PATIENT DEMOGRAPHIC INFORMATION

Name:			DOB:	Sex: M [ ] F [ ]
Address:			Home Phone:	
			Cell Phone:	
City:	State:	Zip:	Work Phone:	

Pharmacy Name:	Marital Status: [ ] Married [ ] Single
Pharmacy Phone:	[ ] Divorced [ ] Widow
Email:	Preferred Language:
Ethnicity: [ ] Hispanic or Latino [ ] Non-Hispanic or Latino	
Race: [ ] Asian [ ] American Indian or Alaska Native [ ] Black or African American	
[ ] White [ ] Native Hawaiian or Other Pacific Islander [ ] Patient Declined	

Employment Information: [ ] Employed [ ] Unemployed [ ] Retired [ ] Other	
Employer's Name:	Occupation:

Referring Physician:	Primary Physician:

Emergency Contacts		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

Responsible Party (if patient is under 18)		
Name:		Home Phone:
DOB:	Address:	
Employer:		

Primary Insurance:	Secondary Insurance:
Insurance Name:	Insurance Name:
ID#:	ID#:
Group#:	Group#:
Subscriber Name:	Subscriber Name:
Relationship to Patient:	Relationship to Patient:
Subscriber DOB:	Subscriber DOB:

Work Related Injury: [ ] YES (complete section below) [ ] NO	
Insurance Name:	Insurance Phone:
Claim Number:	Date of Injury:
Employer at time of injury:	

Medical History Form

To help us better evaluate your condition, please complete the following form. If you have any questions, we will be glad to help you. Thank you.

Name: ____ **DOB:**_____________________________

Please List Current Medications and Dose

____ ____

____ ____

____ ____

____ ____

Please List Medical Allergies and Corresponding Reactions

____ ____

____ ____

_____**I have no known allergies.**

Past Medical History
(Please circle conditions that you have a history of)

Alcoholism	Blood Transfusions	Heart Pain /Angina	Lung Cancer	Severe Allergy
Anemia	Bowel Disease	Hepatitis A	Lung / Respiratory Disease	Skin Cancer
Anesthetic Complications	Breast Cancer	Hepatitis B	Mental Illness	Stroke / CVA Brain
Anxiety	Cervical Cancer	Hepatitis C	Migraines	Suicide Attempt
Arthritis	Colon/Rectal Cancer	High Blood Pressure	Osteoporosis	Tyroid Problems
Asthma	Depression	High Cholesterol	Prostate Cancer	Ulcer
Autoimmune Problems	Diabetes	HIV	Reflux / Gerd	Other Disease or Cancer
Birth Defects	Development Disorder	Kidney / Bladder Disease	Seizures / Convulsions	NONE of the Above
Bleeding Disease	Heart Attack	Liver Cancer	Sexually Transmitted Disease	
Blood Clots	Heart Disease	Liver Disease		

Past Surgical History

Type of Surgery	Date
_______________________________________	_____________________
_______________________________________	_____________________
_______________________________________	_____________________
_______________________________________	_____________________

Family History
(Please circle conditions your family has a history of)

Family History Unknown	Bleeding Disorders	High Blood Pressure	Seizures / Convulsions
Alcoholism	Breast Cancer	High Cholesterol	Severe Allergy / Hives
Anemia	Colon /Rectal Cancer	Kidney / Bladder Disease	Stroke / CVA of Brain
Anesthetic Problems	Depression	Lung / Respiratory Disease	Thyroid Problems
Arthritis	Diabetes	Migraines	Other Disease or Cancer
Asthma	Heart Disease	Osteoporosis	None of the Above

Has your mother, grandmother or a sister developed heart disease before the age of 65? YES NO

Has your father, grandfather, or a brother developed heart disease before the age of 55? YES NO

Name: ____ DOB: _____________________________

RISK FACTORS:

Tobacco Use

Are you exposed to passive (second hand) smoke? YES NO

How would you describe your cigarette smoking status? Current Previous Never

(If you marked Never, skip to next section)

At what age did you begin smoking? _______ If you quit smoking, at what age did you quit? _______

How many cigarettes do you currently smoke or did you previously smoke per day? _______

How many cigars or pipes do you smoke per week? _______

How many cans of smokeless/chewing tobacco do you use per week? ______

Drug Use

Do you use recreational drugs? YES Type: _____________________ NO

HIV High Risk Behavior

Do you have a history of?
IV Drug Use / More than one sexual partner / Unprotected Sexual Contact YES NO Prefer to Discuss with Physician

Alcohol Use

How often do you drink alcohol? Never or Number of drinks per week:______

(If you marked Never, skip to next section)

What type of alcohol do you drink? Beer Wine Liquor

How many drinks do you have per occasion? ______

How often do you have more than five drinks per occasion? Never Rarely Occasionally Frequently

Habits

Do you drink caffeine-containing products? Coffee Tea Soft Drinks N/A

How many per day? ________

Do you exercise? Never Occasionally Frequently Times per Week: 1-2 3-4 4-6 7+

Types of Exercise Bicycling Running Swimming Walking Aerobics Other

How often do you wear a seatbelt? % of time used: 100% 75% 50% 25%

What is your sun exposure? Rare Occasional Frequent

Preventative Care (female only):

Date of last mammogram (approximate date ok) :________________
Date of last pap smear (approximate date ok): __________________

Current Height: _________inches Current Weight: ________pounds

Name: ____ **DOB:** _____________________________

STOP-Bang Scoring Tool

To detect suspected Obstructive Sleep Apnea (OSA)

Have you ever been diagnosed with OSA?	YES	NO
a. If YES, do you have a CPAP machine?	YES	NO
b. If YES, are you currently using the CPAP machine?	YES	NO

If you answered NO to the above question, please answer the questions below.

Snore	**Do you snore loudly?** *(Louder than talking or loud enough to be heard through closed doors)*	**YES**	**NO**
Tired	**Do you often feel tired, fatigued or sleepy during daytime?**	**YES**	**NO**
Observed	**Has anyone observed you stop breathing during your sleep?**	**YES**	**NO**
Pressure	**Do you have, or are you being treated for high blood pressure?**	**YES**	**NO**
BMI	**Is your BMI more than 35?** *(We can calculate Height_____ Weight_____)*	**YES**	**NO**
Age	**Are you over 50 years old?**	**YES**	**NO**
Neck	**Is your neck circumference greater than 17”(male) or 16”(female)?** *(We can measure)*	**YES**	**NO**
Gender	**Are you a male?**	**YES**	**NO**

If you answered YES to 3 more questions, you are at high risk of having obstructive sleep apnea (OSA). We will talk to you more during the visit about OSA increased risk when having surgery and when taking prescription narcotics. In addition, we’ll send a letter to your PCP recommending further evaluation and consideration of sleep study.

Oswestry Pain Disability Questionnaire

Patient Name:___________________________________ **DOB:**________________

Please complete this questionnaire. It is designed to tell us how your back pain affects your ability to function in everyday life.

Rate your **Back or Neck pain** (1=minimal pain and 10=worst pain):

0 1 2 3 4 5 6 7 8 9 10

Rate your **Limb Pain** (1=minimal pain and 10=worst pain):

0 1 2 3 4 5 6 7 8 9 10

Please answer each section below by checking the One Choice that applies the most to you at this time.

(You may feel that more than one of the statement relates to you at this time, but it is very important that you, but please check only one choice that best describes your problem at this time.)

Section 1: Pain Intensity
□ I can tolerate the pain I have without having to use pain killers.
□ The pain is bad but I manage without taking pain killers.
□ Pain killers give complete relief from pain.
□ Pain killers give moderate relief from pain.
□ Pain killers give very little relief from pain.
□ Pain killers have no effect on the pain and I do not use them.

Section 2: Personal Care
□ I can look after myself normally without causing extra pain.
□ I can look after myself normally but it causes extra pain.
□ 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 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 for example 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 1 mile.
□ Pain prevents me walking more than 0.5 miles.
□ Pain prevents me walking more than 0.25 miles.
□ 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 only sit in my favorite chair as long as I like.
□ Pain prevents me sitting more than 1 hour.
□ Pain prevents me from sitting more than 0.5 hours.
□ Pain prevents me from sitting 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 for more than 1 hour.
□ Pain prevents me from standing for more than 30 minutes.
□ Pain prevents me from standing for more than 10 minutes.
□ Pain prevents me from standing at all.

Section 7: Sleeping
□ Pain does not prevent me from sleeping well.
□ I can sleep well only by using tablets.
□ Even when I take tablets I have less than 6 hours sleep.
□ Even when I take tablets I have less than 4 hours sleep.
□ Even when I take tablets I have less than 2 hours of sleep.
□ Pain prevents me from sleeping at all.

Section 8: Sex Life
□ 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 gives 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 energetic interests such as dancing.
□ Pain has restricted my social life and I do not go out as often.
□ Pain has restricted my social life to my home.
□ I have no social life because of pain.

Section 10: Traveling
□ I can travel anywhere without extra pain.
□ I can travel anywhere but it gives me extra pain.
□ Pain is bad but I manage journeys over 2 hours.
□ Pain restricts me to journeys of less than 1 hour.
□ Pain restricts me to short necessary journeys under 30 minutes.
□ Pain prevents me from traveling except to the doctor or hospital.

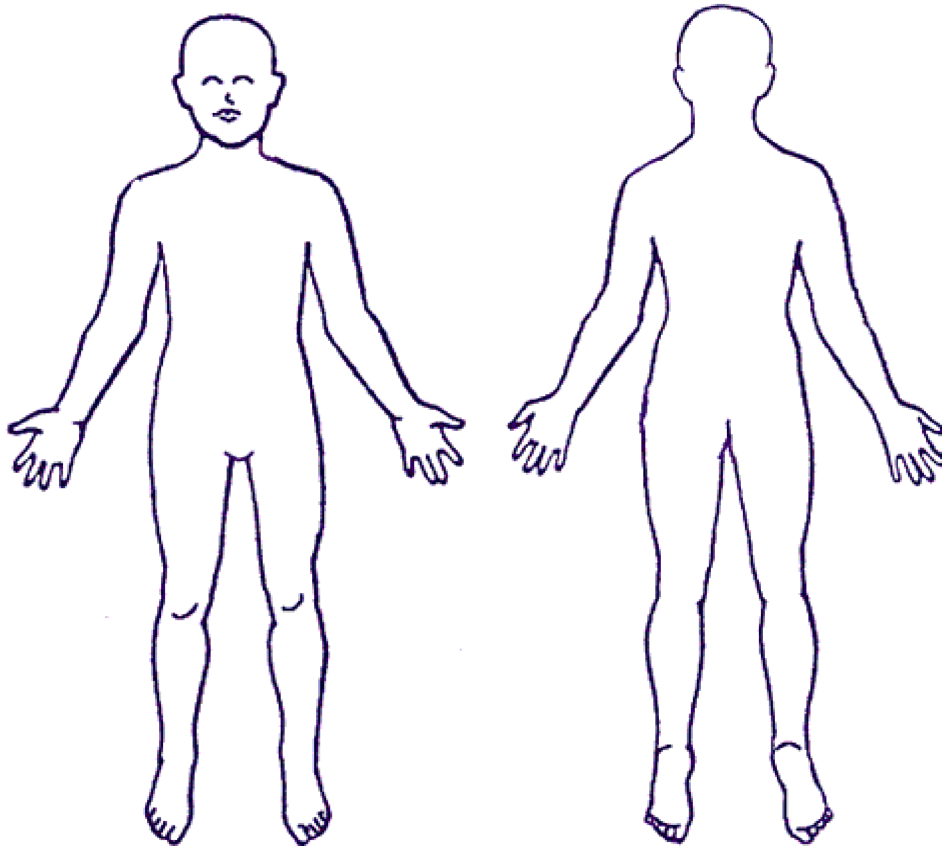
PAIN CHART

Patient Name: ______________________________________ **DOB: ______________**

Current Problem Pain Diagram

Mark the area of your body where you feel painful sensations. Use the appropriate symbols::

Numbness, pins and needles, burning - 00
Aching, grabbing, cramping - XX
Shocking, stabbing, electric - \\



When did symptoms start? ____

Review of Systems

Patient Name: ____ **DOB:** _____________________

General: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Fevers
- ☐ Appetite loss
- ☐ Fatigue (always tired)
- ☐ Chills
- ☐ Weight loss
- ☐ Sweats
- ☐ "feeling sick"
- ☐ None

Eyes: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Vision loss – 1 eye
- ☐ Vision loss – both eyes
- ☐ "halos" around lights
- ☐ Double vision
- ☐ Blurring
- ☐ Discharge
- ☐ Eye irritation
- ☐ Eye pain
- ☐ Light sensitivity
- ☐ None

Ears/Nose/Throat: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Ringing in the ears
- ☐ Decreased hearing
- ☐ Difficulty swallowing
- ☐ Ear discharge
- ☐ Nasal congestion
- ☐ Hoarseness
- ☐ Earache
- ☐ Nosebleeds
- ☐ Sore throat
- ☐ None

Cardiovascular: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Difficulty breathing at night
- ☐ Racing/skipping heart beats
- ☐ Shortness of breath with exertion
- ☐ Difficulty breathing while lying down
- ☐ Bluish discoloration of lips or nails
- ☐ Near fainting
- ☐ Fatigue
- ☐ Palpitations
- ☐ Fainting
- ☐ Weight gain
- ☐ Chest pain or discomfort
- ☐ Lightheadedness
- ☐ Swelling of hands or feet
- ☐ Leg cramps with exertion
- ☐ None

Respiratory: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Sleep disturbances due to breathing
- ☐ Coughing up blood
- ☐ Excessive sputum
- ☐ Cough
- ☐ Chest discomfort
- ☐ Excessive snoring
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ None

Gastrointestinal: (Mark all that apply; If no symptoms, please mark "none")

- ☐ Excessive appetite
- ☐ Vomiting blood
- ☐ Yellowing skin color
- ☐ Abdominal bloating
- ☐ Change in bowel habits
- ☐ Bloody stools
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Indigestion
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Dark tarry stools
- ☐ None

Genitourinary: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Foul urinary discharge
- ☐ Inability to empty bladder
- ☐ Trouble starting urinary stream
- ☐ Inability to control bladder
- ☐ Excessively heavy periods
- ☐ Other abnormal vaginal bleeding
- ☐ Blood in urine
- ☐ Urinary urgency
- ☐ Painful urination
- ☐ Genital sores
- ☐ Missed periods
- ☐ Pelvic pain
- ☐ Urinary frequency
- ☐ Kidney pain
- ☐ Night time urination
- ☐ Lack of sexual drive
- ☐ Unusual urinary color
- ☐ None

Musculoskeletal: (Mark all that apply; if no symptoms, please mark “none”)

- ☐ Muscle cramps
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Presence of joint fluid
- ☐ Back pain
- ☐ Stiffness
- ☐ Muscle weakness
- ☐ Arthritis
- ☐ Gout
- ☐ Loss of strength
- ☐ Muscle aches
- ☐ None

Skin: (Mark all that apply; if no symptoms, please mark “none”)

- ☐ Excessive perspiration
- ☐ Dryness
- ☐ Itching
- ☐ Changes in nail beds
- ☐ Skin cancer
- ☐ Rash
- ☐ Unusual hair distribution
- ☐ Flushing
- ☐ None
- ☐ Changes in color of skin
- ☐ Suspicious lesions
- ☐ Night sweats
- ☐ Poor wound healing

Neurologic: (Mark all that apply; if no symptoms, please mark “none”)

- ☐ Difficulty with concentration
- ☐ Poor balance
- ☐ Headaches
- ☐ Disturbances in coordination
- ☐ Numbness
- ☐ Inability to speak
- ☐ Falling down
- ☐ Tingling
- ☐ Brief paralysis
- ☐ Visual disturbances
- ☐ Seizures
- ☐ Weakness
- ☐ Sensation of room spinning
- ☐ Tremors
- ☐ Fainting
- ☐ Excessive daytime sleeping
- ☐ Memory loss
- ☐ None

Psychiatric: (Mark all that apply; if no symptoms, please mark “none”)

- ☐ Sense of great danger
- ☐ Anxiety
- ☐ Thoughts of violence
- ☐ Mental problems
- ☐ Depression
- ☐ None
- ☐ Frightening visions or sounds
- ☐ Thoughts of suicide

Endocrine: (Mark all that apply; if no symptoms, please mark “none”)

- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ none
- ☐ Excessive urination
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Weight change

Heme/Lymphatic: (Mark all that apply; if no symptoms, please mark “none”)

- ☐ Enlarged lymph nodes
- ☐ Bleeding
- ☐ Skin discoloration
- ☐ Abnormal bruising
- ☐ Fevers
- ☐ None

Allergic/Immunologic: (Mark all that apply; if no symptoms, please mark “none”)

- ☐ Persistent infections
- ☐ HIV exposure
- ☐ Hives or rash
- ☐ Seasonal allergies
- ☐ None

PAIN CONTRACT AND MATERIAL RISK NOTICE FOR USE OF NARCOTICS

Effective 09/21/2015

SUMMIT SPINE INSTITUE

Patient Name:_________________________________ **DOB**:_________________

I have been diagnosed with spinal disc disease/spondylosis and have been or may be prescribed one or more of the following controlled substances: Hydrocodone, Oxycodone, Dilaudid, Morphine, Fentanyl, and any other narcotics not listed.

Alternatives to the use of narcotics and pain medication are physical therapy, acupuncture, chiropractic care, etc.

Notice of Risk: The use of controlled substances may be associated with certain risks such as, but not limited to:

1. **Central Nervous System**: Sleepiness decreased mental ability, and confusion. Avoid alcohol while taking these medications and do not drive or operate machinery. Your ability to make decisions may be impaired.
2. **Cardiovascular**: Irregular heart rhythm from mild to severe.
3. **Respiratory**: Depression (slowing) of respiration and the possibility of inducing bronchospasm (wheezing) causing difficulty in catching your breath or shortness of breath in susceptible individuals.
4. **Gastrointestinal**: Constipation is common and may be severe. Nausea and vomiting may occur as well.
5. **Dermatological**: Itching and rash.
6. **Endocrine**: Decreased testosterone (male) and other sex hormones (female); dysfunctional sexual activity
7. **Urinary**: Urinary retention (difficulty urinating).
8. **Pregnancy:** Newborn may be dependent on opioids and suffer withdrawal symptoms after birth.
9. **Drug Interactions** with or altering the effect of other medications cannot be reliably predicted.
10. **Tolerance:** Increasing doses of drug may be needed over time to achieve the same (pain relieving) effect.
11. **Physical dependence and withdrawal:** Physical dependence develops within 3-4 weeks in most patients receiving daily doses of these drugs. If your medications are abruptly stopped, symptoms of withdrawal may occur. These include nausea, vomiting, sweating, generalized malaise (flue-like symptoms), abdominal cramps, palpitations (abnormal heartbeats). All controlled substances (narcotics) need to be slowly weaned (tapered off) under the direction of your physician.
12. **Addiction (Abuse):** This refers to abnormal behavior directed towards acquiring or using drugs in a non-medically supervised manner. Patients with a history of alcohol and/or drug abuse are at increased risk for developing addiction.
13. **Allergic reactions** are possible with any medication. This usually occurs early after initiation of the medication. Most side effects are transient and can be controlled by continued therapy or the use of other medications.
14. **Accidental Overdose:** In some instances, controlled substances may accumulate, leading to respiratory difficulty, coma, or death. This risk is increased by certain medical conditions, higher dose opioid treatment, other medications including tranquilizers, CNS depressants, alcohol, marijuana or other illicit drugs.
15. **Interactions:** other prescription medications (such as medications to treat anxiety, depression, etc.) when combined with narcotic pain medication may greatly increase side effects including sedation and cognition.

The following are guidelines for continued pain treatment under the care of Summit Spine Providers.

- Patient Treatment Goals: Reduction of pain, improved function and quality of life.

- I agree to use pain medication sparingly as part of my treatment but understand these medications may not totally eliminate my pain, rather will reduce and improve what I am able to do each day.

- I will not use illegal street drugs or use another person's prescription (including my immediate family's prescriptions). I will inform my physician of alcohol use and other legal drug use (marijuana, pain medications etc), past or present, as well as any history of alcoholism/addiction. If I am in a treatment program, I will provide documents from the treatment program to validate my progress and treatment.

- I consent to random or scheduled intermittent drug screening to assure I am taking only prescribed drugs. I understand that a drug screen is a laboratory test in which a sample of my urine is checked to see what drugs I am taking.

- I will keep all my scheduled appointments. If I need to cancel my appointment, I will do so a minimum of 24 hours before it is scheduled. A late cancelation fee of $50 may be applied for insufficient notification.

- **I understand that I have the following responsibilities with the prescribed medications:**

- I will notify my provider of an existing pain contract with another physician's office.

  [ ] YES Existing Pain Contract [ ] NO Existing Pain Contract

  ____

  Name and Phone Number of Provider with whom I have existing pain contract

- I will take my medications at the dose and frequency prescribed.
- I will not increase or change how I take my medications without the approval of the above providers.
- I will arrange for refills at the prescribed interval **ONLY during regular office hours**.
  Please allow our office 48 hours to process any refill requests.
- I will obtain all pain medications only at one pharmacy. I will inform my physician if I change pharmacies.
  - Pharmacy: ____
- I will authorize my physician to provide a copy of this contract to my pharmacy.
- I will not request any pain medications or controlled substances from other providers and will inform my provider of all other medications I am taking. I understand that other providers should not change the dose of my pain medications.
- I will inform other health care providers that I am taking these pain medications and of the existence of this contract. In the event of an emergency, I will provide this same information to emergency department providers.
- I will inform my physician of any new medications or medical conditions.
- I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced or refilled.
- I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.
- I will actively participate in any recommended assessments and programs designed to improve function, including social physical, psychological, and daily or work activities.

.

- **I understand that the above physicians may stop prescribing my pain medications if:**

- I do not show any improvement in pain or my activity has not improved.
- I develop rapid tolerance or loss of improvement from the treatment.
- I develop significant side effects from the medications.
- I break any part of the contract outlined above, which may also result in being prevented from receiving further
- care from this clinic.
- I refuse to consent to a drug screening.
- I miss two consecutively scheduled appointments with the above physicians.
- If my physician determines for any other reason that the pain treatment is not advisable.

- **Our office will prescribe pain medication only for the 60 day period immediately following surgery and for surgical pain only. For Spinal Cord Stimulator Surgery, patients receive ONE TIME prescription at discharge. After this time, should you continue to need assistance with pain management, please contact your PCP, referring provider, or ask for a referral to a pain management specialist. If you are already established with a pain management doctor who is prescribing pain medications for you, we will coordinate with their office to determine who should provide your post operative medications.**

I have read this contract or have had it read to me. I understand all of it. I have had a chance to have all my questions regarding this form answered to my satisfaction and desire no further explanation of information.

I am signing this form voluntarily, and I have full right and power to be bound by this agreement.

____ ______________________

Patient's Signature or Legal Guardian **Date**

Relationship to Patient:_______________________________

Financial Policy

Patient Name:____ **DOB:**__________________

J Rafe Sales MD, P.C is committed to providing the highest level of quality care and customer service to our patients. In an effort to provide clear communication with our patients, we have outlined our financial policies below. Please speak to your Physician or the Office Manager if you have any questions about this document.

Financial Responsibility:
It is the patient and/or their guardian's responsibility to meet the financial obligations for all healthcare services received. As we accept a large variety of different insurance plans, it is impossible for us to know all the covered benefits, co-pays and deductibles for each plan. In addition, insurance companies will not guarantee payment to us. Your insurance benefits are a contract between you and the insurance company. While our office will do everything within our means to obtain necessary authorizations and communicate with your insurance company, it is still your responsibility to ensure that all services rendered are paid in full.
Co-payments and deductibles are a contract responsibility between the patient and their insurance company. These amounts are non-negotiable.

Patients Without Insurance Coverage:
Payment at the time of service is required for all self-pay patients. Before being seen, we require a deposit of $200.00 for all new patient office consults and 50% of total estimated costs for all surgical procedures.

Participating Insurances:
We participate with a variety of insurance plans. It is your responsibility to:

- Verify with your insurance company that we are a contracted provider
- Bring your insurance card and picture ID to every visit
- Be prepared to pay your co-pay, if applicable, at the time of your visit
- Provide any referral required by your insurance prior to or at the time of your visit

Motor Vehicle Insurance:
Our office does accept motor vehicle insurance and, as a courtesy to our patients, we will bill third party motor vehicle plans on your behalf. Please provide all necessary billing and policy information at the time services are rendered. Our office does NOT accept legal letters of protection. We are willing and able to make special arrangements where legal cases are pending. However, these arrangement need to be made prior to the date of service. In the event that you are involved in a pending legal case, and surgery becomes necessary, a lien may be filed against your pending settlement in order to guarantee payment of your medical bills. You will be notified in writing if this is required.

Workers Compensation Claims:
If your visit is for a work related injury, our office cannot see you without a referral from the attending provider on your claim. J Rafe Sales MD, P.C providers will NOT serve as attending provider on workers compensation claims, except as required during the 90 day surgical global period following surgery. It is your responsibility to provide all necessary claim information prior to your first visit and your claim must be open and allowed for the condition we will be treating you for.

Appointments:
As a courtesy, 48 hours' notice is expected if you need to cancel or reschedule your appointment. Missed appointments may be assessed a fee.

Surgical Costs:
Your insurance company will be contacted to verify benefits and eligibility prior to surgery. Pre-payment of deductibles may be required. You will be provided with a surgical financial policy in the event you are scheduled for surgery.

Payment Plans:
In special situations, we are able to provide payment plans when necessary and appropriate. These arrangements can be made with our billing office. Please notify your physician's staff, if you require this option. All payment plan agreements will be submitted in writing. Should you be unable to keep to the terms of the agreement, your account will be sent to collections.

Collection Accounts:
If your account is sent to collections, you will need to contact our collection agency to make payment arrangements. You will be required to pre-pay for future office visits after having a bad debt account with us, even if you have paid the amount owing with the collection agency.

Form Fees

Because of the large volume of FMLA/Legal forms that come to our office, a $25.00 charge is due at the time the form is presented for completion. Please turn in forms as soon as possible as it may take up to 10 days for completion of your forms.

____ ______________________________

Patient's Signature or Legal Guardian **Date**

Relationship to Patient:_______________________________________

Patient Consent for Use and Disclosure of Health Information

Patient Name:____ **DOB:** _______________

I hereby give my consent for **J Rafe Sales MD** to use and disclose protected health information about me to carry out treatment, payment, and health care operations.
(The Notice of Privacy Practices provided by J Rafe Sales MD describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. J Rafe Sales MD reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to J Rafe Sales MD, 9155 SW Barnes Rd, Ste 210 Portland OR 97225.

With this consent, J Rafe Sales MD may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, J Rafe Sales MD may mail to my home or other alternative location any items that assist the practice in carrying out health care operations, such as appointment reminder cards and patient statements.

With this consent, J Rafe Sales MD may e-mail to my home or other alternative location any items that assist in carrying out health care operations, such as appointment reminders and patient statements.

I authorize the following individuals to have access to my protected health information:

____
Name Phone Number Relationship

____
Name Phone Number Relationship

I have the right to request that J Rafe Sales MD restrict how it uses or discloses my personal health information to carry out health care operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow J Rafe Sales MD to use and disclose my personal health information to carry out health care operations.

I authorize having my photograph taken for my Electronic Medical Record.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, J Rafe Sales MD may decline to provide treatment to me.

Insurance Authorization and Assignment

I attest that the insurance information I have given to the office is correct and true to the best of my knowledge. I hereby assign benefits to be paid to the doctor, and authorize J Rafe Sales MD to furnish information regarding my illness to my insurance carrier.

____ _________________________
Patient's Signature or Legal Guardian **Date**
Relationship to Patient:____________________________