Atlantic Brain and Spine , PA

Dear_____, you're scheduled with our provider,_____,for an appointment on_____. **ARRIVE** at_____, for your schedule appointment time of,_____, you appointment will be in the location of: ☐ 2208 South 17th Street Wilmington, NC 28401 ☐ 2800 Ashton Dr. Suite 200 Wilmington, NC 28412 ☐ 215 Station Street Jacksonville NC 28546

What to bring on your first visit?

1. **Bring ALL Radiology CD's** related to your condition, paperwork mailed from our office, a list of medications, a Photo ID, and Insurance card. **If we do not have your films, your appointment will need to be rescheduled.**
2. All paper work that was sent to you should be filled out **prior to your appointment time**. **DO NOT MAIL BACK TO OFFICE.**

Office Policies & Procedures

- **INSURANCE:** Currently, we participate with Blue Cross/Blue Shield, Medicare, United Healthcare, Aetna, Cigna and Vocational Rehab. We do not file liability claims. If you have an attorney, you will still be required to pay for each visit in full at the time of service. Although we are out of network for other insurances, it may be possible for you to obtain an In-network (GAP Authorization) by contacting your insurance company. It is your responsibility (or your referring provider) to contact your insurance company about authorization prior to your initial visit.
- **PAYMENT:** Co-payments are collected at the time services are rendered. If you do not have payment, your appointment will be rescheduled. Payment is due from the time of service which may include deductibles, percentages, and/or co-pays. We bill your insurance for all services we provide, and other treating physicians/facilities may send separate bills for services. There will be a $30.00 service fee for returned checks. Past due balances MUST be paid prior to your returning appointments. We accept Cash, Check, and all major Credit Cards. A $35.00 fee for completion of forms, including but not limited to disability.
- **NEW PATIENTS: Radiology CD's and an updated medications will be required for your visit.**
- **MIDLEVEL PROVIDERS:** Our office consists of Physician Assistants and Nurse Practitioners who are utilized in our office to both evaluate and treat patients. They are well trained and competent in their evaluation process, available to answer questions, and will be a part of your plan of care in our office.
- **PHONE CALLS:** In the event of a question during office hours, we are available Monday through Thursday 9am-5pm and Friday 9am-3pm. If you leave a message with our office we will make every effort to return your call within 24 hours.
- **PAIN MEDICATIONS:** Typically medications are not prescribed unless a patient has had surgery with one of our providers. If you are in need of pain medicine and have not had surgery within the past 90 days, please contact your primary care doctor or your pain management doctor to request medications.

Acknowledgement of Office Policies, Procedures, Release of Medical Information, and Notice of Privacy Practices (HIPAA)

- **I have received** electronically or was offered a copy of the Office Policies and Procedures as well as a copy of the Notice of Privacy Practices (HIPAA) for Atlantic Brain and Spine, P.A.
- **I understand** that this practice has the right to modify or change its office policies and privacy practices and that I may obtain any revised notices from the practice, upon my request. All revisions would remain HIPAA compliant.
- **I understand** that I have the right to request a restriction of how my health information is used. I also understand that the practice is not required to agree to the request. I may revoke this consent at any time by making a request in writing.
- **I understand** that Atlantic Brain and Spine participates with the Coastal Connect Health Information Exchange ("CCHIE") which is a not-for-profit organization to facilitate the exchange of health information among health care providers, health plans, and other health industry stakeholders.
- **I understand** that the same federal health information privacy protections that apply to paper information also apply to electronic health records. CCHIE complies with the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to "opt out" of CCHIE anytime which means healthcare providers cannot search for your medical information.
- **I hereby authorize** and direct payment to Atlantic Brain and Spine, P.A. for the medical and/or surgical benefits. I understand that the final responsibility of any unpaid balances is mine.
- **I hereby authorize** Atlantic Brain and Spine to release any information acquired during my treatment to anyone involved in said treatment or payment of treatment.
- **It is agreed** that in the event the services of an attorney or collection agency are required to collect any outstanding balance owed to Atlantic Brain and Spine, the cost of reasonable attorney's fees will be added to the outstanding balance. Any outstanding balances on my account over 90 days old may be subjected to a 1-½ % per month (18% annual) finance charge.

I have read, understand, and agree to follow all the above stated office policies, procedures, and privacy practices, and authorize photocopies of this form to be valid as the original.

Signature:_____ Date: _____

MEDICARE - ONE TIME SIGNATURE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Atlantic Brain and Spine for any services furnished to me by the physician(s). I authorize any holder of medical information about me to release any and all information requested to the Health Care Financing Administration and its agents as needed to determine these benefits or the benefits payable for related services.

Signature:_____ Date: _____

ATLANTIC BRAIN AND SPINE, P.A.

*****PLEASE USE BLACK INK***** PLEASE COMPLETE FORM IN FULL *****PLEASE USE BLACK INK*****

PATIENT: _____
LAST NAME FIRST NAME MIDDLE/MAIDEN SEX

_____
ADDRESS: STREET P.O. BOX CITY STATE ZIP

(_____)_____-_____-_____-_____
HOME PHONE NUMBER DATE OF BIRTH AGE SOCIAL SECURITY NUMBER

(_____)_____-_____(_____)_____-_____
CELL PHONE NUMBER EMPLOYER WORK PHONE NUMBER

EMAIL ADDRESS: _____

_____
SPOUSE'S NAME EMPLOYER DATE OF BIRTH SPOUSE'S SOCIAL SECURITY

_____
NEAREST FRIEND OR RELATIVE TO CONTACT IN CASE OF EMERGENCY HOW RELATED? PHONE NUMBER

Do you have a healthcare Power of Attorney? Yes ☐ No ☐ Do you have a Do Not Resuscitate (DNR)? Yes ☐ No ☐

Race: ○ American Indian or Alaskan Native ○ Asian ○ Black or African American ○ White ○ Native Hawaiian or other Pacific Islander ○ Other ○ Declined **Ethnicity:** ○ Hispanic/Latino ○ Not Hispanic/Latino ○ Declined

REFERRING PHYSICIAN: _____
NAME PHONE NUMBER

FAMILY PHYSICIAN: _____
NAME PHONE NUMBER

REASON FOR VISIT:_____ **ONSET DATE/DATE OF INJURY:** _____

IS THIS A 2ND OPINION:_____ **PREVIOUS DOCTOR TREATING CONDITION:**_____

Pharmacy Name:_____
Name City Phone

PRIMARY INSURANCE:_____ POLICY HOLDER _____
POLICY ID#:_____ GROUP# _____

SECONDARY INSURANCE:_____ POLICY HOLDER: _____
POLICY ID#:_____ GROUP #:_____

IF PATIENT IS A MINOR, PLEASE PROVIDE PARENT INFORMATION

PARENT(S) NAME(S):_____
HOME PHONE #:_____ OTHER PHONE #: _____

Under the requirements of HIPAA we are not allowed to give any information to anyone without the consent of the patient. **I authorize Atlantic Brain and Spine to release my medical and/or billing information to the following individual(s):**

1._____ Relation to Patient_____

2._____ Relation to Patient_____

3._____ Relation to Patient_____

This authorization is effective through ___/___/___ unless revoked or terminated by the patient or the patients' personal representative in writing by contacting our office at 763-3333. If left blank, authorization will end 2 years from signed date. I authorize that all the above information is correct.

I have read, understand, and agree to follow all stated office policies, procedures, and privacy practices that I received.

Signature:_____ Date: _____

ATLANTIC BRAIN AND SPINE

Office Use

Arrival:_____

Checked In: _____

Roomed: _____

___CD(s) Scanned: ☐

New Patient History Inventory

*****PLEASE USE BLACK INK*****

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

What brings you to the office, and when was the date it started? _____

Did your pain begin gradually or suddenly? _____

Was there any trauma or any other inciting event that caused the pain? _____

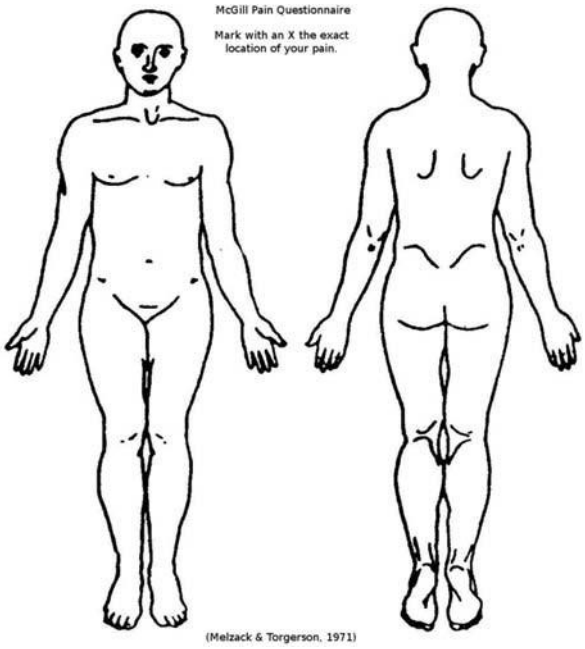
Is this a work-related injury? (Required) Y N if yes, did you file a Worker's Comp Claim? Y N

Are you still working? Y N If no, when was your last day of work? _____

Are you on disability? Y N If yes, when did you go on disability? _____

How bad is your pain now? (Circle ONE)

0 1 2 3 4 5 6 7 8 9 10
No pain Excruciating pain



Please mark the body diagram where you feel:

Ache:
^^^^^^^^

Burning:
XXXXXXXX

Numbness:
0000000

Pins & Needles:
////////

Stabbing:
====

Have you fallen in the past year?_____If yes, how many times:_____Did the fall result in injury? _____

Is your pain constant or does it vary based on your activity or position? _____

How does the following affect your pain?	Increases	Decreases	No effect
Sitting	☐	☐	☐
Standing	☐	☐	☐
Lying down	☐	☐	☐
Bending	☐	☐	☐
Lifting	☐	☐	☐
Walking	☐	☐	☐
Coughing/Sneezing	☐	☐	☐

Have you had treatment by the following for your neurosurgical problem (see below)?

	Yes	No	When?	Result?
Physical therapy	☐	☐		
Chiropractic	☐	☐		
Acupuncture	☐	☐		
Injections	☐	☐		
Other (specify)	☐	☐		

Do you have any weakness associated with your pain? Yes No Explain: _____

Does your pain wake you up at night? Yes No

Overall, would you say you are (circle one): improving worsening about the same

Medical History:

Do you have any of the following medical conditions?

Medical	Y	Medical	Y	Medical	Y
Asthma/ Emphysema	☐	Hepatitis	☐	Parkinson's disease	☐
Tuberculosis	☐	Pacemaker	☐	Tremor	☐
COPD	☐	Heart Attack	☐	Stroke	☐
Cancer (list type):	☐	Hypertension	☐	Epilepsy/Seizures	☐
_____		Atrial Fibrillation	☐	Multiple Sclerosis (MS)	☐
Depression	☐	High Cholesterol	☐	Peripheral Neuropathy	☐
Diabetes	☐	Congestive Heart Failure	☐	Arthritis	☐
Thyroid (Low/High)	☐	Irregular Heart Beat	☐	Osteo Arthritis	☐
Osteoporosis	☐	Murmur	☐	Rheumatoid Arthritis	☐
Kidney Problems	☐	Scoliosis	☐	Acid Reflux Disease	☐
Stomach Ulcers	☐	Carotid Disease	☐	Sarcoidosis	☐
Polio	☐	Blood/Bleeding Disease	☐	Fibromyalgia	☐
HIV	☐	Blood Clots/PE	☐	Chronic Fatigue Syndrome	☐

Other: _____

_____

Previous Surgery (include dates)	
Previous Hospitalizations (include dates)	

Family History:

Family History	Age if Living	Age at Death	Present Condition or Cause of Death
Father			
Mother			
Brothers: Number:_____			
Sisters: Number:_____			
Children: Number:_____			

Check if any Relatives have had:

Diabetes……☐ Tuberculosis……☐ Mental Illness… ……☐
Heart Trouble……☐ Thyroid Trouble……☐ Suicide… ……☐
Heart Attack……☐ Arthritis……☐ Melanoma… ……☐
High Blood Pressure……☐ Obesity (Overweight)……☐ Cancer… ……☐
Stroke……☐ Aneurysm……☐ Cancer Type:_____

Social History:

Marital Status (Please Circle One): Single Married Divorced Widowed Separated

Occupation (Job):_____Highest level of education completed: _____

Smoking/Tobacco Use:
Yes ☐ No ☐ Quit ☐
How many cig per day_____?
Pipe ☐ Cigar ☐ Chew ☐
If quit, years stopped_____
How soon after you wake up do you smoke your first cigarette? _____

Drink Alcohol:
Yes ☐_____per day____per week
(Circle) Beer / Wine / Liquor
No ☐

Do you drink more than 6 drinks in one day? Yes ☐ No ☐
Problem with Alcohol? Yes ☐ No ☐

Recreational Drugs:
Yes ☐ No ☐
If yes, list drugs:
_____
_____

Medications & Supplements:

Name of Medication	Dosage	Frequency	Name of Medication	Dosage	Frequency
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Allergies:

Do you have any allergies to medications? Yes ☐ No ☐ **If yes**, please list medication and reaction to the medication(s):

Medication	Reaction	Medication	Reaction
1.		3.	
2.		4.	

Please mark a check ✓ for **symptoms** you have **RIGHT NOW:**

PLEASE CHECK HERE IF YOU HAVE **NO SYMPTOMS**: ☐

CONSTITUTIONAL
- Weight Loss ☐
- Fatigue ☐
- Fever ☐

EYES
- Double Vision ☐
- Glaucoma ☐
- Cataracts ☐

EAR, NOSE, THROAT
- Difficulty Hearing ☐
- Ringing in Ears ☐
- Dizziness ☐
- Sinus Trouble ☐

CARDIOVASCULAR
- Murmur ☐
- Chest Pain ☐
- Palpitations ☐
- Fainting Spells ☐
- Shortness of Breath ☐
- Difficulty Lying Flat ☐
- Swelling Ankles/Other ☐

ENDOCRINE
- Loss of Hair ☐
- Heat/Cold Intolerances ☐
- Change in Nails ☐

RESPIRATORY
- Cough ☐
- Coughing Blood ☐
- Wheezing ☐

GASTROINTESTINAL
- Heartburn ☐
- Nausea/Vomiting ☐
- Constipation ☐
- Difficulty Swallowing ☐
- Jaundice ☐
- Abdominal Pain ☐
- Black Stools ☐

GENITOURINARY
- Pain Urinating ☐
- Urinary Frequency ☐
- Nighttime Urination ☐
- Difficulty Urinating ☐
- History Kidney Stone ☐
- History STD ☐
- Abnormal Discharge ☐
- Blood in Urine ☐

FEMALE ONLY
- Menopause ☐
- Are Your Periods Regular? ☐

HEMATOLOGIC/LYMPH
- Prolonged Bleeding ☐

NEUROLOGICAL
- Seizures ☐
- Weakness/Paralysis ☐
- Numbness ☐
- Tremors ☐
- Headache ☐
- Memory Loss ☐
- Trouble Finding Words ☐
- Balance Problems ☐

MUSCULOSKELETAL
- Joint Pain/Swelling ☐
- Stiffness ☐
- Muscle Pain ☐
- Back Pain ☐
- Neck Pain ☐
- Shoulder Pain ☐

PSYCHIATRIC
- Anxiety/Depression ☐
- Mood Swings ☐
- Difficult Sleep ☐

ALLERGIC/IMMUNOLOGIC
- Hay Fever/Asthma ☐
- Hives/Eczema ☐

SKIN
- Rash ☐
- Lesions ☐

How did you hear about us? (✓ all that apply):

- ☐ Referral from my physician
- ☐ Friend/relative
- ☐ TV ad
- ☐ Online ad
- ☐ Online search
- ☐ Other: _____

Patient Signature:_____ **Date**_____

Oswestry Disability Index

Please mark the bubble next to the statement that applies to you:

Section 1 – Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it is very painful.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

Section 4 – Walking

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than 1mile.
- Pain prevents me walking more than ¼ of a mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6 – Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than ½ an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 – Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain, I have less than 6 hours sleep.
- Because of pain, I have less than 4 hours sleep.
- Because of pain, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

Section 9 – Social Life

- My social life is normal and causes me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

Section 10 – Traveling

- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys of over two hours.
- Pain restricts me to short necessary journeys less than 30 minutes.
- Pain prevents me from traveling except to receive treatment.

Patient name: _____

Today's date: _____