VERMA SPINE

Kushagra Verma, M.D., M.S., FAAOS

3851 Katella Ave, Suite 255 • Los Alamitos, CA 90720
(562) 732-4578 Phone • (562) 452-9207 Fax
www.vermaspine.com

PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION

(Please type or print legibly)

PATIENT INFORMATION:

Last: ______________________ First: ______________________ Middle: ______________

Date of Birth: ______________ Age: ________ Sex: ☐ M ☐ F HT: ________ WT: ________

Mailing:

Address: ____

City: ____ State: ________ Zip: __________

Cell Phone: ______________ Home/other: ______________ Email: ____________________

Emergency Contact: __________________ Relationship: ____________ Phone: ____________

How did you hear about our office? ☐ Website ☐ Social Media ☐ Magazine ☐ Emergency Room/Urgent Care

☐ Primary Care Doctor ☐ Current Patient ☐ Other ______________________________

Preferred Language ☐ English ☐ Other __________________ ☐ Translator ______________

PHARMACY INFORMATION:

Please provide name, address and phone number of your pharmacy of choice.

Pharmacy Name: ________________________________ Phone Number: __________________

Pharmacy Address: ____

PHYSICIAN INFORMATION:

Referring
Physician (If any): ________________________________ Phone #: __________________

Primary Care
Physician (If any): ________________________________ Phone #: __________________

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CLINICAL PATIENT INFORMATION AND MEDICAL HISTORY

(Please type or print legibly)

CHIEF COMPLAINT:

(Reason for visit) ______________________ Date of Injury/trauma: ____________

Where did the injury occur? ☐ Work ☐ Other ____________ / Body Part ____________ ☐ R ☐ L

How EXACTLY did the injury/trauma occur? ______________________

Have you been treated for this problem by another doctor? ☐ Yes ☐ No If so, who? ____________

Prior Treatments: ☐ Physical Therapy ☐ Bracing ☐ Pain Medications ☐ Epidural Injections ☐ Chiropractic ☐ Surgery ☐ Other

What is your pain on a scale of 0-10, zero is no pain, 10 is severe disabling pain

(i.e. causes sweating, tears, high heart rate, etc.) 1 2 3 4 5 6 7 8 9 10

What makes the pain worse? (activities. body positioning, etc.) ______________________

What relieves the pain? (medications, Ice. heat, therapy, activity modifications. body positioning, etc.) ____________

Do you have any mechanical symptoms with your pain? Locking, popping, catching? If so, when does it occur?

____

Do you feel any instability with your current problem? Buckling, shifting, giving way? ____________

☐ Other (please list): ______________________

PREVIOUS SURGERIES: (Medical Comorbidities)

1. ______________________
2. ______________________
3. ______________________

CURRENT MEDICATIONS:

1. ____________ 5. ____________
2. ____________ 6. ____________
3. ____________ 7. ____________
4. ____________ 8. ____________

ALLERGIES:

☐ LATEX ☐ OTHER: ____________

☐ PENICILLIN ☐ OTHER: ____________

☐ VANCOMYCIN ☐ OTHER: ____________

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SERVICE AND FINANCIAL AGREEMENT

PAYMENT SERVICES:

Except as noted below, co-payments are due in full at the time of service. Our office staff is here to assist you. However, It is your responsibility to be aware of your health Insurance benefits and how to obtain them. Please be aware that you are ultimately responsible for payment of your bills; not your insurance company. If your insurance company fails to pay your claim(s) for whatever reason, you are still responsible for the charges Incurred.

Please inform the staff if pre-authorization is required by your insurance. HMO patients are required to have all services and office visits pre-authorized before scheduling appointments. Please notify us of any changes In your contact information or Insurance coverage.

As a courtesy, Verma Spine's professional fees will be billed to your insurance company on your behalf. Once payment is received from your insurance company, your balance, If any, will be due within 30 days. If your insurance fails to pay within 80 days, the entire balance becomes immediately due.

Whether Verma Spine is in or out of network with your insurance company, please understand that your insurance company may deny coverage for a particular treatment, surgery, or piece of equipment. If you agree to that treatment, surgery or piece of equipment, for instance, you are assuming responsibility for payment regardless of whether your insurance company pays for It or not.

_______________ Initials

HOSPITAL PROCEDURES/SURGERY:

We will attempt to pre-authorize all surgeries and procedures with your insurance company prior to any surgery being scheduled. Please be aware that in addition to the physician and hospital charges, there will likely be additional bills for anesthesiologists, assistant surgeons, laboratory/radiology tests, and internal medicine physicians. Verma Spine is not associated with these entities and has no control over them or their fees. We also do not know whether they are in or out of network for your insurance.

_______________ Initials

MEDICAL RECORDS TRANSFERS:

Any requested copies of your medical records require a signed release form. ***A fee to cover the cost of copying and mailing is due prior to release of records.***

_______________ Initials

NO ACCIDENT/INJURY:

I hereby state with my signature that I was not involved in any auto accident, slip, fall, or work injury. My treatment is in no was associated with any 3rd party, and no other party is responsible or liable for the cost of my treatment.

Please process and pay all claims immediately.

_______________________________________ _______________

Patient Signature Date

METHODS OF PAYMENT:

For your convenience, we accept cash, personal checks (U.S. dollars), Cashier check, MasterCard, Visa, Discover, and American Express. A $25.00 bank fee (or the actual bank charges if more than $25.00) is charged on all returned checks, and nonpayment orders.

_______________ Initials

MEDICAL CONSENT:

I consent to routine evaluation and treatment under general and specific instructions of Verma Spine . If necessary, I agree to emergency treatment and/or transport to the nearest available hospital. I reserve the right to refuse specific services at any time.

I hereby authorize and give consent to routine evaluation and treatment to my emergency contact, and/or transport to the nearest available hospital. I reserve, as guardian or legal representative to my daughter/son, and/or dependent, the right to refuse specific services at any time.

_______________ Initials

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FINANCIAL RESPONSIBILITY:

I have read and understand the above statements regarding my financial responsibility and the release of information. I accept full financial responsibility for my treatment regardless of whether my insurance company pays my bills. If my account becomes delinquent and is referred to a collection agency or attorney, I agree to pay all collection expenses, attorney and court costs associated with such. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I acknowledge that if my child/dependent is cared for by Verma Spine that I will be responsible for the payment of services provided under the same terms and conditions.

__________ Initials

HMO OR OTHER CONTRACTED PATIENTS:

For authorized covered services, I agree to pay Verma Spine my portion of charges for the requested services and understand that exact amount of my obligation may not be known to me until after my healthcare plan has processed the claim. Verma Spine may bill my insurance and receive payment for services provided to me under the provisions of my plan's contract with Verma Spine. For services not covered by my insurance (authorization denied) I agree and understand that I may be asked to pay the full amount of Verma Spine standard fee for the services provided at the time of services.

PATIENTS WITH NON-CONTRACTED HEALTH PLANS:

I authorize Verma Spine to bill my insurance company. I understand that any pre-determination of benefits by my insurance company is an estimate and the actual benefit payment will not be determined until the claim is processed. I agree to pay Verma Spine in full for services provided to me regardless of the amount reimbursed to me by my insurance company. I am responsible for paying all outstanding charges after 60 days.

__________ Initials

24 HOUR CANCELLATION AND "NO SHOW" FEE POLICY:

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, we will charge a fee of $50.00 for all missed appointments ("no shows") and appointment which, absent a compelling reason are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

__________ Initials

This assignment/financial agreement will remain in full force and effective until revoked by me In writing.
A photocopy of this agreement is to be considered as valid as the original.

____________________ ____________________

Signature of Patient and/or Legal Representative | Relationship to Patient (if not self)

____________________ ____________________

Print Name | Date

____________________ ____________________

Witness Signature | Date

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