SPINE & BRAIN NEUROSURGERY CENTER

Expertise when you need it most.

Acct#:_____

Date: _____ Time:_____ ☐ – Nizam Razack, MD, JD, FACS ☐ – Michael LaFleur, PA-C

Last Name: _____ First: _____ MI: _____ SS#: _____

Home Address: _____City _____State/Zip_____

Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Age: _____ Marital Status: _____ Spouse's Name: _____

Employer: _____ Occupation: _____

Referring Physician: _____ Phone: _____

Family Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Relationship: _____ Alternate Phone: _____

HEALTH INSURANCE INFORMATION:

Primary Insurance: _____ Phone: _____

Policy Number: _____ Group Number: _____

Claims Address/City/Zip: _____

Policy Holders Name: _____ Relationship: _____

SS#: _____ D/O/B: _____

Secondary Insurance: _____ Phone: _____

Policy Number: _____ Group Number: _____

Claims Address/City/Zip: _____

Policy Holders Name: _____ Relationship: _____

SS#: _____ D/O/B: _____

I authorize the release of any medical information necessary to process the claims(s) rendered to me. I also authorized payment of medical benefits directly to Spine and Brain Neurosurgery Center for services rendered to me. I understand that I will be responsible for all copays, deductibles and non covered services as determined by my Insurance Carrier. I accept full responsibility for any outstanding balance with Spine and Brain Neurosurgery Center.

Signature: X_____ Date: _____

Page Two:

Last Name: _____ First: _____ MI: _____ SS#: _____

→ [ ] Worker's Compensation:

Date of Injury: _____ Case Manager: _____ Phone: _____

Claim Number: _____

Insurance Company: _____

Claim Address: _____

City: _____State: _____Zip:_____

→ [ ] Auto Accident:

Date of Injury: _____ Adjuster: _____ Phone: _____

Claim Number: _____ Policy Number: _____

Location of Accident: _____

Insurance Company: _____

Claim Address: _____

City: _____State: _____Zip: _____

→ [ ] Attorney Information:

Attorney's Name: _____

Firm Name: _____

Address: _____State: _____Zip: _____

Phone: _____ Fax:_____

Letter of Protection: [ ] Yes [ ] No

ALL FIELDS MUST BE COMPLETED

Patient History Form

NAME: _____ DATE: _____ DOB:_____ AGE: _____

RIGHT____ OR LEFT____ HANDED BIRTH PLACE/NATIONALITY/RACE: _____

EDUCATIONAL BACKGROUND: _____OCCUPATION: _____

LIST ALL SYMPTOMS OR COMPLAINTS RELATED TO TODAY'S VISIT:

_____

_____

ARE THE SYMPTOMS CAUSED BY AN AUTOMOBILE ACCIDENT: YES/NO WORK COMP INJURY: YES/NO

IF YES: DATE OF INJURY: _____ HAVE YOU RETAINED AN ATTORNEY: YES/NO IF YES: ATTORNEY NAME _____ PHONE NUMBER: _____

DO YOU SMOKE: _____ HOW MUCH PER DAY: _____ NO. OF YEARS: _____ DRUGS: _____

DO YOU DRINK ALCOHOL: _____ HOW MUCH: _____ HOW OFTEN: _____

WEIGHT TODAY _____ HEIGHT: _____ ANY RECENT WEIGHT LOSS: YES/NO HOW MUCH: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING OVER-THE-COUNTER MEDICATIONS:

_____

_____

_____

_____

ARE YOU ALLERGIC TO: (IF YES, PLEASE LIST NAMES)

MEDICATIONS _____

FOODS _____ CONTRAST DYE _____ OTHER_____

HAVE YOU EXPERIENCED NECK OR BACK PROBLEMS IN THE PAST: YES/NO (IF YES, PLEASE EXPLAIN, GIVE DATES)_____ _____

_____

_____

HAVE YOU HAD ANY PROCEDURES OR SURGERY IN THE PAST: YES/NO IF YES PLEASE GIVE YEAR, TYPE OF SURGERY, SURGEON'S NAME, AND HOSPITAL NAME:

_____

_____

_____

_____

HAVE YOU OR BLOOD RELATIVE HAD EXCESSIVE BLEEDING DURING SURGERY: YES/NO IF YES, PLEASE EXPLAIN AND STATE RELATIONSHIP: _____

_____

HAVE YOU BEEN HOSPITALIZED FOR ANY PROBLEMS NOT MENTIONED ABOVE: YES/NO

IF YES, PLEASE STATE REASON, YEAR AND HOSPITAL: _____

_____

ALL FIELDS MUST BE COMPLETED

NAME: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING: IF YES, PLEASE CHECK.

- ☐ MEASLES
- ☐ MUMP
- ☐ CHICKEN POX
- ☐ DIPHTHERIA
- ☐ TUBERCULOSIS
- ☐ INFECTIOUS MONO
- ☐ ENCEPHALITIS
- ☐ POLIO
- ☐ MENINGITIS
- ☐ RHEUMATIC FEVER
- ☐ GONORRHEA
- ☐ SYPHILIS
- ☐ ASTHMA
- ☐ EMPHYSEMA
- ☐ PNEUMONIA
- ☐ DIABAETES
- ☐ JAUNDICE
- ☐ HEPATITIS
- ☐ LIVER DISEASE
- ☐ CANCER
- ☐ NEURITIS
- ☐ ARTHRITIS

- ☐ DIFFICULTY WITH URINATION
- ☐ DRIBBLE /BLOOD IN URINE
- ☐ FREQUENCY & BURN URINATING
- ☐ KIDNEY AILMENTS OR STONES
- ☐ HIGH CHOLESTEROL
- ☐ ACCIDENT (DATE) _____
- ☐ CONCUSSION
- ☐ LOSS OF CONSCIOUSNESS
- ☐ EPILEPSY
- ☐ THYROID CONDITION
- ☐ NERVOUS BREAKDOWN
- ☐ PSYCHIATRIC TREATMENT
- ☐ DRUG POISONING/OVERDOSE
- ☐ EXPOSURE TO TOXINS
- ☐ EYE DISEASE
- ☐ IMPAIRED SIGHT
- ☐ DOUBLE VISION
- ☐ HEARING PROBLEMS
- ☐ RINGING IN EARS
- ☐ FAINTING SPELLS
- ☐ CONVULSIONS
- ☐ HEADACHES

- ☐ LOW BLOOD PRESSURE
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ ANEMIA/OR BLOOD DISEASE
- ☐ HIV/AIDS
- ☐ SHORTNESS OF BREATH
- ☐ CHRONIC COUGH
- ☐ WHEEZING
- ☐ SPITTING UP OF BLOOD
- ☐ NIGHT SWEATS
- ☐ DIZZINESS
- ☐ PARALYSIS/WEAKNESS
- ☐ NUMBNESS
- ☐ TINGLING
- ☐ CHEST PAIN
- ☐ PALPATIONS
- ☐ SWELLING OF FEET
- ☐ NAUSEA OR VOMITING
- ☐ ULCER
- ☐ STOMACH PAIN
- ☐ BLOOD IN STOOL

***WOMEN ONLY: ARE YOU PREGNANT: ☐ YES/ NO ☐ MENSTRUAL PERIODS ARE: REG ☐ IRREG ☐ NONE ☐

SOCIAL HISTORY: MARITAL STATUS:_____ NUMBER OF CHILDREN: _____

ARE YOU CURRENTLY WORKING: ☐ YES/NO ☐ IF NO, IS THIS DUE TO YOUR PAIN: ☐ YES/NO ☐

FAMILY HISTORY: LIST AGE, HEALTH CONDITION FOR EACH MEMBER OR AGE AT AND CAUSE OF DEATH

PARENTS _____

_____

BROTHERS/SISTERS _____

_____

HAS ANY BLOOD RELATIVE EVER HAD: (IF YES, CHECK AND GIVE RELATIONSHIP)

- ☐ DIABETES _____
- ☐ HEART DISEASE _____
- ☐ STROKE _____
- ☐ KIDNEY PROBLEMS _____
- ☐ ANEMIA _____
- ☐ HEADACHES _____

- ☐ TUBERCULOSIS _____
- ☐ MENTAL ILLNESS _____
- ☐ EPILEPSY _____
- ☐ HIGH BLOOD PRESSURE _____
- ☐ ARTHRITIS _____
- ☐ CANCER _____

PLEASE NOTIFY THE OFFICE OF ANY CHANGES IN MEDICATIONS OR MEDICAL HISTORY.

PATIENT SIGNATURE: _____ DATE: _____

REVIEWED BY: _____ DATE: _____

ALL FIELDS MUST BE COMPLETED

FORM COMPLETION POLICY

Effective April 2nd, 2007 Spine & Brain Neurosurgery Center will begin charging for form completions. The first requested form from each patient will be completed at no charge. Each additional form will be completed at a charge of $20.00 per form. This charge will be payable by the patient requesting completion and will not be billed to insurance companies, attorneys, etc. Requests will be completed in seven to ten business days and payment is due prior to or upon completion of the form.

MEDICATION REFILL POLICY

PLEASE SEE OUR NEW POLICY/ATTACHED: Do **not** wait until you are out of medication before your request is called in. Your doctor may not be in the office or available to approve your refill on an emergency basis.

MEDICAL RECORDS RELEASE POLICY

You will need to sign a release form to allow our office to release any records to the doctor(s) of your choice. If your attorney(s) are requesting records they must submit a written records request and release to our office with your signature. Please allow one to two weeks for request to be processed. If you, as the patient, are requesting a copy of your records, the cost is $1.00 per page. Please allow up to one week for your request to be processed.

NO SHOW/CANCELLATION POLICY

If it is necessary to cancel/reschedule your appointment, please do so prior to 24 hours of your appointment to avoid a $25 charge and to allow someone else to use that appointment time. The fee of $25.00 is to be paid by the patient and is not billable to any insurance, attorney, etc.

NO SHOW/CANCELLATION POLICY FOR MRI SCANS AND INJECTIONS

If it becomes necessary to cancel or reschedule your appointment for an MRI scan or epidural steroid injection, you must do so prior to 24 hours of the scheduled appointment time to avoid a **$100.00** charge and to allow someone else to use that appointment time. MRI scans and injection appointments are scheduled over several "normal" appointment slots due to the nature of the procedure and the time involved for such procedures. It is therefore very important that notification is given if you are unable to make your scheduled appointment. This fee of $100.00 is to be paid by the patient and is not billable to any insurance companies.

BILLING OF CO-PAYS/BALANCES

Co-pays are due at the time of your visit and must be collected per our contracts with your insurance company. We reserve the right to reschedule your appointment if you are unable to pay at the time of visit. If we do agree to see you at the time of the visit without payment of your required co-pay and/or payment on your balance you will be charged a $5.00 statement fee for **each** statement that is mailed to you for collection of these fees.

COLLECTION FEE

A fee totaling 30% of the balance due will be added to your account if we have to send your account to an outside collection agency.

_____ _____ _____

Signature Print Date

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LEGAL ASSIGNMENT OF BENEFITS & RELEASE OF MEDICAL/PLAN DOCUMENTS:

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the previously listed insurance company, and hereby assign and convey directly to Spine & Brain Neurosurgery Center all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and/or clinic. I understand that I am financially responsible for **all** charges regardless of any applicable insurance or benefit payments. I authorize the doctor to release any/all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and/or my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I herby convey to the above named provider to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and laboratory in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor's expense.

This lifetime assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Patient Date

I understand that I am entering into a contractual relationship with Spine & Brain Neurosurgery Center for professional care. I understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Spine & Brain Neurosurgery Center, I (the patient) and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice.

Furthermore, should a meritorious medical malpractice claim or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use an ABMS board certified expert witness in the same or similar specialty. I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined by the specialty societies for expert witnesses in the area of medicine that would typically have the background and experience to opine on such a case. In further consideration for this, I (the physician), agree to the same stipulations.

_____ _____

Physician Signature Patient Signature

ALL FIELDS MUST BE COMPLETED

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AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

I hereby authorize the release or use of my individually identifiable health information ("protected health information") and medical record information by The Spine and Brain Neurosurgery Center (from here forth referred to as "the Practice") in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do make changes to the terms of the Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restrictions(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

I agree that the Practice may also disclose the following types of information contained in my medical record (**please initial the appropriate categories listed below**):

____ HIV/AIDS Information
____ Substance Abuse Information
____ If Patient is under the age of eighteen (18), Pregnancy Information
____ Mental Health Information
____ Sexually Transmitted Disease Information

I agree and consent to the Practice releasing information to me in the following alternative manners (**please initial the appropriate categories listed below**):

____ Via email to the Patient's designated e-mail address which is: (I am responsible for notifying the practice of any changes to my e-mail address.) _____

____ Via regular mail with any envelopes being marked personal/confidential and addressed to me.

____ Via telephone, if I contact the Practice and provide the appropriate information (including name, social security number and unique personal identifier).

____ Via fax to my designated fax number which is _____. At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice **in writing**. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior Consent.

The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form. If you (or authorized representative sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent and I am the patient or the authorized party to act on the behalf of the patient, to sign this document verifying consent to the above terms.

Date: _____ Time: _____ ☐ ☐ am/pm

_____ _____
Signature of Patient or Authorized Representative | Please Print Name

_____ _____
Authorized representatives' relationship to Patient | Description of Authority to act on patient's behalf.

ALL FIELDS MUST BE COMPLETED

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Spine & Brain Neurosurgery Center would like to secure your acknowledgement of receipt of this Notice of Privacy Practices ("Notice"). Your acknowledgement or lack of acknowledgement of this Notice will not affect your medical benefits. You will continue to receive the same service as usual.

Please note that this acknowledgement applies only to you. Other members of your family who are on your medical benefits plan should make a separate acknowledgement that they have read the Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____

Witness: _____ Date: _____

Print Name: _____

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CONTROLLED SUBSTANCE CONTRACT

Controlled substance medications (i.e. narcotics) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following: **(Please review and initial EACH of the 9 policies below and sign the bottom of the page)**

___ 1. I am responsible for the controlled substance medications prescribed to me. If my prescription is misplaced, stolen, or if I "run out early", I understand this medication **will not be replaced**.

___ 2. If you have a reaction to your medication do not flush it or throw it away as you may be required to bring the remainder of the medication into the office for a pill count prior to any other medications being prescribed.

___ 3. Due to recent changes in DEA regulations, Class II medications will no longer be able to be called in, faxed in or refilled. EACH prescription must be written. Therefore you must allow for **4 working days** for prescriptions to be written as our physicians are not in the office every day.

___ 4. I understand that all prescription requests are to be made Monday – Friday between the hours of 8:00am to 5:00pm and that medication requests will NOT be addressed or refilled after hours.

___ 5. I understand that my medications may slow my reflexes and reaction times. Because of this, I will not be involved in any activity that may be dangerous to myself or someone else while I am taking controlled medications. This includes driving a car, working at heights or using dangerous equipment. I also understand that I should not care for another individual who is unable to care for themselves while I am under the influence of this medication.

___ 6. I understand that the main treatment goal is to reduce pain and improve my ability to function. In consideration of this goal, I agree to help myself by following good health habits and will avoid use of these medications with tobacco and alcohol.

___ 7. I promise not to alter my medication in any way. I will take my medication whole unless otherwise instructed and will not break, chew, crush, inject or snort my medication.

___ 8. I understand that as specialists, the physicians at Spine & Brain Center can **NOT** prescribe controlled substances "long term" and that it may become necessary for a referral to a Pain Management physician for future medication management.

___ 9. I understand that if I violate **ANY** of the above conditions, my prescriptions for controlled medications will be terminated immediately. If the violation involves obtaining these medications from another physician or individual I may also be reported to the other physician, pharmacies and appropriate authorities. I may also be dismissed from the practice.

I have read, acknowledged and will adhere to each of the above policies.

_____	_____	_____
Printed Name	Signature	Date

ALL FIELDS MUST BE COMPLETED