# ATLAS SPINE, LLC

**201 Creek Crossing Blvd**
**Hainesport, NJ 08036**
**Ph. (609) 261-5800 Fx. (609) 261-5801**

Date____________________

Patient's Name:______________________________ Age:______Date of Birth:__________Sex: M____ F_____

Address:_________________________________City:______________State:________Zip Code: ____________

S.S.#:________________Marital Status:__________Home Phone#____________Cell Phone#________________

Race:________________Ethnicity:______________Language(s):_____________________________________

Employer:____________________________Phone#:________________________ Retired: Yes____ No________

Occupation:_________________ Full-time or Part-time(circle one) Full Time Student: Yes_____No_________

Address:_____________________________City:____________________State:________ZipCode:____________

Spouse's Name:____________________________Date of Birth:________________S.S.#_____________ ______

Employer:________________________________Phone#____________________________________________

Employer Address:________________________City:________________State:________ZipCode:____________

In case of an emergency contact (other than spouse): ___________________________________________________

Relationship:__________________________ Phone#: ______________________________________________

INSURANCE

Please list insurance companies you have coverage through below in order of coverage, and provide your card to be copied. Also, you must notify us if this is an accident or work related visit.

1) __________________________________________________________________________________________

2) __________________________________________________________________________________________

3) __________________________________________________________________________________________

**AUTHORIZATION:**

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. ALL COPAYS ARE PAYABLE AT THE TIME OF SERVICE.

I HERBY AUTHORIZE ATLAS SPINE, LLC TO FURNISH INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENTS) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO CHARLESTON DIABETES & ENDOCRINE CONSULTANTS, PLLC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Signature of Patient or ResponsibleParty:____________________________________Date:___________________________

**HIPAA ACKNOWLEDGEMENT: I have been given ATLAS SPINE, LLC's HIPAA Policy.**

Signature of Patient or ResponsibleParty:____________________________________Date:______________ ___________

I would like ____________________________ to be my Authorized Representative if I am not available.

***Please give receptionist a current copy of your insurance card(s) along with photo ID

**Atlas Spine, LLC**
**Orin K. Atlas, M.D.**
**201 Creek Crossing Blvd.**
**Hainesport, NJ  08036**

**Primary Insurance**

**Insurance Policy Holder's Name** ______________________________________________

**Relationship to Patient** _____________________________________________________

**Carrier** __________________________________ **Phone** ___________________________

**Address** _________________________________________________________________

**Policy ID** ________________________________ **Group** ___________________________

**Subscriber's Birth Date** ______________________________________________________

**Subscriber's SS# (if other than patient)** __________________________________________

**Does your insurance require pre-authorization for office visits or testing?**

**Yes** ________________ **No** ___________________ **Uncertain** ______________________

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**Secondary Insurance**

**Insurance Policy Holder's Name** ______________________________________________

**Relationship to Patient** _____________________________________________________

**Carrier** __________________________________ **Phone** ___________________________

**Address** _________________________________________________________________

**Policy ID** ________________________________ **Group** ___________________________

**Subscriber's Birth Date** ______________________________________________________

**Subscriber's SS# (if other than patient)** __________________________________________

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**Worker Compensation or Motor Vehicle Information**

**If your injury is Workers Compensation or Motor Vehicle related, please specify by circling below and completing this page. If not, please circle Not Applicable and go to the next page.**

**Worker Compensation** **Motor Vehicle** **Not Applicable**

**Carrier** ____________________________________________ **Claim #** ____________________________

**Claims Office Address** ____________________________________________________________________

________________________________________________________________________________________

**Adjuster/Case Manager Name** ____________________________________________________________

**Adjuster's Phone/Fax #** __________________________________________________________________

**Date of Injury** __________________________________________________________________________

**Employer Name** _________________________________________________________________________

**Are you represented by an attorney?** **Yes or No** **(circle one)**

**Please provide attorney name/address/phone/fax below:**

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

**Are you presently working?** **Yes or No** **(circle one)**

**If not, when was your last day of work?** ___________________________________________________

________________________________________________________________________________________

**Atlas Spine, LLC**
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**201 Creek Crossing Blvd.**
**Hainesport, NJ 08036**

**Symptoms and Conditions**

**What is your main complaint?** ____________________________________________

**What symptoms have you been having?** ______________________________________

______________________________________________________________________

______________________________________________________________________

**How long have you been having these symptoms?** _______________________________

______________________________________________________________________

**Have you been seen by another doctor for this condition? Yes or No (circle one)**

**Please describe your past treatment for this condition:**

**Please List Previous Spine Surgeries**

**Type** ___________________________________________________________________

**Date** ____________________ **Surgeon** _______________________________________

**Type** ___________________________________________________________________

**Date** ____________________ **Surgeon** _______________________________________

**Type** ___________________________________________________________________

**Date** ____________________ **Surgeon** _______________________________________

**Physical Therapy**

**Place & Therapist** _________________________________________________________

**Name** __________________________________________ **Date** __________________________

**Pain Management/Injections**

**Doctor** _________________________________________________________________

**Type of Injection** ________________________________ **Number of Injections** ______________

______________________________________________________________________

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**Medical Conditions, Medications, Allergies and Studies**

**Please list all your medical conditions:** ________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**Please list all the medications your are currently taking:**

**Medication** ______________________ **Dosage** ______________ **Duration** ______________

**Medication** ______________________ **Dosage** ______________ **Duration** ______________

**Medication** ______________________ **Dosage** ______________ **Duration** ______________

**Medication** ______________________ **Dosage** ______________ **Duration** ______________

**Pharmacy Name & Phone** ________________________________________________________

**Known Allergies** ______________________________________________________________

**Please list any tests/studies you have had in the past pertaining to this visit such as MRI, CT scans, or X-rays:**

______________________________________________________ **Date** ________________

______________________________________________________ **Date** ________________

______________________________________________________ **Date** ________________

______________________________________________________ **Date** ________________

______________________________________________________ **Date** ________________

**Please list what test/studies you have with you today for doctor to review:**

________________________________________________________________________________

________________________________________________________________________________

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**Review of Symptoms**

**Please check below all that you are currently experiencing:**

**General**
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ Memory Loss/Confusion
- ☐ Depression
- ☐ Night Sweats
- ☐ HIV infection or AIDS
- ☐ Arthritis

**Head and Neck**
- ☐ Eye Disease or Injury
- ☐ Wear Glasses/Contacts
- ☐ Blurred or Double Vision
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Earaches or Drainage
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Mouth Sores
- ☐ Bleeding Gums
- ☐ Bad Breath or Taste
- ☐ Sore Throat/Voice Change
- ☐ Swollen Glands in Neck
- ☐ Snoring
- ☐ Facial Pain
- ☐ Allergies

**Heart and Cardiovascular**
- ☐ Heart disease
- ☐ Chest pains
- ☐ Hypertension
- ☐ Angina
- ☐ Anemia
- ☐ Pacemaker
- ☐ Swelling of ankles, hands

**Musculoskeletal**
- ☐ Joint Pain
- ☐ Joint Stiffness/Swelling
- ☐ Muscle Weakness
- ☐ Back Pain
- ☐ Difficulty walking

**Neurological**
- ☐ Headaches
- ☐ Head Injury
- ☐ Numbness
- ☐ Black-Outs
- ☐ Paralysis
- ☐ Tremors
- ☐ Seizures
- ☐ Strokes

**Respiratory System**
- ☐ Hoarseness
- ☐ Chronic Cough
- ☐ Throat Clearing
- ☐ Heart Burn
- ☐ Spitting up blood
- ☐ Shortness of Breath
- ☐ Asthma/Wheezing
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Lung Cancer

**Endocrine**
- ☐ Diabetes
- ☐ Thyroid Imbalance
- ☐ Glandular/Hormone
- ☐ Menstrual disorders
- ☐ Heat/Cold intolerance
- ☐ Excessive thirst

**Hematological/Lymphatic**
- ☐ Anemia
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Swollen glands
- ☐ Slow to heal after cuts
- ☐ Easily bruised

**Gastrointestinal**
- ☐ Difficulty/Pain Swallowing
- ☐ Constipation
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Diverticulosis
- ☐ Gallbladder disease
- ☐ Diarrhea

**Urologic**
- ☐ Difficulty on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Prostate problems

**Skin and Breath**
- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Varicose Veins
- ☐ Breast pain
- ☐ Breast lump
- ☐ Breast Discharge

**Patient Name** ______________________________________________ **Date** ______________

_____________________________________________________________________________

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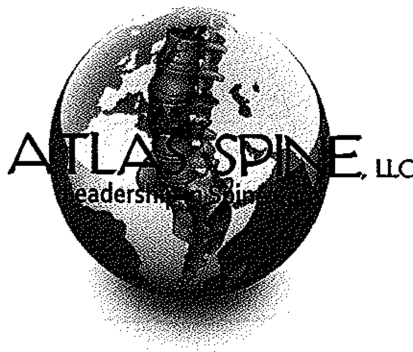
**Orin K. Atlas, MD**
Board Certified in Orthopedic Surgery
Fellowship Trained Spine Surgeon

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www.atlasspinellc.com

# MEDICATION AGREEMENT/POLICY

I _________________________________________understand that I am entering into an agreement between myself and ATLAS SPINE, LLC and Dr. Orin Atlas. The conditions of this agreement cannot be changed or altered under any condition. They are as follows:

1. I will take **ONLY** the amount of medication prescribed at the frequency prescribed. Increasing the amount of medication prescribed without consent may be harmful. It may also result in me completing my medication prior to my renewal date. In this case I will have to wait until my renewal date to refill my medication.

2. I will not interchange medication or give prescription drugs away.

3. It is the policy of ATLAS SPINE, LLC that prescription refills will require **72 hours notice.** Also, **NO** prescriptions will be written or called in to a pharmacy between Friday 2:00 pm and 8:00 am on Monday. Please be sure to evaluate your prescription requirements accordingly.

4. I understand that treatment can be discontinued if I:
   - A. Give away, sell or misuse the drug(s)
   - B. OBTAIN narcotics from any other doctor or source
   - C. If the doctor feels that the narcotic has not been effectively managing your pain

5. I will use only one pharmacy to fill my medication.. I agree to utilize: Name of Pharmacy:________________________ Located:________________________________
Pharmacy phone number is:________________________________________ If I change my pharmacy for any reason, I agree to notify ATLAS SPINE, LLC at the time I receive a new prescription.

6. I also understand that my usage of narcotic medications will be communicated with my family/referring physician and pharmacy on a regular basis.

7. I agree to random drug testing via methods of saliva, urine, or blood testing to determine my compliance with the use of my pain medications and to determine if I am using any illegal controlled substances such as marijuana, cocaine, etc. I understand this information is crucial in my care and the Doctors ability to treat my pain. My misuse or abuse of any medication, prescribed or illegal will immediately terminate my doctor/patient relationship and will cause my care to be transferred back to my primary care physician at his or her discretion. Atlas Spine, LLC at such time that it is found that I have misused any substance will be obligated only to provide me with the names and phone numbers of facilities that I may contact on my own to seek treatments if I feel necessary.

I have read and understand this document in its entirety. I consent to the terms and conditions stated. I also know that failure to abide to the terms of the agreement will result in the immediate termination of my Doctor/Patient relationship.

Signed:____________________________________Dated:__________________

# HIPAA FORM 1

## ATLAS SPINE, LLC

## NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### A. PURPOSE OF THE NOTICE

Atlas Spine, LLC ("Atlas") is committed to preserving the privacy and confidentiality of your health information. We are required by law to explain how we may use health information about you and when we can give out information about you to others. You also have rights regarding your health information, as described in this Notice. "Protected Health Information" or "PHI" includes any information that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care. We are required to abide by the terms of this Notice currently in effect. We also have the right to change our privacy practices.

### B. HOW WE USE OR DISCLOSE HEALTH INFORMATION

1. We must use and disclose your PHI to provide information:

   a. To you or someone who has the legal right to act for you (your personal representative).

   b. To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

   c. Where required by law.

2. We have the right to use and disclose PHI to treat you, pay for your health care, and operate our business. For example, we may use your PHI:

   a. *For Treatment*. We may disclose PHI to other health care providers, like your family doctor to help them provide care to you. We may also use your PHI to plan your care and treatment.

   b. *For Payment*. We may use your PHI to bill and receive payment from you, your insurer, or a government program for the services we provide to you.

   c. *For Health Care Operations*. We may use your PHI to assess and improve the services that we provide.

3. We may use or disclose your PHI for the following purposes in limited circumstances:

   a. *To Family Members and Friends*. We may disclose your PHI to family members and people who identify themselves as close personal friends, who are involved in your care or who help pay for your care, so long as you do not object.

   b. *In an Incidental Disclosure*. We may disclose your PHI as a byproduct of another use or disclosure. For example, if an employee of Atlas is talking to you, another employee may inadvertently overhear the conversation.

   c. *To Comply With the Law*.

   d. *For Public Health Activities* such as reporting disease outbreaks and other public health reporting.

   e. *For Reporting Victims of Abuse, Neglect or Domestic Violence* to government authorities, including a social service or protective service agency.

   f. *For Health Oversight Activities* such as audits by government agencies that oversee the services provided by Atlas.

   g. *For Judicial or Administrative Proceedings* such as in response to a court order, search warrant or subpoena.

   h. *For Law Enforcement Purposes* such as providing limited information to locate a missing person.

   i. *For Research Purposes* such as research related to the prevention of disease or disability, if the study meets all privacy law requirements.

   j. *To Provide Information Regarding Decedents*. We may disclose information to a coroner, medical examiner or funeral director as necessary to carry out their duties.

   k. *For Organ Procurement Purposes*. We may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.

   l. *To Avoid a Serious Threat to Health or Safety* by, for example, disclosing your PHI to a police officer if we reasonably believe it is necessary to prevent a serious threat to your safety.

m. *For Specialized Government Functions* such as military and veteran activities, national security and intelligence activities.

n. *For Workers Compensation* including disclosures required by state workers compensation laws of job-related injuries.

o. *To Disaster Relief Agencies*. We may disclose your PHI to disaster relief agencies, such as the Red Cross.

## C. USES AND DISCLOSURES PURSUANT TO YOUR WRITTEN AUTHORIZATION

The law only allows us to use and disclose your PHI for the purposes described in Section B above. If we would like to make a use or disclosure for any other purpose – including using or disclosing psychotherapy notes, using or disclosing PHI for marketing purposes, or making certain disclosures that constitute the "sale of PHI" – we will ask you to sign an authorization. If you have provided an authorization, you may revoke it at any time in writing, but the revocation will not apply to uses or disclosures we have already made in reliance on that authorization.

## D. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI. You may exercise each of these rights, in writing, by providing us with a completed form that you can obtain from any employee of Atlas. However, you are permitted to request access to your clinical records either orally or in writing. In some instances, we may charge you for the cost(s) associated with providing you with the requested information.

1. Right to Inspect and Copy. You have the right to see and obtain a copy of your health records and other PHI maintained by Atlas that may be used to make decisions about you. Immediate access to your records is not guaranteed. In certain limited circumstances, we may deny your request and you have a right to review such denial. If your PHI is maintained in an electronic form (e.g., in an electronic medical record), you have the right to request an electronic copy of your record be given to you or transmitted to another individual or entity.

2. Right to Amend. You have the right to ask to amend PHI that we maintain about you if you believe that the information about you is wrong or incomplete. We may deny your request if it was not properly submitted or for other reasons. If we deny your request, you may have a statement of your disagreement added to your file.

3. Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures of your PHI made by us. We may charge a reasonable fee for the second request made by you within the same 12 months. This accounting will not include certain disclosures of PHI including those that we made to you or for purposes of treatment, payment or health care operations, incidental disclosures, or pursuant to a written authorization that you have signed (unless such disclosures were made through an electronic medical record, in which case you have a right to request an accounting of those disclosures made during the 3 years before your request).

4. Right to Request Restrictions. You have the right to request a restriction or limitation on how we use or disclose your PHI. You also have a right to restrict disclosures to family members or others who are involved in your health care or payment for your care. Please note that while we will consider your request, we are not required to agree to any restriction.

5. Right to Request Confidential Communications. You have the right to request that we communicate with you about your health care in certain ways or at certain locations (for example, by sending information to a P.O. box rather than your home). We will accommodate all reasonable requests.

6. Out of Pocket Payments. If you pay out-of-pocket in full for an item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

7. Right to Notice of Security Breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive notice by e-mail) of any breach of your unsecured PHI as soon as reasonably practicable but in any event within 60 days of discovering the breach.

8. Right to a Paper Copy of this Notice. You have the right to receive a paper copy of this Notice.

## H. QUESTIONS OR COMPLAINTS

If you have any questions regarding this Notice or wish to receive additional information about our privacy practices, please contact our Privacy Officer who can be reached by calling 609-261-5800. If you believe your privacy rights have been violated, you may file a complaint with Atlas or with the Secretary of the DHHS (1-800-368-1019). To file a complaint with Atlas, contact our Privacy Officer at the number above. All complaints must be submitted in writing.

## HIPAA FORM 2

**Atlas Spine, LLC**

**Acknowledgement of Receipt of Notice of Privacy Practices**

I, ______________________________ (name of patient), date of birth ________________, Social Security No. ___________________, acknowledge and agree that I have received a copy of Atlas Spine, LLC's Notice of Privacy Practices.

| ______________________________ | ______________________________ |
|---|---|
| Signature Patient or Personal Representative | Date |
| ______________________________ | ______________________________ |
| Print Name of Personal Representative (if applicable) | Relationship of Personal Representative to Patient |

If this acknowledgement is signed by someone who is not the patient listed at the top of this form, provide a description of the signer's authority to act for the patient.

______________________________________________________________

**FOR OFFICE USE ONLY:**

**Atlas Spine, LLC** made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Information Practices:

( ) Patient/ personal representative was offered copy and individual refused to accept delivery.

( ) Patient/ personal representative accepted delivery of copy but refused to sign form to acknowledge Receipt of Notice.

( ) Other: ______________________________________________

| ______________________________ | ______________________________ |
|---|---|
| **Staff Member Signature** | **Date** |

______________________________

**Print Name**