PATIENT REGISTRATION FORM

PATIENT INFORMATION

Today's Date: | PCP:

Patient's Last Name: | First: | Middle: | Birth Date: | Age: | Sex: ◯ M ◯ F | Race:

Marital Status: ◯ Single ◯ Married ◯ Partnered ◯ Divorced ◯ Separated ◯ Widowed | ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Miss | Email Address:

Address: | City: | State: | Zip Code:

Cell Phone: | ☐ Home ☐ Work ☐ Other _____ | Social Security #: / /

Occupation: | ☐ Full-time ☐ Part-time | Employer: | Employer Phone #:

Chose clinic because/ Referred to clinic by: ◯ Dr. _____ (Specialty)_____ ◯ Hospital
◯ Family ◯ Friend ◯ Close to home/work ◯ Internet search/Yellow pages ◯ Insurance ◯ Other _____

Other family members seen here: ◯ Yes By Dr. _____ ◯ No | Provider preference? ☐ First Available ☐ Yes _____ ☐ No | Preferred Language: ☐ English ☐ Spanish ☐ Other _____

INSURANCE INFORMATION

Is this patient covered by Insurance? ◯ Yes ◯ No | Date effective:

Primary Insurance Company: | Group #: | Policy #:

Insurance Company Address (on back of card) | Customer Service Phone #:

Who is the Primary Policy Holder? | Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Other _____

Policy Holder's Date of Birth: ◯ Self ◯ _____ | Policy Holder's Social Security #: ◯ Self ◯ _____/_____/_____ | Insurance obtained through employer? ◯ Yes – Employer _____ ◯ No

Name of Secondary Insurance (if applicable): | Group #: | Policy #:

Insurance Company Address (on back of card) | Customer Service Phone #:

Who is the Primary Policy Holder? | Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Other_____

Policy Holder's Date of Birth: ◯ Self ◯ _____ | Policy Holder's Social Security #: ◯ Self ◯ _____/_____/_____ | Insurance obtained through employer? ☐ Yes – Employer _____ ☐ No

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | ( ) _____-_____ ☐ Home ☐ Cell
( ) _____-_____ ☐ Other _____

- I hereby certify that I have reviewed the above information and made any necessary corrections. I understand that the above coverage information is what was quoted directly from my insurance carrier and is not a guarantee of benefits. I understand that by signing below I am stating that this information is correct and I will be held responsible for any services denied for lack of coverage or inability to identify the patient and/or subscriber in the insurance carrier's system.
- I hereby authorize my insurance benefits be paid directly to The Physicians Spine & Rehabilitation Specialists realizing I am responsible to pay non-covered services. I hereby authorize the release of pertinent medical information to insurance carriers.

_____ PRINTED PATIENT NAME | _____ PATIENT SIGNATURE | _____ DATE

NEW PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____ Date: _____

Location of Pain: _____ **Onset of pain:** _____

Description (aching, sharp, burning, etc.): _____

Was the pain caused by an injury? ◯ **YES** ◯ **NO** **If YES, describe injury:** _____

Were you injured at work? ◯ **YES** ◯ **NO Date of Injury:** **Unable to work due to pain?** ◯ **YES** ◯ **NO**

What is the status of your claim? ◯ **N/A** ◯ **Retained Attorney** ◯ **Claim Settled** ◯ **Currently in Litigation**

Have you had any of the following treatments for your pain?

Physical/ Occupational Therapy: _____ **When?** _____

Injections or Nerve Blocks: When? _____ **Performed Where?** _____

Surgery: When? _____ **Name of Surgeon:** _____

Past Imaging (X-Ray, MRI, CT-Scan): _____ **Place of test:** _____

Past Medical History: (Personal and Family):

Disease/Condition	Patient History		Family History		Which family Member?
	YES	NO	YES	NO	
Any contagious disease	◯	◯	◯	◯	
High blood pressure	◯	◯	◯	◯	
Diabetes	◯	◯	◯	◯	
Heart Disease	◯	◯	◯	◯	
Kidney Disease	◯	◯	◯	◯	
Liver Disease	◯	◯	◯	◯	
Thyroid problems	◯	◯	◯	◯	
Bleeding disorders	◯	◯	◯	◯	

Other (please specify):

_____

_____

Questionnaire: **Mark each box that applies**

FAMILY HISTORY OF SUBSTANCE ABUSE	
) **Alcohol**	☐
) **Illegal Drugs**	☐
) **Prescription Drugs**	☐
PERSONAL HISTORY OF SUBSTANCE ABUSE	
) **Alcohol**	☐
) **Illegal Drugs**	☐
) **Prescription Drugs**	☐
AGE BETWEEN 16-45 years	☐
HISTORY OF PREADOLESCENT SEXUAL ABUSE	☐

Allergies:

Please Check if you have an allergy to: ☐ Eggs-Reaction: _____ ☐ Iodine-Reaction: _____
☐ Shellfish-Reaction: _____ ☐ Latex-Reaction: _____

Medication Allergy	Reaction	Medication Allergy	Reaction
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Current Medications: **Please list ALL current medications (or provide us a copy of current list)**

****Are you taking any BLOOD THINNERS?** ◯ **YES** ◯ **NO** **If yes, please list below:**

MEDICATION NAME	DOSE	HOW OFTEN TAKEN

Surgical History: **Please list ALL previous surgeries and dates**

SURGERY	DATE	SURGERY	DATE
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Pharmacy Information: **Name:** _____ **Phone #:** _____

Address: _____

Review of Systems: Please check all that apply

Patient Name: _____ **Date:** _____

GENERAL	EYES	MUSCULOTSKELETAL	PSYCHIATRIC
☐ Fatigue	☐ Light Intolerance	☐ Muscle Pain	☐ Depression
SKIN	**HENT**	**NEUROLOGICAL**	**ENDOCRINE**
☐ Skin Color changes	☐ Congestion	☐ Numbness	☐ Incontinence
RESPIRATORY	**CARDIOVASCULAR**	**HEMATOLOGY**	**GASTROINTESTINAL**
☐ Shortness of Breath	☐ Chest Pain	☐ Abnormal Bleeding	☐ Constipation

OTHER: _____

Social History:

Marital Status ◯ Married ◯ Partnered ◯ Single ◯ Divorced ◯ Widowed

Do you have children? ◯ Yes ◯ No If yes, how many children do you have? _____ Age of children _____

Current Occupation: _____ ◯ Full-time ◯ Part-time

If unemployed, previous occupation: _____ ◯ Full-time ◯ Part-time

*** Please answer the following questions:**

1. Do you have an Advanced Directive? ◯ NO ◯ YES **If yes, what type?** ☐ DNR ☐ POA ☐ Living Will

2. Have you received the Influenza Vaccine in the past? ◯ NO ◯ YES **If yes, when did you last receive it?**

3. Have you received the Pneumonia Vaccine in the past? ◯ NO ◯ YES **If yes, when did you last receive it?**

4. Do you smoke Tobacco? ◯ NO ◯ YES **If no, did you smoke in the past?** ◯ NO ◯ YES Year Quit: _____

5. Do you drink Alcohol? ◯ NO ◯ YES **If yes, please answer the following questions:**

*** How often did you have a drink containing alcohol in the past year?**

☐ Never ☐ < Monthly ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

*** How many drinks did you have on a typical day when you were drinking in the past year?**

☐ 1 or 2 drinks ☐ 3 or 4 drinks ☐ 5 or 6 drinks ☐ 7 or 8 drinks ☐ 10 or more drinks

*** How often did you have 6 or more drinks on one occasion in the past year?**

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

6. Have you fallen in the past year? ◯ NO ◯ YES If yes, how many times? ____ **Were you injured?** ☐ NO ☐ YES

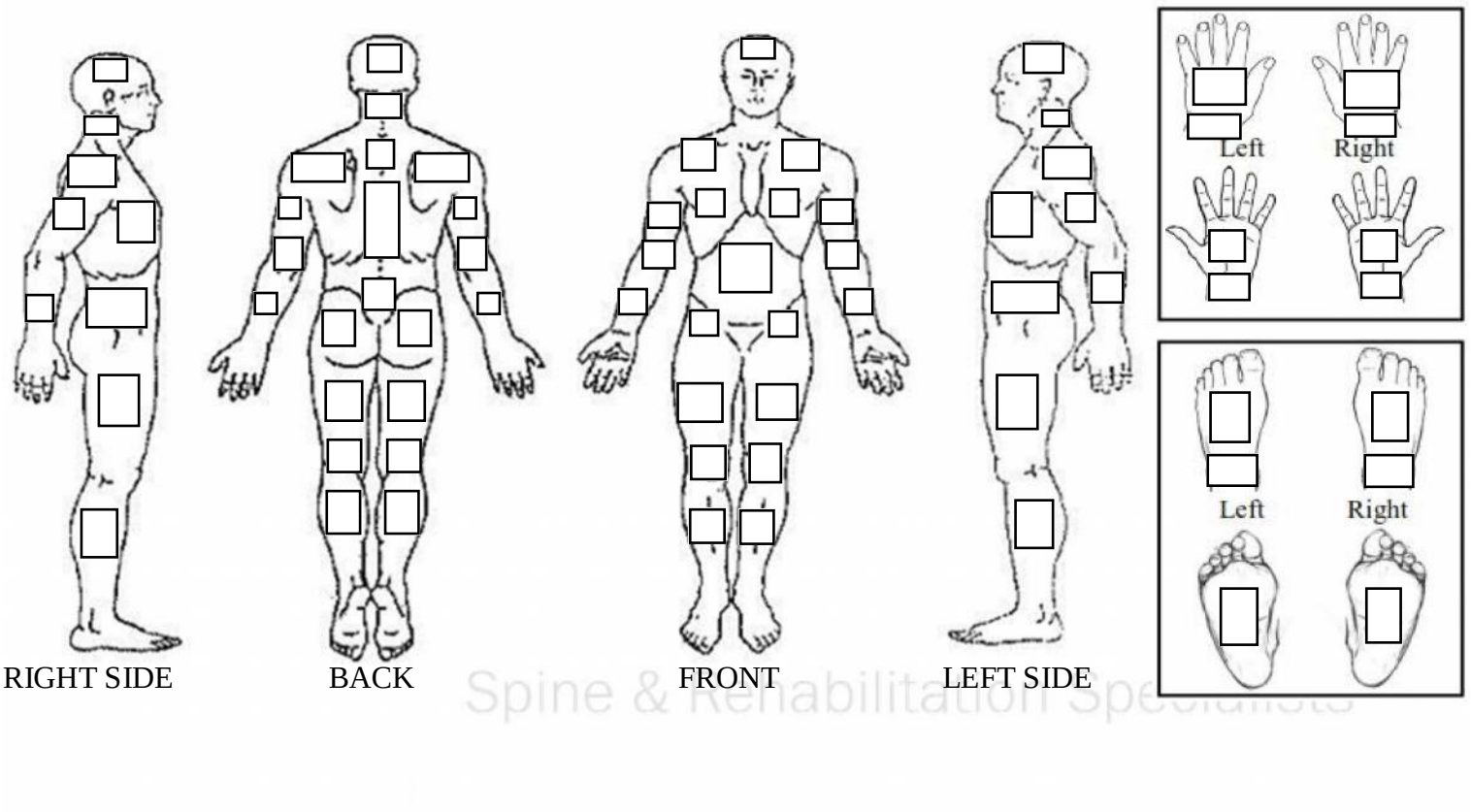
I hereby certify that I have reviewed the above information and made any necessary corrections. I understand that by signing below I am stating that this information is correct to the best of my knowledge.

Patient Printed name _____ **Date:** _____

Patient Signature: _____

Patient Name: _____ Birthdate: _____ Date: _____

Indicate the areas where you are currently having pain on the diagrams below



Function and Pain Assessment

Evaluation of current pain interference-- this scale's examples of activities at different levels are not meant to be exclusive. In the last month, how much has pain interfered with the worker's daily activities and functions? Circle number:

◯ 0	No interference. **Goes to work each day, has a social life outside of work, takes an active part in family life**
◯ 1	Can work/volunteer, is active eight hours daily, takes part in family life, has limited outside social activities
◯ 2	Can work/volunteer for at least six hours daily, has energy to make plans for one evening social activity during the week, is active on weekends.
◯ 3	Can work/volunteer for a few hours daily, is active at least five hours daily, does simple activities on weekends
◯ 4	Can work/volunteer limited hours, has limited social activities on weekends.
◯ 5	Not able to work/volunteer, struggles with home responsibilities and outside activities
◯ 6	Does simple chores around the home, has minimal outside activities two days a week
◯ 7	Gets dressed in the morning, has minimal activities at home, has contact with friends via phone or email
◯ 8	Gets out of bed but doesn't get dressed, stays at home all day
◯ 9	Stays in bed at least half the day, has no contact with the outside world
◯ 10	**Unable to carry out any activities.** Stays in bed all day, feels helpless and hopeless about life.

PRACTICE POLICIES

In an effort to best meet the needs of all of our patients, we would like to remind everyone of the following policies. Thank you.

1. APPOINTMENT CONFIRMATION/CANCELLATION POLICY

As a courtesy, you will receive a COMPUTER call 2 days prior to your appointment to remind you of the date and time. Please follow the computer prompts to confirm. If you would like to cancel, please contact our office at least one business day PRIOR to your appointment.

*Effective November 2008, there will be a patient charge of $25 for any appointment not cancelled with at least a 1 business day notice

2. MEDICATION PRESCRIPTIONS

All medication prescriptions will be given during your scheduled appointment time. These prescriptions will be for the amounts appropriate to control your pain until your next visit and must be utilized as directed by your provider. Early refills are only allowed with authorization by the prescribing physician. Refills requests cannot be given over the phone. You are responsible for your prescriptions. Stolen or lost refills will not be replaced until the date for which they were originally scheduled. We do not prescribe medication for undiagnosed pain.

You must inform us of any prescription controlled substances you are obtaining through other physicians. Failure to do so may result in discharge from our practice. It is illegal to share prescription drugs and to alter or forge prescriptions, and our practice reserves the right to discharge patients engaging in such activities. Our practice also reserves the right to discharge patients engaging in activities considered “drug-seeking”, such as persistent medication use past the period indicated by the physician; repeated visits to emergency rooms with pain complaints; and other activities in this category, at the discretion of your provider.

3. CLINICAL QUESTIONS

If you have questions, would like to leave a patient update or request information you can contact us via the WEB PORTAL. Please visit www.thephysicians.com and select PATIENT PORTAL. However, if the question requires extensive medical decision making, you will need to schedule an appointment.

4. FORMS AND ADDITIONAL REQUESTED SERVICES

There will be a processing fee for completing insurance and disability forms not directly associated to billing your visits. The fee will be determined by the physician, depending on the extent required of the form. This fee also applies to the insurance medication prior approval process, which your insurance carrier does not include in your physician services. We appreciate your understanding with these policies. We unfortunately cannot control the additional work insurance companies are requesting for patients and providers each year that are not included in the medical services provided. We are doing our best to make sure that we remained focused on the services we provide –medical care- in order to treat our patients with the highest level of care possible.

5. MEDICAL RECORDS

Please note that any requests for medical records copies needs to be in writing. We will fax records directly to your other treating providers, upon this written request, for no fee. Appropriate copying charges will apply for all others, to cover the time and resources required.

I have read and understand the above policies.

Printed Patient Name or Representative	Patient Signature	Date

FINANCIAL POLICY – WE WANT YOU TO BE INFORMED!

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. As part of this commitment, we provide several services as a courtesy to you, the patient, as outlined below:

If you have:	**You are responsible for:**	**As a courtesy to you, our staff will:**
An **HMO, POS, PPO, or other insurance** with which we **are contracted**	1) Obtaining a referral from your PCP (if applicable) 2) Payment of Co-pays & Deductibles at the time of service	File an insurance claim on your behalf
An **HMO. POS, PPO or other insurance** with which **we are not contracted**	If your insurance plan offers "out of network" benefits payment is **REQUIRED** at time of service based on your **"out of network**" benefits. Many insurance companies base their payment on **"usual and customary"** charges. The patient is responsible for **ALL FEES** above **"usual and customary." (UCR**) If your insurance plan does not have **"out of network"** benefits, we will not file these claims. We will provide you the option to pay at the time of service with prompt pay discount.	For **POS** and **PPO**, we will file an insurance claim on your behalf. **HMO** plans do not have out of network benefits and will not cover any charges. We will not file these claims. These patients will be provided the option to pay at the time of service with prompt pay discount.
Medicare **without secondary**	Payment of deductible and coinsurance at time of service	File an insurance claim on your behalf
Medicare, HMO, POS, PPO, and commercial ins. **w/secondary**	Payment of deductible and coinsurance at time of service if not covered by secondary insurance	File an insurance claim on your behalf, as well as any claims to your secondary
Prompt Pay Patients (Patients with no insurance, or those who choose **NOT** to file with insurance)	**PAYMENT MUST BE MADE AT TIME OF SERVICE.** The discount **DOES NOT** apply if payment is not made **IN FULL** at time of service. Patient will be responsible for 100% of **ALL** charges incurred that day.	Providing a prompt pay discount for paying at time of service. Patient or Provider **WILL NOT** file charges from that date of service with insurance of any sort.
Workers Compensation	Provide us with the accident date, claim number, attending physician, employer, and adjuster information.	File an insurance claim on your behalf
Accident Related **(non Workers' Compensation)**	Payment must be made in full at time of service or filed with your insurance plan (see above responsibilities), if a Lien is not on file. If the accident is related to an automobile accident, we will file with auto insurance. Auto insurance must be provided with claim number and med pay confirmed. If not on a Lien and not related to a work related injury or automobile accident, we will need written acknowledgement confirming this is not work or auto accident related and not being litigated.	File an insurance claim on your behalf with required documentation (i.e. written acknowledgement confirming this is not work or auto accident relate and not being litigated.) If an auto accident, will file with auto insurance until Med Pay is exhausted. Once Med Pay has been exhausted, file insurance claim with health insurance including letter from auto insurance stating Med Pay is exhausted.

Patient Initials _____

Billing Process and Notices

We file insurance as a courtesy but this does not release the patient from financial obligation. We will attempt to verify benefits prior to your appointment to determine eligibility, deductibles, coinsurance, and obtain approval. THIS DOES NOT GUARANTEE REIMBURSEMENT. The patient remains fully responsible for the entire amount of the bill.

Charges not covered by insurance company, as well as applicable co-payments and deductibles, are patient's responsibility.

Patients are expected to pay for all estimated copay, deductible and co-insurance cost at time of service as required by insurance company. If for some unforeseen reason a patient cannot pay the co-payment, the patient will have the option to reschedule or agree to pay an additional $10.00 fee that will be added to the account for the collection cost of the co-payment, deductible and/or co-insurance after the date of service.

In order to help keep you informed, you will receive monthly statements or notices about your services with us as long as there is a balance on your account.

If we are filing insurance on your behalf, we will not send these statements to you until we have received payment or other information from your insurance. You may receive an EOB from your carrier, prior to our statements.

You will continue to receive statements monthly, as long as there is a balance. After 90 days of statements, if you have not made payment arrangements, your account balance will be sent to CBA collection agency.

If you are scheduled for a procedure, ***PLEASE NOTE THE BILLING FOR THE PHYSICIAN AND FACILITY IS SEPARATE.*** The bill from the facility (surgery center or hospital) includes the costs of the procedure room, medical supplies, and medications. The physician bills separately for their services.

Patient signature below authorizes The Physicians Spine & Rehabilitation Specialists to release pertinent medical information to your insurance company when requested, or to facilitate payment of a claim.

I have read and understand the above Financial Policy. I authorize my insurance benefits to be paid directly to The Physicians Spine & Rehabilitation Specialists

_____	_____	_____
PATIENT SIGNATURE	**PRINTED NAME**	**DATE**

PRIVACY NOTICE AKNOWLEDGEMENT

PATIENT NAME: _____ Date of Birth: _____

I acknowledge that I have reviewed a copy of the Privacy Notice for The Physicians Spine & Rehabilitation Specialists

Privacy Notice Revision Date: April 14, 2003

Patient Printed name

_____ _____

Patient or Personal Representative Signature Date

_____

Personal Representative's Relation to Patient

OFFICE USE ONLY

DOCUMENTATION OF GOOD FAITH EFFORT

The patient identified above was provided a copy of the Provider's Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgment of the patient's receipt of the Privacy Notice. However, acknowledgement has not been obtained because:

☐ There was a medical emergency. Provider will attempt to obtain acknowledgment as soon as practical.
☐ Other reason, described below:

_____

☐ Patient refused to sign the Privacy Notice Acknowledgment
☐ Patient was unable to sign because:

_____

_____ _____ _____

Employee Printed Name Employee Signature Date

Employee Position

AUTHORIZATION TO DISCLOSE/PROVIDE INFORMATION

My signature below indicates the authorization to release my medical information, including history, treatment, diagnosis and prognosis and any information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care provided, health related utilization review or quality assurance activities.

By signing below, I hereby consent for this practice to use or disclose information about myself (or another person for whom has the authority to sign) that is protected under federal law, for the sole purpose of treatment, payment and healthcare operations. I understand that I may refuse to sign this form.

My signature below indicates my authorization of any medical information including history, treatment, diagnosis, and prognosis to be released to:

The Physicians Spine & Rehabilitation Specialists

790 Church Street, Suite 550, Marietta, GA 30060

Phone: (770) 419-9902, Fax: (770) 419-7457

The Physicians Spine & Rehabilitation Specialists

5730 Glenridge Drive, Suite 100, Sandy Springs, GA 30328

Phone: (404) 816-3000, Fax: (678) 904-5797

The Physicians Spine & Rehabilitation Specialists

18 Riverbend Drive, Suite 100, Rome, GA 30161

Phone: (706) 314-1900, Fax: (706) 314-1901

The Physicians Spine & Rehabilitation Specialists

1060 Red Bud Road, Calhoun, GA 30701

Phone: (706) 314-1919, Fax: (706) 629-4904

The Physicians Spine & Rehabilitation Specialists

1035 Southcrest Drive, Stockbridge, GA 30281

Phone: (678) 275-2200, Fax: (678) 275-2201

PATIENT TO COMPLETE: The practice may communicate with the following individuals regarding my condition or course of treatment:

1. _____ 2. _____

3. _____ 4. _____

You may communicate confidential information to me, including invoices for services, to the home address, home phone and cell phone listed on my patient demographics.

I understand that pursuant to the Health Insurance Portability and Accountability Act (HIPAA) this protected health information is being used by The Physicians Spine & Rehabilitation Specialists for the purpose of providing treatment, and the business operations and billing that go along with this treatment. By signing below, I recognize that the protected health information used or disclosed pursuant to the consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

_____ _____ _____

Printed Patient Name/Personal Representative | Patient/Representative Signature | Patient Date of Birth

_____ _____

Date | Personal Representative's Relation to Patient

THE PHYSICIANS
Spine & Rehabilitation Specialists

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or midlevel provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

PATIENT RIGHTS & RESPONSIBILITIES

Patient Rights and Responsibilities are posted in the waiting room of the practice and are offered to patients.**Please note that this facility employs various types of licensed health care practitioners, including Medical Doctors (MD), Doctors of Osteopathic Medicine(DO), Registered Nurses (RN), Medical Assistants (MA), and Radiology Technicians (RT). As a patient, you have the right to inquire about a practitioner's license.

My signature below confirms that I have read and understand my rights and responsibilities as a patient.

_____	_____
Signature of Patient or Representative	**Date**
_____	_____
Printed Name of Patient or Representative	**Date**
_____	_____
Signature of Witness	**Date**
_____	_____
Printed Name of Witness	**Employee Job Title**