The Spine Care Center

REGISTRATION FORM

Today's Date ____/____/____ PCP_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )

P.O. Box	City	State	Zip Code	Cell Phone #	E-Mail:

Occupation	Employer	Employer Phone No. ( )

Chose Clinic Because/Referred to Clinic by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Other Family Members Seen Here _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No.
Is this person a patient here?	❑ Yes ❑ No		( )

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize NOVA Advanced Pain Management, PLLC or insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

PLEASE USE BLACK BALL POINT PEN ONLY

The Spine Care Center
Financial Agreement

Thank you for choosing ***The Spine Care Center***. The following is our Financial Policy. If you have any questions or concerns about our payment policies please do not hesitate to ask our policies business office personnel. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Forms prior to seeing the doctor.

The Patient portion of patient is due at the time services are rendered unless prior arrangements have been made with the business office manager.

We accept assignment with most major insurances companies and participating provider plans. However, you must understand that:

1.) Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier.
2.) All charges are your responsibility whether your insurance company pays or not.
3.) Fees for services, along with unpaid deductibles and co-payments, are due at the time of treatment.
4.) If the insurance company does not pay your balance in full within 30 days we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.
5.) Returned checks will be subjected to a $40.00 collection charge.
6.) Balances over 90 days will be subject to additional collections charges of the greater of 10% per month, or the maximum amount allowed by law.
7.) Unpaid balances over 90 days are subject to collections via small claims court, attorney, and/or collections agency with applicable collections fees.
8.) Failure to cancel an office visit 24 hours prior to the appointment will result in a $60.00 fee. Failure to cancel 48 hours before a procedure will result in a $200.00 fee. Failure to cancel 7 days prior to a surgery will result in a $750.00 fee.
9.) Upon requesting medical records, there will be a $0.50 charge per page up to 50 pages and $0.25 thereafter.
10.) For prescription refills made without an office visit, a $20.00 charge will be accessed to your account.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign **to The Spine Care Center** all medical and/or surgical benefits I am entitled to from my insurance company and/or Medicare.

Permission to Access Pharmacy Records: I authorize the providers **The Spine Care Center** to access my pharmacy records through Virginia Prescription Monitoring Program.

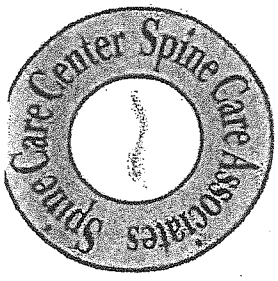
These authorizations are in effect for all future claims, until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment.

_____ _____
Patient's Signature (Or Authorized Signature) Date

_____ _____
Printed Name of Patient Relationship to patient if not patient

Authorized Witness: _____



The Spine Care Center & Spine Care Associates

Restoring Function. Relieving Pain.

www.spinecareva.com
8525 Rolling Rd Suite 200
Manassas, VA 20110
Tel: 703-257-2266
Fax: 703-257-2269

The Spine Care Center

Notice of Privacy Practices

Acknowledgement of Receipt

I acknowledge that I have been offered a copy of The Spine Care Center Notice of Privacy Practices. I have also had the opportunity to ask questions and receive explanations regarding this policy.

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient's Representative Date

_____

Representative's Relation to Patient

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Prescription Refill Policies

The providers and staff of The Spine Care Center would like to welcome you to our practice. We would like to take the opportunity to explain our policies regarding prescription pain medications. Part of our treatment plan may include prescribing controlled medications (narcotics) for your pain. As you are aware, significant problems may occur when these medications are used for purposes other than the reason for which they are prescribed. Our providers and staff are committed to protecting our community from the improper use, abuse and diversion of pain medications. **Please understand that compliance with these policies is mandatory and exceptions will NOT be considered.**

1.) In general, narcotic pain medications will be filled at the time of your office visit only. **Please do NOT request these medications to be refilled over the phone. If you are running low on these medications and treatment will need to continue, then we ask that you make an appointment to be seen for medications with your provider.** If there is a question as to whether or not your medication is a narcotic, please do not hesitate to ask us.

2.) Non-narcotic pain medication may be refilled for up to three (3) months without an office visit. Please note: All refill requests may take up to 72 hours to process. **Please contact your pharmacy and ask them to contact us for refill approval. Please do not call our office directly for refills. For prescription refills made without an office visit, a $20.00 charge will be accessed to you. Please note your insurance company will not pay for these charges.**

3.) Requests for refills received after 12:00 pm (noon) on Friday, will not be processed until the following business day.

4.) If you lose a prescription given to you by our office, we will not replace it. It is your responsibility to keep track of your prescriptions and to ensure that they are correct before you leave our office.

5.) Please take your medications exactly as prescribed on the bottle. If you find that you are experiencing excessive side effects or feel that your medication is not working, you need to call our office and let one of our clinical staff know so we can advise you on how to proceed.

6.) **Do NOT dispose of your medication for any reason.** You may be asked to bring in any unused medication for us to dispose of.

I have read and understand the above policies regarding my prescribed medications from The Spine Care Center. I have been given the opportunity of ask any questions regarding these policies

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature Date

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PERMISSION TO DISCLOSE INFORMATION

Print Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I hereby give my permission to the person(s) listed below to authorize treatment and to receive information about the care of the above named patient.

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____

I understand that if the person that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be re-disclosed and is no longer protected by these regulations.

I understand that written notification is necessary to cancel this authorization and can be addressed to the company listed at the top of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) of infection with HIV regulated by Federal Statute (42 CFR Part 2)

Signature of Patient, Parent or Guardian: _____ Date: _____

(This authorization will expire one year from date of signature)

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Health/Pain History Questionnaire

Patient Information:

Name: (Last, First, M.I.)	☐ M ☐ F	Today's Date: ___/___/___	
DOB ___/___/___	Age: _____	Height:	Weight:
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Referring Doctor:		Telephone:	
Primary Care Physician:		Telephone:	

Symptoms

Reason for today's visit:

Have you had this problem before? If yes; please describe your symptoms and when did they first begin: (accident, injury, etc)

PERSONAL HEALTH HISTORY

Please check and/or list all medical problems:

- ☐ High Cholesterol
- ☐ High Blood Pressure/Low Blood Pressure
- ☐ Hyper/Hypo Thyroidism
- ☐ Diabetes: Type _____ Being Treated _____
- ☐ Cardiac Issues – to include implanted devices
- ☐ Respiratory Problems
- ☐ Kidney Problems
- ☐ Cancer: Type _____ Treated _____
- ☐ HIV/AIDS
- ☐ Hepatitis: Type _____ Treated _____
- ☐ Bypass: Type _____

Other Medical Conditions: _____

List all prior surgeries you have had in the past: Include Year, Reason, Hospital and Doctor

What recent (within the past 2 years) tests have you had performed for diagnosis of your current condition

- ☐ MRI: Body Part _____ Year _____ Facility _____
- ☐ X-Ray: Body Part _____ Year _____ Facility _____
- ☐ CT Scan: Body Part _____ Year _____ Facility _____
- ☐ Bone Scan
- ☐ EMG/Nerve Conduction

Other Tests: _____

Are you currently taking any anticoagulants (blood thinners)? If yes, please list _____

List your CURRENT Prescribed Drugs and Over the-Counter Drugs, Such as Vitamins and Inhalers (additional space on last page):

NAME OF DRUG	Strength	Frequency Taken

☐ ***Please check if continued on back***

Allergies to Medications: NAME OF DRUG	REACTION YOU HAD

Have you had any adverse reaction to anesthesia/sedation? If yes, Explain:

Are you currently involved in any LEGAL action or COURT case as a result of an injury? ☐ Yes ☐ No

Review of Systems

Please circle symptoms or history you have experienced or NONE for each section.

Constitutional/General: Easy Fatigue Unexplained Fevers Insomnia(trouble sleeping) Loss of Appetite Easy Bruising Weight gain/loss None Other _____

Musculoskeletal: Joint Pain Joint Stiffness Morning Stiffness Joint Surgery Joint Swelling Leg Cramps Muscle Cramps Osteoarthritis Rheumatoid Arthritis Scoliosis Sjogrens Syndrome Lupus Back Pain Neck Pain None Other _____

Neurology: Head Injury Mini-Stroke(TIA) Stroke Headache Learning Disabilities Loss of Balance Loss of Feeling in Legs Loss of Feeling on One Side Memory Loss Seizures Tremors Vertigo Weakness in Arms Weakness in Legs None Other _____

Heart/Lungs: Chest Pain High Blood Pressure Heart Attack Congestive Heart Failure Dizziness Irregular Heartbeats(palpitations) Leg Edema Leg Blood Clots(DVT) Shortness of Breath Cough Sputum Wheezing None Other _____

Endocrine: Diabetes Excessive Sweating Excessive Thirst Excessive Urination Thyroid Disease Hormonal Diseases Heat Intolerance None Other _____

Head/Neck: Change in Vision Double Vision Drooping Eyelids Light Intolerance Loss of Hearing Loss of Smell Loss of Vision Trouble Swallowing Sore Throat Change in Voice Nose Bleeds Ringing in Ears None Other _____

Gastrointestinal: Abdominal Pain Bleeding from Bowel Blood in Stool Change in Bowel Habits Constipation Cirrhosis Colitis Diarrhea Reflux(GERD) Heartburn Hepatitis Hiatal Hernia Irritable Bowel Syndrome(IBS) Nausea Ulcers Vomiting None Other _____

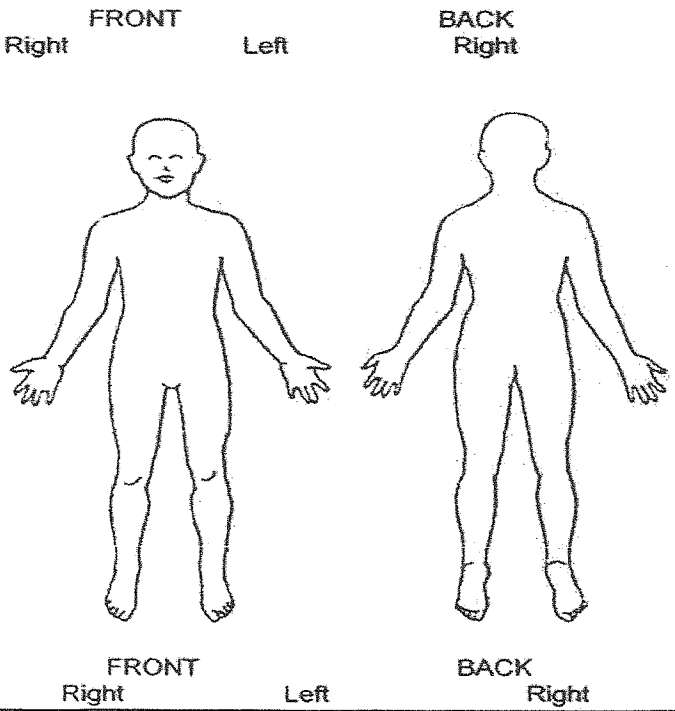
Blood/Immune System HIV Exposure Persistent Infections Abnormal Bleeding Abnormal Bruising Anemia Enlarged Lymph Nodes None Other _____

Female: Frequent Yeast Infections Breast Cancer Breast Fibrocystic Disease Post Menopausal Abnormal Vaginal Discharge Heavy/Painful Periods Infertility Diminished Sex Drive None Other _____

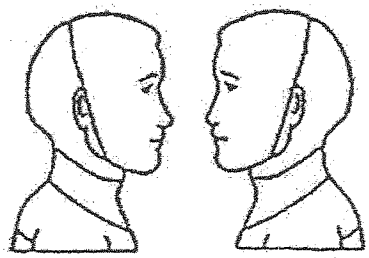
Male: Difficulty Urinating Difficulty with Erection Diminished Sex Drive None Other _____

Psychology: Currently Receiving Counseling Eating Disorder High Stress Level Depression Suicidal Thoughts Mania Psychosis Psychiatric Hospitalizations None Other _____

Diagram Pain



Please mark the area where you are having pain with an **X**. Mark the area where you have numbness/tingling with and **O**.



On a Scale of 0-10 with zero being NO PAIN and 10 being the worst pain you have experienced in your life, where would you rate your pain: NOW_____ AT ITS WORST _____
AT REST _____ WITH ACTIVITY _____ ON AVERAGE _____

PAIN HISTORY

The Pain is: ☐ Constant ☐ Intermittent (comes and goes) ☐ Worse in the AM ☐ Worse in the PM

The Pain is Best Described As: ☐ Aching ☐ Throbbing ☐ Sharp ☐ Shooting ☐ Stinging ☐Burning ☐ Stabbing ☐ Dull ☐ Other:

The Pain is improved with: ☐ Rest ☐ Standing ☐ Exercise ☐ Moving Around ☐ Lying Down ☐ Sitting ☐ Heat ☐ Cold ☐ Massage ☐ Medications ☐ Other

The Pain is made worse with: ☐ Standing ☐ Bending ☐ Walking ☐ Lying Down ☐ Stress ☐ Rest ☐ Lifting ☐ Twisting ☐ Coughing ☐ Sneezing ☐ Other:

Treatments I have Tried for this Pain in the Past Include: ☐ Chiropractor ☐ Massage Therapy ☐ Acupuncture ☐ Surgery
☐ Physical Therapy: How long ago attended _____ How many sessions completed _____
☐ Injections : Type _____ How long ago _____

Medications I have Tried and failed in the Past for this Pain Include:

NAME OF DRUG	DOSAGE	EFFECT

HEALTH HABITS AND PERSONAL SAFETY

Are you employed? ☐ Yes ☐No If yes, what is your title and describe your responsibility's:_____

_____

Do you exercise? ☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf) ☐ Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.) ☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)
Do you drink alcohol? ☐ Yes ☐ No If yes, what kind? _____How many drinks per week? _____
Do you use tobacco? ☐ Yes ☐ No ☐ Cigarettes - Pks/day_____ ☐ Chew - #/day _____
☐ Pipe - #/day _____☐ Cigars - #/day _____ ☐ # of Years _____ ☐ or Year Quit _____

Do you currently use recreational or street drugs? (including marijuana)	☐ Yes	☐ No
Have you EVER used recreational or street drugs in the past?	☐ Yes	☐ No
Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Have you ever been treated for addiction of any kind?	☐ Yes	☐ No
Have you ever used prescription pain medications in ways other than the way they were prescribed?	☐ Yes	☐ No
Is there any history of drug or alcohol abuse in your family?	☐ Yes	☐ No
Are you sexually active?	☐ Yes	☐ No
If yes, are you trying for a pregnancy?	☐ Yes	☐ No
Have you ever been treated for a sexually transmitted disease (STD)?	☐ Yes	☐ No
Do you live alone?	☐ Yes	☐ No

Other than yourself please list the number of people who live in your home, their ages, and their relationship to you: _____

_____

FAMILY HISTORY

Family Member		Age	Age at Death	Significant Health Problems/Cause of Death
Mother				
Father				
Siblings	(M or F)			
	(M or F)			
	(M or F)			
	(M or F)			
Children	(M or F)			
	(M or F)			
	(M or F)			
	(M or F)			
	(M or F)			
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				