The Spine Center
P: 540-725-9771
F: 540-725-3624

New Patient Registration

Patient Information:

Name: _____ Date: _____

Address: _____
Street City State Zip Code

Phone (Home): _____ (Work): _____ (Cell): _____

Social Security Number: _____-_____-_____ Birth Date: _____/_____/_____ Sex: (M / F)

Email: _____ Alternate Email: _____

Employer: _____ Employer Phone: _____

Address: _____
Street City State Zip Code

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

Policy #: _____ Policy #: _____

Group #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ SSN: _____-_____-_____

Patient Relationship to Policy Holder: _____

Pharmacy Information:

Pharmacy Name: _____ Phone: _____

Address: _____ City: _____ State: _____

Emergency Contact:

Name: _____ Relationship to Patient _____

Phone (Home): _____ (Cell): _____

Address: _____

Patient Name: _____ Date of Birth_____

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent form(s) prior to the test(s) or procedure(s).

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed, and the Public Health Department and appropriate counseling will be offered.

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

Financial Agreement.

- I acknowledge, that as a courtesy, **The Spine Center** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

Third Party Collection. I acknowledge that **The Spine Center** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to **The Spine Center** any insurance or other third-party benefits available for health care services provided to me. I understand **The Spine Center** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **The Spine Center,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **The Spine Center** by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for **The Spine Center**, or EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **The Spine Center** or

_____

Patient Name: _____ Date of Birth_____

Extended Business Office (EBO) Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **The Spine Center** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I understand that **The Spine Center** includes consent at satellite offices under common ownership. A photocopy of this consent shall be considered as valid as the original.

This entire consent will remain in full force until revoked in writing.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

★

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Printed Name of Patient or Personal Representative

If you are not the patient, please identify your relationship to the patient. (Circle or mark relationship(s) to patient from list below):

Spouse
Parent
Legal Guardian
Guarantor
Healthcare Power of Attorney
Other (please specify)_____

_____ _____

Printed Name of Witness (Employee) Employee Job Title

_____ _____

Signature of Witness Date

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent legal guardian/representative, etc)	Date

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

LGP The Spine Center **James M Leipzig, MD**

Patient Name: _____ Gender: ☐Male ☐Female Date: _____

Date of Birth (MM/DD/YYYY):_____ Current Age: _____ Height:_____Weight:_____

Primary Care Physician: _____Referring Physician:_____

What are you being seen for today?

_____

How and when did your problem begin? (Please mark each answer that applies to your current pain)

☐ I don't know how it began ☐ It comes and goes ☐ I've had it a long time (_____years)

☐ Injury (Date of Injury_____)
On the job? ☐Yes ☐No
Have you been laid off work? ☐Yes ☐No

Are you in current litigation with regards to current pain? ☐Yes ☐No

What makes your pain better?

_____
_____

What makes your pain worse?

_____
_____

How would you rank your pain?

1 2 3 4 5 6 7 8 9 10
No pain Worst Possible

Previous Treatment and Diagnostic Testing:

Have you had any of the following for your current problem? If Yes, did it make your condition better or worse?			Have you had any of the following in regards to your current pain? If Yes, when and where did you have them performed?
NSAID Therapy	☐Better	☐Worse	Plain X-rays Date:_____ Where:_____
Physical Therapy	☐Better	☐Worse	MRI Scan Date:_____ Where:_____
Chiropractic Care	☐Better	☐Worse	CT Scan Date:_____ Where:_____
Corticosteroid injection	☐Better	☐Worse	EMG/NCV(nerve test) Date:_____ Where:_____
Other _____	☐Better	☐Worse	Other _____ Date:_____Where:_____

Have you had previous surgery for your current pain or problem? Yes No
Type of Surgery
_____Date:_____Surgeon_____
Did it make your pain: ☐Better ☐Worse

Have you had any other alternative forms of medical treatment that we should know of?
_____

Patient Initials Date

LGP The Spine Center **James M Leipzig, MD**

Medical History:

- ☐Heart Attack
- ☐Heart Murmur
- ☐Angina
- ☐High Blood Pressure
- ☐Stroke
- ☐Varicose Veins
- ☐Stomach Ulcer
- ☐Duodenal problems
- ☐Anemia
- ☐ALS
- ☐Colon Problems
- ☐Diabetes
- ☐Hepatitis A, B, C
- ☐Cirrhosis
- ☐Kidney Stones
- ☐Kidney Infection
- ☐Degenerative arthritis
- ☐Rheumatoid arthritis
- ☐Bleeding Tendency
- ☐HIV
- ☐Gout
- ☐Anxiety
- ☐Depression
- ☐Emphysema
- ☐Tuberculosis
- ☐Chronic Bronchitis
- ☐Frequent Pneumonia
- ☐Asthma
- ☐Seizure Disorder
- ☐Tremor
- ☐Enlarged Prostate
- ☐Menstrual Problems
- ☐Cancer-Type_____
- ☐Osteoporosis
- ☐Multiple Sclerosis
- ☐Visual Changes
- ☐Blood Clots
- ☐Dizziness
- ☐Other_____

Current Medications:

Medication	Reason Taken	Dose	Frequency	Prescribing Physician

Allergies:

Medication/Allergen	Reaction

Gyn History:

_____

Ob History:

_____

Surgical History:

Surgery	Date

Hospitalizations:

Reason	Date

Patient Initials

Date

LGP The Spine Center **James M Leipzig, MD**

Family History:

	Alive/Deceased	Diabetes	High Blood Pressure	Asthma	Cancer (type)	Heart Attack	CAD	High Cholesterol	Other
Mother									
Father									
Sister									
Brother									
Son									
Daughter									

Social History:

Alcohol	☐None ☐ Occasional _ drinks per ☐ day ☐week ☐month
Tobacco Use	☐Never ☐Current daily ☐Current some ☐ Smokeless former ☐Smokeless current
Caffeine	☐Yes ☐No If yes, frequency ____cups a day
Illicit Drug Use	☐Yes ☐No
Exercise	☐Yes ☐No If yes, how many days per week? _____
Marital Status	☐Married ☐Separated ☐Divorced ☐Single ☐Widow/Widower
Work Status	☐Full time ☐Part time ☐Disabled ☐Retired
Education	☐Grammar School ☐High School ☐College

Review of Systems:

General

Recent weight loss of more than 10 lbs	☐Yes ☐No
Recent weight gain of more than 10 lbs	☐Yes ☐No
Fever	☐Yes ☐No
Chills	☐Yes ☐No
Night Sweats	☐Yes ☐No
Have you seen your primary care physician in the past year?	☐Yes ☐No

Cardiac

Chest Pain	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No

Pulmonary

Wheezing	☐ Yes ☐No
Pneumonia	☐ Yes ☐No
Chronic cough	☐ Yes ☐No

Gastrointestinal

Abdominal Pain	☐ Yes ☐No
Nausea	☐ Yes ☐No
Vomiting	☐Yes ☐No
Diarrhea	☐Yes ☐No
Liver Problems	☐Yes ☐No

Dermatological

Open sores	☐Yes ☐No
New Moles	☐Yes ☐No
Poor Healing	☐Yes ☐No
Skin Infection	☐Yes ☐No
Easy Bruising	☐Yes ☐No

Endocrine

Diabetes	☐Yes ☐ No

Dental

Significant problems	☐Yes ☐No

Musculoskeletal

Shoulder pain	☐Yes ☐No
Wrist/Hand pain	☐Yes ☐No
Hip Pain	☐Yes ☐No
Knee Pain	☐Yes ☐No
Low Back Pain	☐Yes ☐No
Lupus	☐Yes ☐No
Muscle weakness	☐ Yes ☐No
Fibromyalgia	☐Yes ☐No

Neurological

Headaches	☐Yes ☐No
Tremors	☐Yes ☐No
Seizures	☐Yes ☐No
Changes in Vision	☐Yes ☐No

Psychological

Sleep trouble	☐Yes ☐No
Feeling of hopelessness	☐Yes ☐No

Genitourinary

Poor Kidney Function	☐Yes ☐No
Pain with urination	☐Yes ☐No
Frequent UTI	☐Yes ☐No

Hematological

Transfusion	☐ Yes ☐No
Transplant	☐ Yes ☐No
Blood Thinner	☐ Yes ☐No

Patient Initials

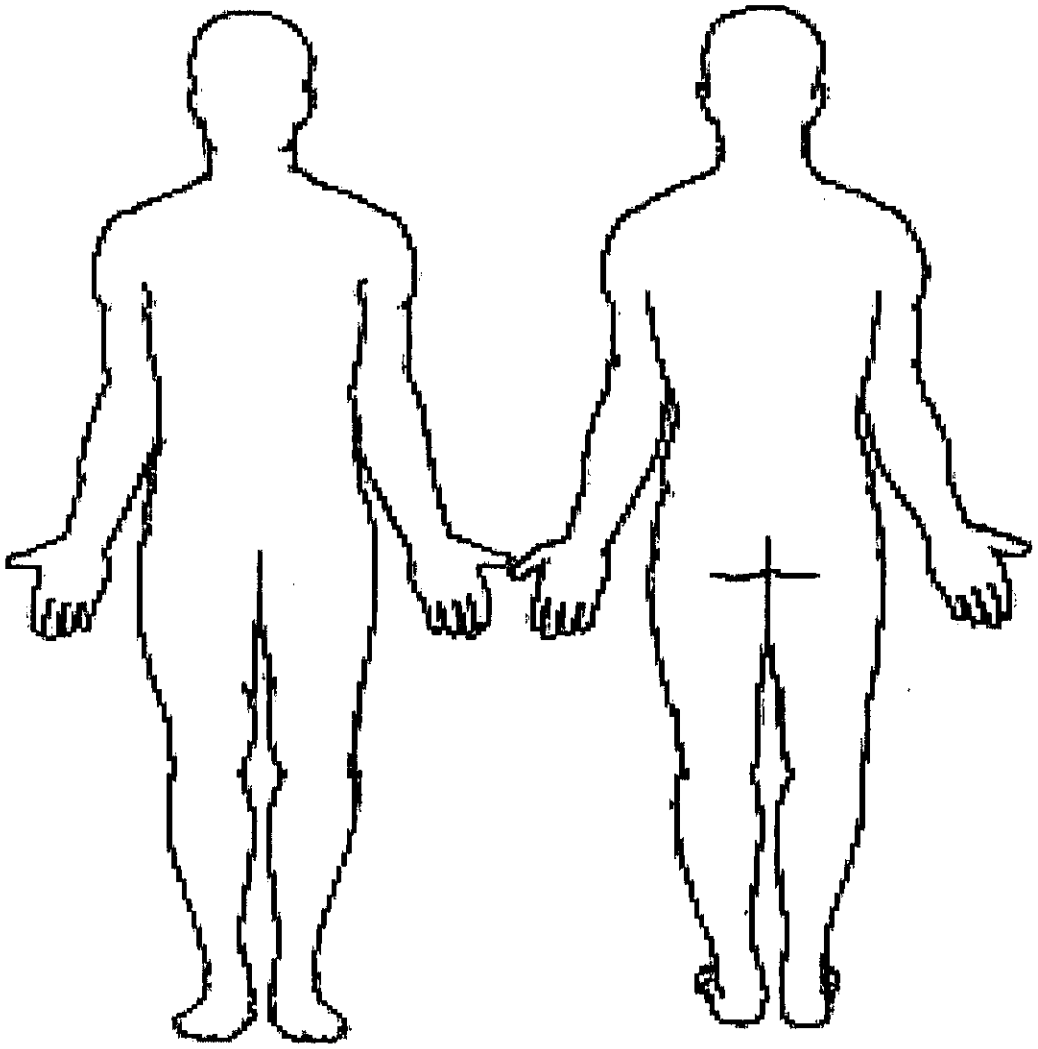
Date

PAIN DIAGRAM

On the diagram below mark where you are experiencing pain.

Use the symbols below to indicate the type and location of your sensations.

DEEP ACHE ^^^^	**NUMBNESS** OOOO	**PINS/NEEDLES** + + + +
BURNING XXXX	**RADIATING PAIN** ////	**SHARP/STABBING** ZZZZ



Numeric Rating Scale