SpineGroup
BEVERLY HILLS

Dr. John Regan, M.D.

Welcome

Please read and sign the following statement and let us know if you have any questions. Thank you.

FINANCIAL POLICY – Payment is due in full at the time of service. We accept cash, checks, Visa, MasterCard, and American Express.

As a courtesy, we will submit insurance claims directly to any PPO insurance carrier, regardless of the physician's preferred provider status. We will not submit claims to any HMO plans.

Insurance Co-payments are due at the time of service; we are contractually obligated to collect co-payments/co-insurance required by your plan. This does not include the cost of any procedures. Please note that your insurance ultimately determines your financial responsibility. Any additional amount due will be billed to you after your insurance company makes this determination.

It is *your responsibility* to be aware of any restrictions, limitations, and requirements outlined by your insurance policy. If pre-authorization is required, YOU are responsible for coordinating all arrangements with your primary care physician, medical group, or insurance representative prior to your appointment. In the event that we have not received payment and/or correspondence from your insurance carrier within six weeks of filing a claim, you may receive a statement for the outstanding balance. We appreciate any assistance you can provide to expedite insurance reimbursement.

APPOINTMENT POLICY – If you need to reschedule or cancel an appointment, please notify us at least 24 hours in advance, or you may be subject to a **LATE CANCELLATION** fee of **$75.00**. A credit card is required at the time of scheduling your appointment. For "No Show" appointments and a less than 24 hour cancellation notice, your card will be charged. This policy applies to appointments with the doctors, registered nurse, or surgery scheduler.

Assignment of Benefits and Authorization to Release Records – My signature below indicates that I hereby request payment of benefits for all medical services provided by my physician be issued directly to him. I accept full financial responsibility of all expenses incurred and agree that any portion not paid by my insurance is due and payable from me upon demand. I grant automation to release any information required to obtain payment of medical benefits.

My signature below indicates that I have read and understand this statement in its entirety and that my questions have been adequately answered.

_____

Signature of Responsible Party Print Name of Responsible Party Date

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BEVERLY HILLS

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Referring Physician: _____

Address: _____

City, State, Zip: _____

Telephone: (_____) _____

Patient Name: _____

Home Address: _____

City, State, Zip: _____

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

Cell Phone: (_____) _____ Fax #: (_____) _____

Date of Birth: _____ /_____ /_____ SSN: _____ - _____ - _____ Sex: M ____ F ____

Marital Status: Married _____ Single _____ Widowed _____ Divorced _____

Email Address: _____ Occupation: _____

Employer Name: _____

Employer Address: _____

City, State, Zip: _____

Emergency Contact: _____

Emergency Contact Telephone #: _____

Medicare Number: _____ Part A ____ Part B ____

Primary Insurance: _____ Subscriber Name: _____

Insurance Address: _____

Insurance Telephone: _____ ID# _____ Group # _____

Effective Date: _____ / _____ / _____ Coverage Code: _____

Secondary Insurance: _____ Subscriber Name: _____

Insurance Address: _____

Insurance Telephone: _____ ID# _____ Group # _____

Effective Date: _____ / _____ / _____ Coverage Code: _____

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CURRENT PROBLEMS

Symptoms:		Duration:	

PAST MEDICAL HISTORY

Previous Operations:		Dates:	

OTHER PAST AND CURRENT MEDICAL PROBLEMS:
(i.e., Hypertension, diabetes, asthma, stroke, cancer, etc.)

FAMILY HISTORY: Parents, grandparents, siblings (alive; if deceased, list cause)

MEDICATIONS: List all current medications, including aspirin

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PATIENT HISTORY:

1. When did the symptoms first start?_____

_____

2. Please describe your symptoms (include the type of pain and the body part affected)

_____

_____

_____

3. Does a position and/or medication relieve your pain? _____

4. Do you have any pain, numbness, tingling, or weakness in your arms or legs? Please describe:

_____

_____

5. Are you presently working?

☐ Full Time ☐ Part Time ☐ Disabled ☐ Retired

6. Please list all tests you have had done and the results (including X-Rays, Lab tests, EMG, MRI, CT Scans, Myelogram, and Physical Therapy) _____

_____

_____

7. Please list previous treatments given or recommended _____

_____

8. Are you currently receiving treatment for any other medical condition? _____

_____

9. **SOCIAL HISTORY:** Age: _____ Height: _____ Weight: _____ Children: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed

Do you smoke? _____No _____Yes If so, how much? _____

Alcohol intake? _____No _____Yes If so, how much? _____

10. Describe your usual physical activity / exercise.

Type	Frequency
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

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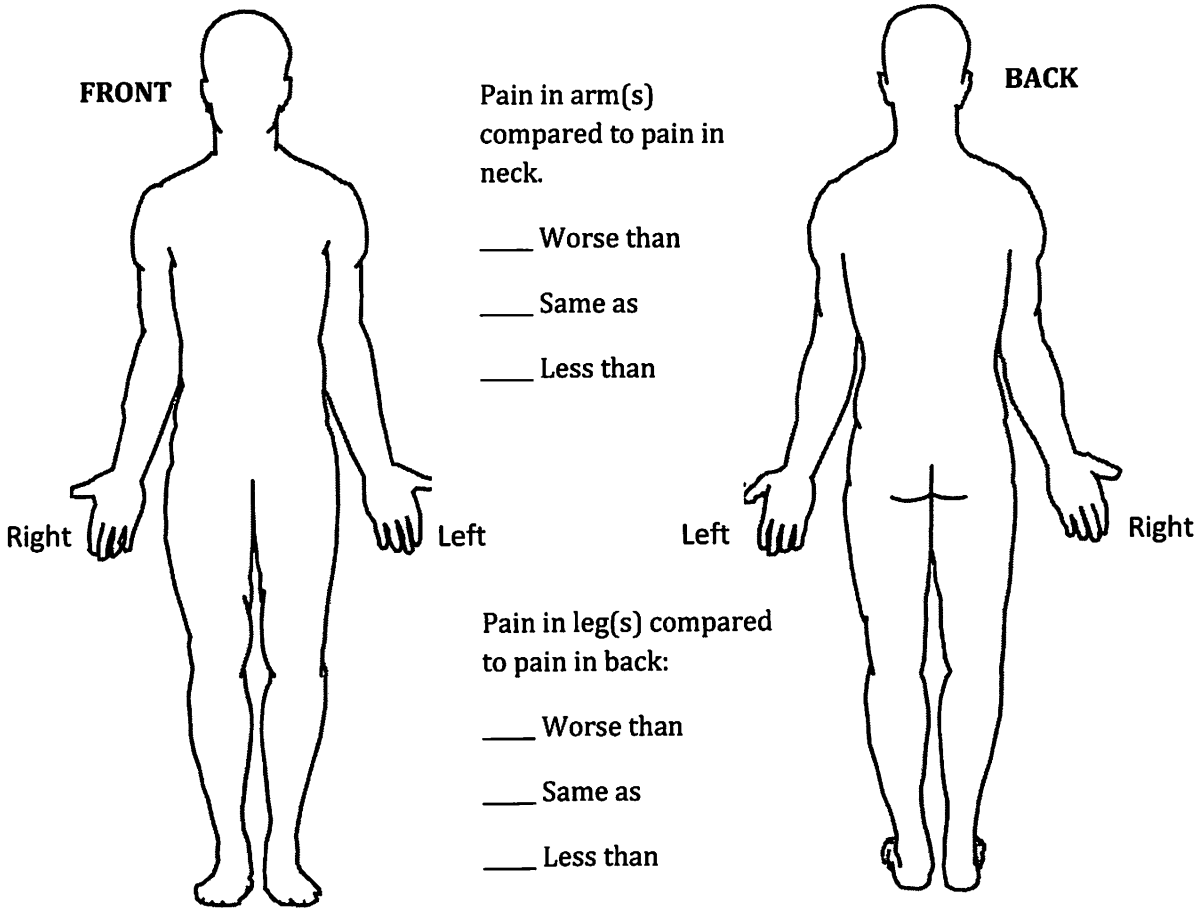
PATIENT PAIN DRAWING

Name _____ Date ____ /____ / ____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Mark the intensity of the pain on the line at the bottom of the page.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
+++++	//////	*******	XXXXX	VVVVV	00000



Pain in arm(s) compared to pain in neck.

____ Worse than

____ Same as

____ Less than

Pain in leg(s) compared to pain in back:

____ Worse than

____ Same as

____ Less than

Is your pain aggravated by any of the following?

____ Coughing or sneezing
____ Sitting in a chair
____ Bending forward to brush teeth
____ When you wake up
____ In the middle of the night
____ Lying flat on your back
____ Lying flat on your stomach
____ Walking a distance

PLEASE MARK ON THE LINE: How bad is your pain now?

1_____2_____3_____4_____5_____6_____7_____8_____9_____10_____

NO PAIN WORST PAIN

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FUNCTIONAL QUESTIONNAIRE

Name _____ Date ____ /____ / _____

Please answer every section, and mark in each section only the **ONE BOX** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just ***mark the box that most closely describes your problem***.

Section 1 – Pain Intensity

- ☐ I can tolerate the pan I have without having to use painkillers.
- ☐ The pain is bad, but I can manage without taking painkillers.
- ☐ Pain killers give me complete 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 me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e., on the table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only life very little weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ Pain prevents me from walking more than 10 min.
- ☐ Pain prevents me from walking at all.

Section 5 – Sitting

- ☐ I can sit in my chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 min.
- ☐ 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 min.
- ☐ Pain prevents me from standing for more than 10 min.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep very well only by using tablets.
- ☐ Even when I take tablets, I have less than 6 hours of sleep.
- ☐ Even when I take tablets, I have less than 4 hours of 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 gives me no extra pain at all.
- ☐ My sex life is normal but increases the degree of pain.
- ☐ My sex life is nearly normal, but it's very painful.
- ☐ 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 (i.e., dancing, etc.).
- ☐ Pain has restricted my social life, and I do not go out as often.
- ☐ Pain has restricted my social life to 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 min.
- ☐ Pain prevents me from traveling, except to the doctor or hospital.

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GENERAL REVIEW OF SYSTEMS

Allergies
- ☐ Asthma
- ☐ Hay Fever
- ☐ Skin eruptions

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ High flow blood pressure
- ☐ Poor circulation
- ☐ Rapid heart rate
- ☐ Swelling of ankles
- ☐ Varicose veins

Constitutional
- ☐ Chills/sweats/fever
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Weight loss

Ears, Nose, Mouth, Throat
- ☐ Bleeding gums
- ☐ Difficulty swallowing
- ☐ Earache
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problem

Endocrine
- ☐ Rapid weight loss/gain
- ☐ Intolerance to warm room
- ☐ Multiple broken bones
- ☐ Cessation of menstrual periods
- ☐ Excessive hunger/thirst
- ☐ Loss of libido
- ☐ Spontaneous nipple discharge

Eyes
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Double vision
- ☐ Vision flashes or halos

Genitourinary
- ☐ Blood in urine
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Poor appetite
- ☐ Rectal bleeding
- ☐ Stomach pain

Hematologic/Lymphatic
- ☐ Swollen lymph nodes
- ☐ Easy bruising skin
- ☐ Prolonged bleeding from cuts, tooth extractions

Integumentary
- ☐ Skin rashes or eruptions
- ☐ Chronic skin itching

Men
- ☐ Breast lump
- ☐ Lump in testicle
- ☐ Penis discharge
- ☐ Sore on penis

Musculoskeletal
Pain weakness, numbness, or swelling in:
- ☐ Hands, wrists, hips, knees, or joints
- ☐ Pain in arms or legs

Neurological
- ☐ Fainting
- ☐ Headaches
- ☐ Numbness in arms/legs
- ☐ Seizures
- ☐ Tingling of hands, feet, arms, or legs

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Panic attacks
- ☐ Restlessness

Respiratory
- ☐ Blood
- ☐ Cough
- ☐ Dizziness
- ☐ Shortness of breath

Women
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse

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Patient Registration Sheet

Please list any medications you have allergies to:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list doctors you want reports sent to:

Doctor: _____	**Doctor:** _____
Address: _____	**Address:** _____
City,	**City,**
State, Zip _____	**State, Zip** _____
Office Number _____	**Office Number** _____
Fax Number _____	**Fax Number** _____

_____

Name:

_____

Date of Birth:

_____

Social Security:

_____

Confidential Phone Number

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Notice Of Privacy Practices

This Notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain confidentiality of your health information.

I, _____ have read and received the HIPAA notice of
(Print Last, First Name)
Privacy Practices.

_____
Signature

_____
Print Name

_____
Date

Medical Records Release Form

By signing this form, I authorize you to release confidential hearth information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician below:

Patient Name: _____

Date of Birth: _____

The information you may release subject to this signed release form is as follows:

Complete Records	History & Physical	Care Plan
Lab Reports	Pathology Reports	Treatment Records
Hospital Reports	Medication Records	Progress Notes
Radiology Reports	Operative Reports	

Other:_____

Release my protected health information to the following physician:

Name: **JOHN J. REGAN MD**
Address: **2811 WILSHIRE BLVD, STE. 930**
City: **SANTA MONICA**
State: **CA**
Zip Code: **90403**
FAX: **310-496-1386**

Patient Name: _____

Patient Date of Birth: _____

Social Security Number: _____

Signature: _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____

Physician's or Authorized Representative's Signature (Date)

_____

Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____ _____

Patient's or Patient Representative's Signature (Date)

By: _____

Print Patient's Name

_____

(If Representative, Print Name and Relationship to Patient)

gned copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

3)

John J. Regan, MD
8929 Wilshire Blvd., Suite 302
Beverly Hills, CA 90211
PH | 310.881.3730

Fees for Form Completion / Administration Services

Insurance Health Plans DO NOT pay for all of your Health Care needs.

They pay for recovered items and services when their rules are met. We have found the need to inform you that their services below are not covered.

Pre-print RCSM form requiring

A check mark only	No charge
Another document	$25.00

Copy of part or all of chart

10-50 pages	$45.00
Each additional page	$0.50

Dictated letters or reports	$150.00

Special Forms

Disability forms	$150.00
Prescription Authorization	$25.00
Disability parking Placard Form	$55.00
No Flying letter	$40.00
Off Work letter	$40.00
Travel Letter	$40.00
Jury Duty Letter	$40.00

NOTE: Patient MUST pay above fees before form is processed.
Your signature below states that you understand this policy.

Signature:_____ Date:_____