Abhishiek Sharma, MD
Erik Curtis, MD

Atlas Neurosurgery & Spine

Personal information

Date: _____

Prefix: ___First name: _____ MI: _____ Last name: _____
Date of birth:_____ Age: _____ Social Security #: _____
Driver's license #: _____ Email: _____
Current mailing address: _____
City: _____ State: _____ ZIP code: _____
Home phone #: _____ Cellphone #: _____
Secondary address _____
City: _____ State: _____ ZIP code: _____
Sex: Male Female Neutral
Marital status: Single Married Partnered Divorced Widowed
If you are married or otherwise partnered, what is the person's name?
_____

Race:	Black/African-American	American Indian	Asian
	White	Hispanic or Latino	Alaska Native
	Native Hawaiian/Pacific Islander	Decline to answer	Other _____

Emergency contact information

I authorize Atlas Neurosurgery and Spine Center to discuss my selected information with the following people:

Contact name 1: _____ Relationship: _____
Home phone #: _____ Cellphone #: _____
Street address: _____
City: _____ State: _____ ZIP code: _____

Contact name 2: _____ Relationship: _____
Home phone #: _____ Cellphone #: _____
Street address: _____
City: _____ State: _____ ZIP code: _____

Patient/guardian signature: _____

Printed name: _____ Date: _____

Abhishiek Sharma, MD
Erik Curtis, MD

Atlas Neurosurgery & Spine

Insurance

Primary insurance: _____ Insurance company's phone #: _____
Policyholder's name (as on card): _____ Policyholder's relationship: _____
Insurance claims address: _____
Policyholder's DOB: _____ Policyholder's SSN: _____
Member ID/policy #: _____ Group #: _____

Secondary insurance: _____ Insurance company's phone #: _____
Policyholder's name (as on card): _____ Policyholder's relationship: _____
Insurance claims address: _____
Policyholder's DOB: _____ Policyholder's SSN: _____
Member ID/policy #: _____ Group #: _____

Attorney information

If your condition is the result of an accident or other injury for which you are represented by an attorney, please provide the following information about your attorney:

Name: _____ Phone #: _____
Street address: _____
City: _____ State: _____ ZIP code: _____

Auto insurance

If your condition or injury is the result of an automobile accident, please provide the following:

Company name: _____ Claim #: _____
Phone #: _____ Date of accident: _____
Name of policyholder: _____ Relationship: _____
State accident occurred in: _____ Adjuster name: _____
Have auto benefits been exhausted? Yes No

Workers' compensation

Company name: _____ Claim #: _____
Phone #: _____ Date of accident: _____
Name of insurance adjuster:_____

Pharmacy information

Name: _____
Address: _____
Phone _____

Abhishiek Sharma, MD
Erik Curtis, MD

Atlas Neurosurgery & Spine

Authorization to Discuss, Release and/or Obtain Medical Information

Patient Name:_____ Date of Birth: _____ Email: _____
Address:_____Preferred Phone: _____

I hereby authorize Atlas Neurosurgery and Spine Center to call and/or leave messages on my home phone, cell phone and/or email. I understand that each of these communications are NOT considered completely secure since someone else could access the information.

- I hereby authorize Atlas Neurosurgery and Spine Center to discuss my medical care with the following individuals (i.e. relatives/caregiver):

Name: _____Relationship:_____
Name: _____Relationship:_____

- I hereby authorize Atlas Neurosurgery and Spine Center to contact the following individual in case of an emergency:

Name: _____ Relationship:_____ Contact Number: (___)____-_____

- I hereby authorize Atlas Neurosurgery and Spine Center to RELEASE copies of the following medical records: ❒all my medical records ❒other records: _____

Release my medical records to this Individual/Institution/Physician: _____
Relationship: _____ Phone: (___)___-_____ Fax: (___)_____-_____
Address: _____ City: _____ ST:_____ ZIP: _____

- I hereby authorize Atlas Neurosurgery and Spine Center to OBTAIN copies of the following medical records: ❒all my medical records ❒other records: _____

Obtain my medical records from this Individual/Institution/Physician: _____
Relationship: _____ Phone: (___)___-_____ Fax: (___)_____-_____
Address: _____ City: _____ ST:_____ ZIP: _____

I authorize Atlas Neurosurgery and Spine Center to send/receive confidential information as the term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996) to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care and as authorized above. "The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning or authorizations in paragraph (b)(4) of [45 C.F.R. § 164.508] applies." 45 C.F.R. § 164.508(c)(2)(ii)(A). I understand a potential for information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy Rule. 45 C.F.R. § 164.508(c)(2)(iii). I may revoke this authorization in writing, except to the extent that we have already used/ disclosed your information. When your medical information is used/disclosed pursuant to this authorization it may be subject to re-disclosure by a person who received your information. This re-disclosure may not be protected by the applicable privacy laws. You have the right to submit a written request to inspect and copy your medical records. In certain limited circumstances this request may be denied. By signing below, I hereby release Atlas Neurosurgery and Spine Center from all legal responsibility/liability that may arise from the act I have authorized above.

_____ _____ _____
Name of Patient/Legal Representative Signature Date

Atlas Neurosurgery & Spine

Abhishiek Sharma, MD
Erik Curtis, MD

Pain Management Agreement

Patient Name:_____ Date of Birth: _____ Email: _____
Address:_____Preferred Phone: _____

Atlas Neurosurgery and Spine Center and I understand that the primary goal of care is to improve my neurological function and/or prevent further deterioration. Therefore, I agree to practice habits to improve my Neurological and spine health including but not limited to smoking cessation, maintaining a healthy body weight and exercise. I understand and acknowledge that Atlas Neurosurgery and Spine Center is not a pain management clinic and is is not responsible for treating my pain. However, pain medications i.e. narcotics, barbiturates, muscle relaxants, etc are prescribed for post-operative pain control for a period of up to 4 weeks post-operatively in accordance with the following:

- Opioids are used to treat acute and chronic pain with a goal to improve one's quality of life. The goal should be to not take the medication at all, or to stop taking it after no more than three days. One the pain is tolerable and you no longer need the opioid, you should dispose of them in a secure location as found on the AZ Department of Health Services safe. It should be understood that sharing or selling left over opioids is against the law. You should not operate a motor vehicle or heavy machinery while taking these medications. Instead of opioids, other over the counter agents such as acetaminophen or ibuprofen as advised by me physician could be used to control pain.
- A prescription for a controlled substance may not be provided if another active prescription is identified in AZPMP.
- Chronic pain patients will discuss their post-operative pain regimen with their primary pain management physician to avoid multiple prescriptions for controlled substances. They will obtain a regimen for post-operative pain control from their primary pain physician.
- I agree not to request, accept or solicit a prescription for a controlled substance while an active prescription exists from a healthcare practitioner at Atlas Neurosurgery and Spine Center.
- I understand that a refill of controlled prescriptions may be requested through clinic during hours of 8am to 5pm during a routine weekday in the immediate post-operative period only. The prescription will be provided electronically to the pharmacy on file in 72 hours' time.
- I understand that a violation of any of the above conditions may result in an immediate termination of the controlled substances prescription and potential treatment with Atlas Neurosurgery and Spine Center.

- I also give Atlas Neurosurgery and Spine Center permission to obtain a list of medications and controlled substances that I am currently taking.
- By signing this, I understand the potential for significant side effects or risks including but not limited to withdrawal symptoms of severe pain, abdominal cramps, muscle aches, joint aches, nausea, diarrhea, sweating, headaches, restlessness, irritability, discontent and cravings for more opioids. In addition, tolerance is state of adaptation in which using a drug routinely may lead to a reduction in ability to control pain over time and need for higher doses to deliver same pain control. Furthermore, addiction can occur in 5-10% of patients taking pain medications, even if they have never previously experienced an addictive disorder. Lastly, drinking alcohol and/or combining opioids with other medications (including but not limited to sedatives such as benzodiazepines, sleeping aides such as Ambien or Lunesta, and certain other psychiatric medications) increase the likelihood of death by overdose markedly.
- Other side effects include constipation, sedation, slowed or cessation of breathing, impaired judgment, impaired ability to drive, decreased libido and function. Taking opioid medications while pregnant (or if one becomes pregnant while taking opioids) may lead to a condition known as neonatal abstinence syndrome, where the newborn is dependent on opioids and go through life threatening withdrawal upon birth.

_____	_____	_____
Name of Patient/Legal Representative	Signature	Date

Abhishiek Sharma, MD
Erik Curtis, MD

Atlas Neurosurgery & Spine

Financial Policy

Atlas Neurosurgery and Spine Center is committed to serving our patients with professionalism and care. Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. As a courtesy, Atlas Neurosurgery and Spine Center will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you. For services performed outside of our clinic, i.e. radiology, laboratory, referrals, surgery centers, physical therapy, hospitals and rehabilitation centers, please consult your insurance prior to scheduling.

Please read, initial each blank and sign where indicated – this document describes your financial responsibilities. This is a legally binding contract between Atlas Neurosurgery and Spine Center and you. The words, I, me, my, you and your refer to the patient.

_____ (initial) I agree to be financially responsible for payment of Atlas Neurosurgery and Spine Center services. Cash, check or credit cards are acceptable forms of payment for these services.

_____ (initial) Current insurance cards must be presented at every office visit. Atlas Neurosurgery and Spine Center is not responsible for filing your insurance claim, but we will do so as a courtesy. Upon payment from my insurance carrier, I agree to pay the remaining balance immediately.

_____ (initial) I agree to give Atlas Neurosurgery and Spine Center my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that a failure to provide complete and accurate information about my insurance benefits may result in a denial of my claim or a delay in payment. I agree to pay the balance on my account after my insurance claim has been processed.

_____ (initial) I agree that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, that I will have to pay the estimated charges for my office visit in advance.

_____ (initial) I understand that I will be responsible for any missed appointments or any cancelled appointments where a 48-hour notice was not provided. There will be a fee of $50 for any missed office visits and $250 for any missed surgical procedures.

_____ (initial) I understand that all services provided to me by Atlas Neurosurgery and Spine Center are considered medically necessary. If I fail to have a procedure performed or do not comply with my provider's instructions it may be against medical advice and may void my insurance benefits. Should this occur, I agree to pay the balance remaining on my account after my insurance payment has been processed.

_____ (initial) I understand that my insurance may or may not agree to the usual, customary or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been approved in advance. In such a scenario, I agree to pay the balance remaining on my account.

_____ (initial) If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

_____ (initial) Atlas Neurosurgery and Spine Center will receive payment from my insurance company for covered services provided by my insurance benefits. I agree to pay co-payments and deductibles at the time of service. If co-payments are not made at the time of service, I understand that my appointment may be rescheduled.

_____ (initial) I understand and agree that if my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

I have read and understand these financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Patient Signature Date

Abhishiek Sharma, MD
Erik Curtis, MD

Atlas Neurosurgery & Spine

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to Atlas Neurosurgery and Spine Center. This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS. This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original document.

I authorize the release of any medical information necessary in order to obtain payment. I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges incurred during the process of settling my account. I understand that I am solely responsible for all charges during a lapse in insurance or lack thereof. I authorize Atlas Neurosurgery and Spine Center to deposit checks received on my account when made out in my name.

I have read and I understand these financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Atlas
Neurosurgery & Spine

Abhishiek Sharma, MD
Erik Curtis, MD

NOTICE TO PATIENTS

A physician must notify a patient that the physician has a direct interest in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-1401(27)(ff). We support this law because it helps patients make reasoned financial decisions concerning their medical care. In compliance with the requirements of this law, you are being advised we have a direct interest in the diagnostic or treatment agency or in the non-routine goods or services named below:

Dr. Sharma has medical consulting agreements with Medtronic, A-tec and Johnson & Johnson. He also has a direct financial interest with Banner Health and Scottsdale Healthcare Hospitals D/B/A HonorHealth whereby the hospital shares with the physicians a portion of the savings attributed to quality enhancement and cost savings arrangement. These arrangements include spine implants, biologics and spine ancillary products.

Dr. Curtis has a direct financial interest with Banner Health and Scottsdale Healthcare Hospitals D/B/A HonorHealth whereby the hospital shares with the physicians a portion of the savings attributed to quality enhancement and cost savings. These arrangements include spine implants, biologics and spine ancillary products.

Multiple other health care companies offer the same equipment that may accomplish the goals of the equipment provided by the above health care companies listed. You are encouraged to ask any of our physicians their reasons for choosing instruments from the above listed companies, or any other instrument, in your treatment. The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. We will keep the signed original in your patient file and you may request a copy.

I hereby give my consent for photography, filming, videotaping and/or audio recording or other means of capturing my image, radiographic or otherwise, or voice and/or being quoted in the media or printed materials (including social media websites) at Atlas Neurosurgery and Spine Center. I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold Atlas Neurosurgery and Spine Center and its personnel and affiliated programs harmless from any and all liability which may or could arise from activities authorized by this agreement. I may request cessation of such use or rescind this Authorization up until a reasonable time before use, but I must do so in writing. I have a right to receive a copy of this Authorization.

_____ _____

Patient Signature Date

Atlas
Neurosurgery & Spine

Abhishiek Sharma, MD
Erik Curtis, MD

HISTORY

Chief complaint
What is your primary concern?

_____
_____

How long have you been bothered by your current symptoms?

_____

How did your symptoms begin? (For auto accident or workers' compensation, please complete the necessary section on page 2.)

_____
_____

Current problem began: ❒Suddenly ❒Gradually ❒Lifting ❒Twisting ❒Fall ❒Bending ❒Pulling

Do your symptoms interfere with your activities of daily living (self-care, meal prep, home maintenance)? ❒ Yes ❒ No If yes, please explain:

_____

Are you able to stand for long periods of time? ❒Yes ❒No

Are you able to sit for long periods of time? ❒Yes ❒No

Does your pain interfere with your daily job functions? ❒Yes ❒No If yes, please explain:

_____
_____

What makes your symptoms worse?

❒During Exercise	❒After Exercise	❒Prolonged Sitting	❒Prolonged Standing
❒Walking	❒Bending Forward	❒Bending Backward	❒Pushing
❒Pulling	❒Squatting	❒Night Pain	❒Other

What makes your symptoms better?

❒Nothing	❒Lying down	❒Sitting	❒Standing	❒Walking
❒Medication	❒Shifting/Changing positions		❒Other	

Have you been diagnosed previously with a spine condition such as spinal stenosis, arthritis, scoliosis, herniated disc or fracture? ❒Yes ❒No
If yes, please explain:

_____

What treatments have you had for this problem? (Check all that apply)

PHYSICAL THERAPY ❒Stretching ❒Strengthening ❒Traction
❒Iontophoresis/Topical Steroid ❒Massage
❒Ultrasound ❒Heat/Ice ❒Therapeutic Ball

MEDICATIONS ❒Muscle Relaxants ❒Pain Medication ❒Anti-Inflammatory
❒Anti-Inflammatory OTC ❒Chiropractic Care
❒Acupuncture ❒Injections ❒Other

What tests have you had for this problem?

❒X-ray ❒MRI ❒Discography ❒CT ❒EMG
❒CT/Myelogram ❒Bone Scan ❒Other

Physician information

Primary care physician: _____ Phone #: _____ Fax #: _____
Street address: _____
City: _____ State: _____ ZIP: _____

Specialist name: _____Type: _____ Phone #: _____ Fax #: _____

Medical History

DATE	SURGERY	SURGEON NAME	Complication (if present)

Atlas Neurosurgery & Spine

Abhishiek Sharma, MD
Erik Curtis, MD

Current or Past Medical Conditions

DATE	Illness or Hospitalization

Allergies: Please list any allergies, medical or non-medical.

Type of allergy	Reaction

Medications: Please list any prescribed and over-the-counter medications you are taking.

Name	Strength	# of pills per day
1.		
2.		
3.		
4.		
5.		

Atlas Neurosurgery & Spine

Abhishiek Sharma, MD
Erik Curtis, MD

Social History

Age: _____Occupation: _____
Handedness: ❒Right-handed ❒Left-handed
Marital Status: ❒Single ❒Married ❒Divorced ❒Widowed
Employment Status: ❒Full Time ❒Part-Time ❒Disabled ❒Retired ❒Not working
Education Level: ❒High School ❒College ❒Graduate Work
Exercise: ❒Daily ❒Weekly ❒Monthly ❒Rarely ❒Never
Children: ❒Yes ❒No How many?
Do you live alone? ❒Yes ❒No
Do you have stairs at your place of residence? ❒Yes ❒No
Do you smoke? ❒Yes ❒No _____ Packs per day for _____ years.
Do you use other forms of tobacco? ❒Yes ❒No
❒Chew ❒Gum ❒Patch ❒Cigars ❒Other
Do you drink alcohol? ❒Daily ❒1-2x/week ❒1-2x/monthly ❒1-2x/year ❒Never
Is there pending litigation? ❒Lawsuit ❒Worker's compensation claim ❒Disability Claim
❒Social Security disability claim ❒Auto accident claim

Family History

Do you have a family history of any of the following:

Condition	Relative
Cancer	
Heart disease	
Diabetes	
Neuromuscular disease	
Osteoporosis	
Stroke	
Brain tumor	

Atlas
Neurosurgery & Spine

Abhishiek Sharma, MD
Erik Curtis, MD

Review of Systems

Please describe if you have any problems with the following:

Eyes	❒Yes	❒No	_____
Ears, Nose, throat	❒Yes	❒No	_____
Cardiac	❒Yes	❒No	_____
Pulmonary	❒Yes	❒No	_____
Gastrointestinal	❒Yes	❒No	_____
Genitourinary	❒Yes	❒No	_____
Hematological	❒Yes	❒No	_____
Neurological	❒Yes	❒No	_____
Psychiatric	❒Yes	❒No	_____
Vascular	❒Yes	❒No	_____
Dermatologic	❒Yes	❒No	_____
Metabolic	❒Yes	❒No	_____
Immunological	❒Yes	❒No	_____

Atlas
Neurosurgery & Spine

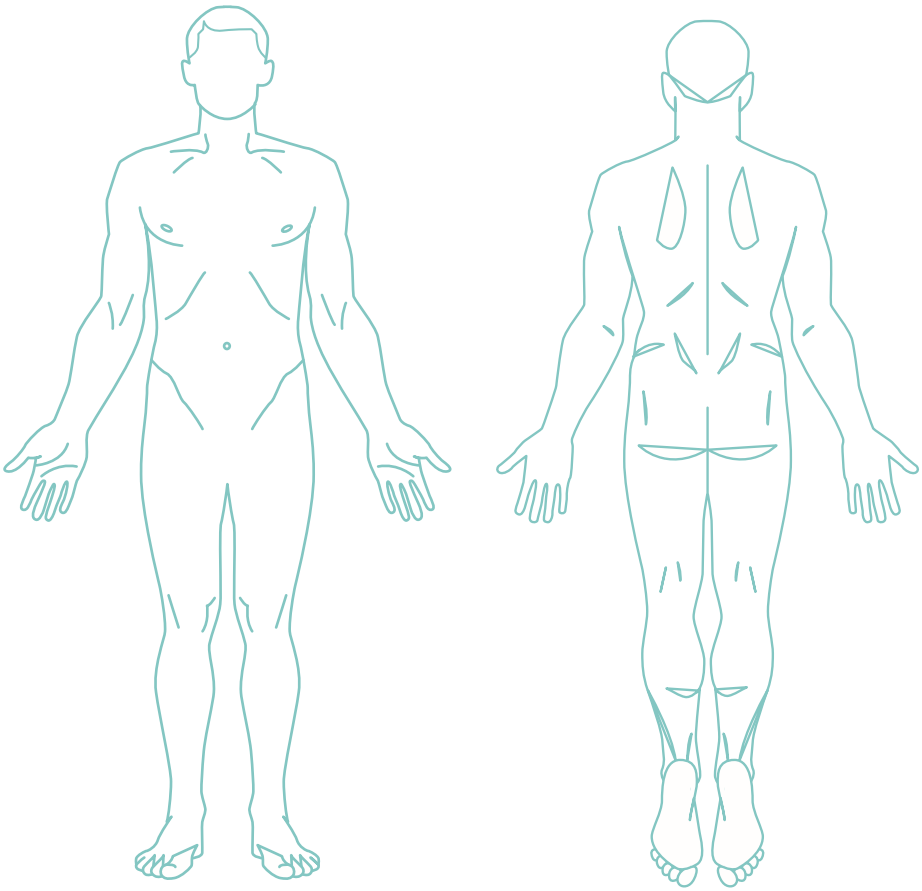
Abhishiek Sharma, MD
Erik Curtis, MD

VISUAL ANALOG SCALE (VAS)

USE THE BODY DIAGRAM TO SHOW WHERE YOU FEEL THE FOLLOWING SENSATIONS

PAIN: Δ
NUMBNESS: O
BURNING: X
STABBING: /
PINS & NEEDLES: =

LEG PAIN	**%**
ARM PAIN	**%**
NECK PAIN	**%**
BACK PAIN	**%**
TOTAL	**100 %**



PLEASE PLACE AN X ON THE HASH MARK THAT MOST ACCURATELY DESCRIBES YOUR OVERALL DEGREE OF PAIN NOW.

None | Mild | Moderate | Severe | Very Severe | Worst Possible

Atlas Neurosurgery & Spine

Abhishiek Sharma, MD
Erik Curtis, MD

Oswestry Disability Index

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 (washing, dressing, etc)
- ❑ 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, eg 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 1/2 mile
- ❑ pain prevents me walking more than 1/4 mile
- ❑ 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 favourite chair as long as i like
- ❑ pain prevents me from sitting more than 1 hour
- ❑ pain prevents me from sitting more than 1/2 hour
- ❑ 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 1/2 hour
- ❑ 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 six hours sleep
- ❑ even when I take tablets I have less than four hours sleep
- ❑ even when I take tablets I have less than two hours 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 my more energetic interests, eg dancing etc
- ❑ pain has restricted 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 - travelling
- ❑ 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 two hours
- ❑ pain restricts me to journeys of less than one hour
- ❑ pain restricts me to short necessary journeys of less than 1/2 hour
- ❑ pain prevents me from travelling except to the doctor or hospital

Atlas Neurosurgery & Spine

Abhishiek Sharma, MD
Erik Curtis, MD

Medication hold list for surgery

- Aggrenox
- Aleve
- Alka-Seltzer
- Amigesic
- Anacin products
- Anaflex
- Anaprox
- Ansaid
- Apo-ASEN
- Arco Pain Tablet
- Argeric
- Arthropan
- Arthrotec
- Ascriptin
- Aspergum
- Aspirin (all products containing aspirin)
- Aspir-Low
- Aspirtab
- Bayer
- Bayer time release
- Buffex
- Bufferin
- Bufferin Arthritis
- Buffinol
- Butalbital Compound
- Butazolidin
- Cama Arthritis
- Carisoprodol Compound
- Cataflam
- Clinoril
- Combunox
- Cope
- Daypro
- Diclofenac
- Diflunisal
- Disalcid
- Doan's
- Dolobid
- Easprin
- Ecotrin 81
- Empirin
- Endodan
- Entrophen
- Equagesic
- Es Anacin
- Etodolac
- Excedrin Migraine
- Feldene
- Fenoprofen
- Fiorinal
- Flector Patch
- Floctafenine
- Flurbiprofen
- Glucosamine
- Goody's
- Halfprin
- Helidac
- Ibuprofen
- Indocin
- Indomethacin
- Instantine
- Kaopectate
- Kava
- Ketoprofen
- Ketorolac
- Lodine
- Lovaza
- Magan
- Magnaprin
- Marthritic
- Meclofenamate
- Meclomen
- Medipren
- Mefenamic acid
- Midol
- Mobic
- Mobiflex
- Momentum
- Mono-Gesic
- Motrin
- Nabumetone
- Nalfon
- Naprelan
- Naprosyn
- Naproxen
- Norgesic Forte
- Nuprin
- Ocuvite
- Oruvail
- Orudis
- Oxaprozin
- Pamperin-IB
- Pepto-Bismol
- Percodan
- Phenylbutazone
- Piroxicam
- PMS-ASA
- Ponstel
- Prevacid NapraPAC
- Relafen
- Robaxisal
- Roxiprin
- Salflex
- Salsalate
- Sine-Aid IB
- Sodium salicylate
- Soma Compound
- St. Joseph Aspirin
- Sulindac
- Suprofen
- Suprol
- Surgam
- Synalgos-DC
- Tandearil
- Talwin Compound
- Tenoxicam
- Tiaprofenic acid
- Tolectin
- Tolmetin
- Toradol
- Tricosal
- Trilisate
- Vanquish
- Vicoprofen
- Voltaren
- Zorprin

We recommend stopping **Aggrenox, Arixtra, Aspirin, Brilinta, Coumadin, Eliquis, Fragmin, Innohep, Lovenox, Plavis, Pletal, Pradax** and **Xarelto** with approval of your prescribing physician to have normal coagulation at the time of surgery. We also recommend stopping supplements and other over the counter agents 7 days prior to surgery.
By signing, I agree that I must not take any of these over-the-counter medications for the time frame specified. I understand that failure to follow these instructions might result in the postponement of my surgery.

_____ _____ _____

Name of Patient/Legal Representative | Signature | Date

Abhishiek Sharma, MD
Erik Curtis, MD

Atlas Neurosurgery & Spine

INFORMED CONSENT

I, _____, (patient or guardian) authorize Doctor _____, his associates and assistants of his or her choosing to perform the following operations or procedure(s).

_____
_____
_____

I have been strongly advised to carefully read and consider this operative consent. I realize that it is important that I understand this material. I also understand that if certain sections are not clear to me, I have the opportunity to ask for clarifications. My doctors have discussed and fully informed me of the nature of my problem, the proposed operation, all known alternative treatments and the possible complications of both operative and non-operative care of my problem. Reasonable alternative treatments and their risks, consequences and probable effectiveness have been discussed with me including doing nothing, conservative therapy with drugs and/or exercise and/or nerve blocks or injections. I do not wish to engage in the alternative treatments. I have had ample opportunity to discuss my condition, treatment and surgery with my doctor(s), his/her associates, and with my family. All of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base my decision regarding the proposed operation and to sign this consent.

- I understand that this document will discuss craniotomy and spinal surgery in a general fashion including cranial, cervical, thoracic, lumbar or sacral disk removal or decompression including foraminotomy, laminectomy and/or facetectomy, anterior or posterior fusion utilizing metal or other non-metallic implants or substances anteriorly or posteriorly to assist in fusion, deformity correction or stability success. Also, the use of instrumentation may not be approved by the Food and Drug Administration (FDA) such as posterior occipital, cervical and thoracic screws or various bio-implants. This may also include use of instrumentation or other spinal implants in other areas of the spine, which to date have not been approved by federal government, but which the surgeon believes is in my best interests as a patient.
- I understand that my doctors may be able to more comprehensively evaluate the problems within my spine at the time of surgery. During the operation, they may deem it necessary to vary the exact nature of the procedure in order to best treat my problem and to obtain the best chance for a good outcome with the smallest possible operative risk. I, therefore, consent to the performance of surgical procedures in addition to, or different than, those now contemplated. If presently unforeseen conditions arise during my surgery, I authorize and fully consent to, my doctors and his associates performing the necessary procedures.
- I understand that medical or non-medical personnel may be present to observe and assist with surgery. I also understand that pictures or videotapes of my surgery or x-rays may be used for educational or marketing purposes. I give my consent to such efforts and realize that they, in no way, will affect my care. My identity will not be disclosed if my images, pictures or videotapes are used at any time.
- I understand that I am free to seek other opinions about the proposed surgery and that my doctors encourage me to do this if I wish.
- I understand that, in general, the goal of surgery is to help relieve pain and to improve function, but I am also aware that after surgery there may be unresolved symptoms or worsening of symptoms as well as other neurological signs or symptoms which may have not been present before surgery. I understand that less common problems may occur as a result of surgery such as muscle weakness or paralysis, airway difficulties, hematoma, prolonged intubation, numbness, hoarseness (i.e. superior or recurrent laryngeal nerve palsy), lack of improvement or worsening myelopathy or neurogenic claudication, esophageal, great vessel or nerve injury or difficulty swallowing with anterior cervical procedures, spinal fluid leakage, loss of bowel or bladder control, arachnoiditis (i.e. scarring of the nerves in the dural sac) and in men, erectile dysfunction, impotence and retrograde ejaculation. I also understand that other problems may require additional treatment or operation. I

am aware that it may not be possible to cure or totally correct my problem and depending on the pathology i.e. tumor or infection, there may be recurrence of spread.

- In procedures requiring bone grafting, I understand that healing of my bone graft into a bone fusion is largely a biological function of my body. Failure of the bone graft to heal may result in persistent symptoms necessitating additional surgery.
- I understand that other general problems may occur with any surgery such as death, deep venous thrombosis (blood clots), stroke, phlebitis, embolism, infection (wound, diskitis, osteomyelitis, epidural abscess), pneumonia, stroke, cardiac arrest, anesthesia problems, worsening vision or blindness, blood loss, allergic reaction to medications or materials and diseases transmitted by blood transfusions or other means.
- It has been determined that, to best treat my spinal problem, a fusion may be necessary. A fusion is an operation designed to eliminate movement between two or more adjacent vertebrae. My doctor may take bone from my body or use bone from a cadaver and place this around vertebrae that are meant to be fused. Therefore, my body must complete the healing process. Unfortunately, not all fusions heal. Excessive motion, smoking, steroid use, use of non-steroidal anti-inflammatory medications and certain medical conditions such as diabetes and renal disease may cause the fusion to not heal. In an effort to provide the highest probability that my fusion will heal, my doctor has determined that the use of a fixation device, bio-implant or fusion enhancer may be appropriate. These devices or substances may consist of screws, hooks, rods, plates, wires, various polymers, cement, bio-implants (absorbable or non-absorbable) or various bone graft alternatives, enhancers or extenders. These devices may be anchored by screws or other attachments inserted into the bony pedicles, vertebral bodies, the cranium or lateral masses of the vertebral bodies. Rods, plates or wires may then be connected to these implanted screws or anchors, thus constructing a rigid framework to hold the bones immobile until the fusion heals. It is my doctor's conviction that the use of the fixation devices will significantly increase the probability that my fusion will heal. My doctor has completed a residency in Neurosurgery with a concentration in spine surgery. His primary practice deals with the evaluation and treatment of Neurological and spinal disorders. By virtue of his special training and practice experience, he has developed the knowledge and ability to safely use these internal fixation devices and bio-substances. Any fixation device may fail or break. If my fusion does not heal, the graft, screws, wires, rods, cages, intervertebral devices or plates may break or disengage and they may be loss of spinal fixation and/or correction. This may cause injury to the surrounding soft tissue structures. When my doctor implants these devices, there exists the possibility of injury to the bones, nerves or adjacent tissues such as blood vessels, tendons or ligaments. There is a possibility that these devices may need to be removed at a later date. Alternatives to the use of fixation devices include the use of no internal fixation at all or the use of brace or cast. I do not wish to engage in these alternatives exclusively.
- The FDA has not approved screws for use in certain pedicles of the spine or several spine disorders. The use of methyl methacrylate or bone cement is also not approved by the FDA for use in the spine. These devices and substances are considered investigational by the FDA. Pedicle screws are approved for use in the sacrum and various lumbar disorders. It is quite common, and legally and medically appropriate, to use FDA approved devices, substances of medications for uses other than those for which they are specifically approved. My doctor believes that use of a pedicle fixation device, occipital screw attachment, lateral mass screws, or other devices or substances within my spine will significantly improve the chances that my fusion will heal or my condition will improve. In spite of the risk inherent in their use and in spite of the investigational nature of the devices. I am aware that my physician strongly believes that he can safely use them to increase the probability that my fusion will heal.
- I understand that during fusion procedures, bone morphogenetic protein (BMP) might be utilized as a growth factor to aid in bony fusion. I understand that BMP use may not be FDA approved in my clinical condition; however, I consent to its use. I also understand that growth factors such as BMP have been associated with adverse outcomes including but not limited to retrograde ejaculation, antibody formation, postoperative radiculitis, postoperative nerve root injury, ectopic bone formation, vertebral osteolysis/edema, dysphagia and neck swelling, hematoma formation, wound healing, interbody graft lucency and oncogenic potential. I

thoroughly and unequivocally understand those risks and consent to BMP use to allow for bony healing and operative success.

- Pre-operative and post-operative bracing may be prescribed for any spinal disorder. I have been instructed on the use of immobilization device, when I must wear it, and various activities that are contraindicated during the bracing period. I consent to such bracing.
- Donor site complications may result from harvesting my bone which includes numbness and tingling, pain, infection, nerve damage, damage to the vessels and muscles and pelvic or bony instability due to bone loss.
- I understand that my surgeon maybe participating as a paid consultant or have a financial interest in the development of products that may be used in my planned surgical procedure.
- I understand that FDA has specific indications for spinal cord stimulation; however, my condition may or not be included in those strict guidelines. I have had ample time to consider my options and have decided to proceed further with a trial and a permanent implant, if successful. I recognize the variety of risks, benefits and alternatives to surgical implantation and have decided to proceed. I recognize obvious risks of coma, death, paralysis, paresis, spinal cord injury, hardware failure or complications, lead migration, potential limitations with obtaining MRI pending device clearance or lack thereof, initial improvement with delayed worsening, re-operation, bleeding, infection, cerebrospinal fluid leak, meningitis and/or encephalitis.
- During my surgery, neurological monitoring may be necessary to protect my spinal cord, brain or nerves from injury. I understand that, although neurological monitoring is useful to provide information on the status of my spinal cord, brain or nerves during surgery, there are risks to its uses including infection, tongue or oral laceration, seizures or failure of the monitoring to effectively determine the status of my spinal cord or nerve roots. For certain technical reasons including the severity of my spinal disease, monitoring may not be able to provide useful information or may fail to provide reliable signals during the course of my surgery. In this event, my surgeon would be blinded as to the status of my brain, spine cord or nerves. I understand that this may increase the risk of a permanent neurological deficit from surgery. I have had the opportunity to discuss my wishes with regard to halting surgery or continuing with the planned procedure in the event that the signals are not available or are lost during the procedure. The mother of neuromonitoring may not be FDA approved and may require specific anesthetic protocols necessary for optimal neurological assessment.
- I understand smoke and nicotine exposure from cigarette, cigars, nicotine patches, chewing tobacco and other forms of smoke/nicotine may significantly worsen the outcomes of my surgery. It is my responsibility to avoid these and other sources of smoke and nicotine exposure. If I choose not to avoid these sources of nicotine or smoke, I understand that my actions may increase my risk of infection, poor healing, scarring, persistent pain, bony non-healing and failure of surgery.
- I understand the necessity for my compliance with post-operative, post-discharge directions that have been explained to me, including among others, possible immobilization, and/or physical therapy, and/or required medications. I am aware that it is medically important that to achieve the best possible recovery, I must continue on the regimen prescribed for me.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date