone Number: __________

Pulmonologist: ______________________ Phone Number: __________

Other Specialist: ______________________ Phone Number: __________

Pharmacy Name: ______________________ Phone Number: __________

Pharmacy Address: ______________________

Pharmacy City: ______________________

Race: ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Black ☐ White ☐ Hispanic

☐ Other:________________

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Language Spoken: ______________________

Sex: ☐ Male ☐ Female ☐ Transgender

****Emergency Contact Information/Release of Information other than Spouse****

Emergency Contact Name: ______________________ Phone Number: __________

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: ______________________ 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? ______________________

How Did You Hear About Us? Who Referred You? ______________________________________

ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage with________________________ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS THAT ARE OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

____

Patient or Representative Signature Date

ATLANTA SPINE & ORTHOPAEDICS

Assignment of Benefits

I certify that I (or my dependent) have insurance coverage with ______________________ and I authorize, request, and assign my insurance company to pay directly to Atlanta Spine & Orthopaedics insurance benefits otherwise payable to me.

Insurance is designed to help you meet the cost of medical services. If you gave us all the requested information, including a copy of your insurance card, we will submit a claim to your insurance company as a courtesy to you. However, your insurance is a contract between you and your carrier or employer. Therefore, the ultimate responsibility for payment rests with you.

PATIENT RESPONSIBILITY: I understand and acknowledge that I am responsible for all charges for services provided to the patient listed below which are not covered by my insurance plan or for which I am responsible for payment under my insurance plan. To the extent no coverage exists under my insurance plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by insurance when services are rendered or when I am notified of charges not covered by insurance. I further agree that, if permissible by law, I will reimburse Atlanta Spine & Orthopaedics for costs, expenses, and attorney's fees that may be incurred by Atlanta Spine & Orthopaedics to collect those charges. This agreement will be in force until balance is paid in full for all services rendered.

PRIMARY INSURANCE		
Insurance Company:		
Policy Holder:	Policy Holders Date of Birth:	
Subscriber ID:		
Group Number:		
Policy Holders Relationship to Patient:		
SECONDARY INSURANCE		
Insurance Company:		
Policy Holder:	Policy Holders Date of Birth:	
Subscriber ID:		
Group Number:		
Policy Holders Relationship to Patient:		
ADDITIONAL BILLING INFORMATION		
Is this a Workers Compensation Case? ☐ Yes ☐ No		Date of Injury:
Carrier:	Employer:	
Is this a Motor Vehicle Accident Case? ☐ Yes ☐ No		Date of Injury:
Please provide Attorneys Name:	Phone Number:	

Patient's Name _________________________________ Date: ______________________

Patient Signature _______________________________

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate tests, diagnosis, analysis, and treatment. I hereby authorize the physicians and staff at Atlanta Spine & Orthopaedics to diagnose and treat my case or the case of my child as they deem appropriate.

The medications prescribed and clinical procedures performed are usually beneficial and seldom cause any serious problems. In rare cases, underlying physical defects, deformities, pathologies, or physiological conditions may render the patient susceptible to injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, deformities, or physiological conditions which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, and agree and acknowledge that they will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Patient Initials: _________

PATIENT MISSED APPOINTMENT POLICY

It is our wish that every one of our patients receive the very best care and service possible. For that reason, it is our office policy that patients must give us at least a 24-hour notice for any appointment changes or cancellations. If you are more than 15 minutes late beyond your scheduled arrival time, you will be considered to have missed your appointment and will need to be rescheduled. There is a $75 service charge for all no call/missed appointments.

Patient Initials: _________

HIPAA/PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a Privacy Rule to help ensure that personal health care information is protected for privacy. Their Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive always to take reasonable precautions to protect your privacy.

I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, to my insurance company, adjuster, attorney, or any other payer involved in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submission. A photocopy of this agreement shall be considered just as effective and valid as the original.

I acknowledge that I have reviewed the Notice of Privacy Practices of Atlanta Spine & Orthopaedics.
(Please initial one of the following options and sign below.)
_____ I wish to receive a paper copy of the Privacy Notice.
_____ I do not request a copy of the Privacy Notice currently. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Answering Machine Voicemail:
_____ Do not leave message other than to return our call   _____ You may leave messages with information

Authorization:
_____ I authorize the following identified individuals to request my treatment records on my behalf or speak with my provider on behalf at Atlanta Spine & Orthopaedics:

1. ____ ____________________________________
   Full Name *Relationship*
2. ____ ____________________________________
   Full Name *Relationship*

I acknowledge that I have received a copy of Privacy Practices, if requested. This notice describes how the practice will disclose my protected healthcare information. I also understand that I may revoke this authorization at any time or receive a copy of this authorization.

Patient Signature: ________________________________   Date: ___________________

FINANCIAL POLICY

We are committed to providing the best care possible. Please understand that payment of your bill is considered part of your treatment. The following statement explains our Financial Policy, which we ask you to *read, initial beside each policy,* and return to us prior to your treatment.

_____ It is imperative that complete personal information and a copy of your current insurance card is provided prior to being seen to ensure accurate billing. **PLEASE NOTE:** If incorrect insurance information is given by the patient or patients guarantor, any denial or unpaid claim will be financial responsibility of the patient.
_____ All applicable co-pays, deductibles, and prior balance are due in full at time of service.

Regarding Insurance:

_____ We participate with Medicare (NOT MEDICAID) and most insurance plans. However, you must realize that your insurance is a contract between you and the insurance company and/or your employer. While we may be a provider, we are not a party to the contract.
_____ Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary. In these instances, you will be responsible for these amounts. Some Policies have deductibles for surgical procedures. The insurance companies consider procedures such as epidurals, joint injections, or other small procedures as “surgery”. If you have a surgical deductible that has not been met and have one of these procedures, you will be responsible for payment at the time of service.

_____Please be aware that insurance companies require a co-payment to be collected for every visit with a provider, whether it be a doctor, physician's assistant, or nurse practitioner.
_____ Our office can **NEVER** guarantee coverage for any service provided because insurance companies will not guarantee benefits until they receive the claim for services. It is important that you educate yourself about your individual insurance benefits. If you are unsure of your coverage benefits, call the customer service number on your insurance card.
_____ If my current policy prohibits direct payment to the physician, then I agree to direct all payments received from my insurance company or any other payer by signing the checks received over to Atlanta Spine & Orthopaedics for services rendered. In the event I fail to direct all payments/make all payments to Atlanta Spine & Orthopaedics I can be legally responsible for all outstanding balances, deductibles, interest, legal fees, collection costs, mediation and court costs. Further, if I forget to have the insured/patient sign the check when leaving it at the clinic, I hereby give permission for the clinic to endorse my name to said check.

Past Due Accounts:

_____ Overdue accounts will be turned over to a collection agency. Please be aware that a $50.00 processing/filing fee as well as a fee of 40% of your balance will be added to your account.

Example: $200 owed +$50 processing +$80(40%) =$330 will be your new account balance

Returned Checks:

_____ For checks returned to us as unpaid by your bank, we will charge a $45 fee.

I have read, understand, and agree to the above policy. My signature below indicates that I understand and agree to the above policy. If I had any questions regarding the policy I have asked and have received sufficient explanation.

____

Printed Patient Name | Patient Signature | Date

ATLANTA SPINE & ORTHOPAEDICS

Patient Name: ________________________________

MEDICATIONS TRIALED

Circle **ALL** medications which you have **PREVIOUSLY** been prescribed and write the dosage.

Opioids:

Medication	Dosage	Medication	Dosage
Tramadol	Dosage: ________	Morphine ER	Dosage: ________
Hydrocodone (Norco)	Dosage: ________	Xtampza	Dosage: ________
Oxycodone/Acetaminophen	Dosage: ________	Dilaudid	Dosage: ________
Oxycodone (Percocet)	Dosage: ________	Oxycontin	Dosage: ________
Morphine IR	Dosage: ________	Other:	

Muscle Relaxants:

Medication	Dosage	Medication	Dosage
Flexeril (Cyclobenzaprine)	Dosage: ________	Metaxalone	Dosage: ________
Robaxin (Methocarbamol)	Dosage: ________	Baclofen	Dosage: ________
Tizanidine	Dosage: ________	Other:	
Soma	Dosage: ________		

NSAIDS/Other Pain Meds:

Medication	Dosage	Medication	Dosage
Ibuprofen (Motrin)	Dosage: ________	Indomethacin	Dosage: ________
Naproxen (Aleve)	Dosage: ________	Meloxicam	Dosage: ________
Celebrex	Dosage: ________	Tylenol	Dosage: ________
Diclofenac Sodium	Dosage: ________	Other:	

Adjuvants:

Medication	Dosage	Medication	Dosage
Gabapentin	Dosage: ________	Amitriptyline	Dosage: ________
Lyrica	Dosage: ________	Cymbalta	Dosage: ________
Nucynta	Dosage: ________	Topamax	Dosage: ________
Nortriptyline	Dosage: ________	Other:	

OIC Meds:

Medication	Dosage	Medication	Dosage
Relistor	Dosage: ________	Polyethylene Glycol	Dosage: ________
Senna/Bisacodyl	Dosage: ________	Other:	
Docusate	Dosage: ________		

Other Significant Meds:

____

____

____

THERAPIES TRIALED

Please **WRITE** location, frequency, and date range of **ANY** therapies.

Physical Therapy ____

Chiropractic Therapy ____

Massage Therapy ____

Dry Needling ____

Acupuncture ____

Tens Unit ____

Heat Pads ____

Ice Packs ____

ATLANTA SPINE & ORTHOPAEDICS

INTERVENTIONAL AND SURGICAL PROCEDURES COMPLETED

Please **CIRCLE** type of procedure and **NOTATE** the dates of any procedures.

Procedure	Date:	Body Part:
Corticosteroid Injections	Date: ______	Body Part: ______
Trigger Point Injections	Date: ______	Body Part: ______
Epidural Injections	Date: ______	Body Part: ______
PRP Injections	Date: ______	Body Part: ______
Prolotherapy	Date: ______	Body Part: ______
Nerve Blocks	Date: ______	Body Part: ______
Medial Branch Blocks	Date: ______	Body Part: ______
Radio Frequency Ablation	Date: ______	Body Part: ______
Viscosupplementation	Date: ______	Body Part: ______
Other: ______ ______	Date: ______	Body Part: ______

Surgical History

	YES	DATE		YES	DATE
Appendectomy	____	______	Neck Surgery (Specify)	____	______
Gall Bladder Removal	____	______	Back Surgery (Specify)	____	______
Tonsil/Adenoid Removal	____	______	Knee Surgery	____	______
Hysterectomy	____	______	Hip Surgery	____	______
Kidney Surgery	____	______	Gastric Bypass	____	______
Heart Surgery (Specify)	____	______	Other:	____	______

PREVIOUS DIAGNOSTIC STUDIES

Please indicate approximate date, location, and type. (If known)

	Date	Location	Type (Body Part, Contrast)
MRI	______	______	______
CT-Scan	______	______	______
X-Rays	______	______	______
EMG/NCS	______	______	______

ATLANTA SPINE & ORTHOPAEDICS

Patient Name: ______________________________

MEDICATION LIST

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

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

ALLERGIES

☐ **NKDA**

ALLERGIC TO:	*REACTION TO MEDICATION (ex: rash, facial swelling, hives, etc.)*

FAMILY HISTORY

Please mark all that apply.

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

SOCIAL HISTORY

Tobacco Smoker: ☐ Yes ☐ No IF yes: 2pack/day, 1 pack/day, ½ pack /day ________________________

What age did you start using Tobacco? _____________________ Chewing Tobacco: ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Have you ever served in the Armed Forces? Yes No

Are you currently employed? ☐ Yes ☐ No If yes, what is your Occupation: _______________________

Are you able to care for yourself? ☐ Yes ☐ No

Alcohol use: ☐ Yes ☐ No If yes, how often: ____________________________

Recreational Drug use: ☐ Yes ☐ No If yes explain: ____

Deaf or Difficulty hearing: ☐ Yes ☐ No Blind or Difficulty seeing: ☐ Yes ☐ No

ATLANTA SPINE & ORTHOPAEDICS

New Patient Packet

PAST MEDICAL HISTORY: Please indicate if you have any of the following medical conditions.

______ Acid Reflux (Gerd)
______ Adverse Reaction to Anes.
______ AIDS/HIV
______ Alzheimer's
______ Anemia
______ Anxiety/Depression
______ Arthritis
______ Asthma
______ Atrial Fibrillation
______ Back Injury
______ Bladder Problems
______ Bleeding Disorder
______ Bleeding Ulcer
______ Blood Transfusion
______ Cancer
______ Chest Pain on Exertion
______ Chronic Ear Infections
______ Congestive Heart Failure
______ COPD
______ Coronary Artery Disease

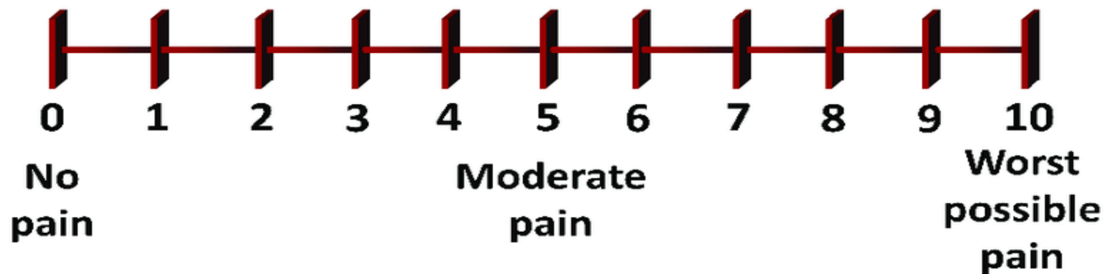
______ Dental Abnormalities/Disorder
______ Diabetes
______ Fibromyalgia
______ Gout
______ Head Trauma/Injury
______ Headaches/Migraines
______ Heart Attack (MI)
______ Heart Problems (Explain: __________)
______ Hepatitis
______ Hernia
______ High Blood Pressure
______ High Cholesterol
______ Home Oxygen ___liters/min
______ Hypertension
______ Infections: __________________
______ Irregular Heartbeat
______ Kidney Disease
______ Liver Disease
______ Lupus/Autoimmune Disease
______ Menier's Disease

______ MRSA
______ Multiple Sclerosis
______ Nasal Polyps
______ Orthotics
______ Osteoporosis
______ Pacemaker
______ Peripheral Vascular Disease
______ Pneumonia
______ Psychiatric Disorder
______ Pulmonary Embolism
______ Rheumatoid Arthritis
______ Seizures/Epilepsy
______ Sickle Cell
______ Significant Memory Loss
______ Sleep Apnea/CPAP
______ Stroke:CVA/TIA
______ Thyroid Disease
______ Tuberculosis
______ Ulcers
______ Other: ___________________

**Menopause: If Post-Menopausal, age of menopause? ___________________*

CURRENT PAIN LEVEL

Circle your current pain intensity. "0" represents No pain and "10" represents the most severe pain imaginable.



ATLANTA SPINE & ORTHOPAEDICS

New Patient Packet

Patient Name: ______________________________________

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
______ Malaise
______ Chills
______ Exercise Intolerance

Cardiovascular
______ Chest Pain
______ Arm Pain on Exertion
______ Shortness of Breath walking
______ Shortness of Breath lying down
______ Palpitations
______ Known Heart Murmur
______ Leg/Ankle Swelling
______ Lightheaded on Standing

Genitourinary
______ Incontinence
______ Difficulty Urinating
______ Hematuria
______ Increased Urinating Frequency
______ Painful Urination

Respiratory
______ Cough
______ Wheezing
______ Shortness of Breath
______ Coughing up Blood
______ Sleep Apnea
______ COPD
______ Asthma
______ Chronic Bronchitis

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

Eyes
______ Blurred Vision
______ Loss of Vision
______ Double Vision
______ Eye Pain
______ Dry Eyes
______ Irritation

Gastrointestinal
______ Abdominal Pain
______ Nausea
______ Vomiting
______ Constipation
______ Abnormal Appetite
______ Diarrhea
______ Vomiting Blood
______ Dyspepsia
______ Gerd
______ Blood in Stool

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

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

HEENT
______ Hoarseness
______ Trouble Swallowing
______ Hearing Loss
______ Ear Pain
______ Nose Bleeds
______ Sore Throat

Neurologic
______ Loss of Consciousness
______ Weakness
______ Numbness
______ Seizures
______ Dizziness
______ Migraines
______ Headaches
______ Tremor
______ Gait Dysfunction
______ Paralysis
______ Loss of Coordination
______ Bowel Incontinence

Psychiatric
______ Depression
______ Sleep Disturbance
______ Feeling Unsafe in a Relationship
______ Alcohol/Drug Abuse
______ Anxiety
______ Hallucinations
______ Suicidal Thoughts
______ Mood Swings
______ Memory Loss
______ Agitation
______ Dementia
______ Delirium
______ Illegal Drug Use
______ Pres. Med. Use for Non-Medical reason
______ Craving Medications
______ Homicidal Thoughts
______ Difficulty Controlling Medication Use

Endocrine
______ Fatigue
______ Heat Intolerance
______ Cold Intolerance
______ Increased Thirst
______ Hair Growth

Immunologic
______ Runny Nose
______ Sinus Pressure
______ Itching
______ Hives
______ Frequent Sneezing

New Patient Packet

Patient Information

First Name: ____________________ Last Name: _______________________ DOB: ____________

Home Address: ____

City: ____________________ State: ____ Zipcode: ________ Phone Number: _________________

I am requesting my health information to be released **from** the following:

Organization Name: ____

Address/Location: ____

Phone Number: ____________________________ Fax Number: __________________________

I am requesting that my health information to be **sent** to the following:

Organization Name: ____

Address/Location: ____

Phone Number: 678-369-6934 Fax Number: 770-679-5556

Information to be released:

___ All Health Information

___ Progress Notes/Office Notes

___ Diagnostic Studies, Lab Results, Radiology

___ Surgical Reports

___ Medications

___ Discharge Letter

___ Emergency Department Records

___ Care Plan

___ Other ________________________________

___ Medical Records from______to_______

I understand that by signing this form, I am consenting that my health information will be released to the above place, and that this authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is completed.

____ ____________________________

Signature of Patient or Personal Representative Date

Patient Rights: I have the right to revoke this authorization at any time. I may inspect/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/disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal/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.