United Spine and Joint Center

44055 Riverside Parkway, STE #216
Leesburg, VA 20176
Tel: (703)-840-0665 | Fax: (571) 346-1924 info@unitedspinecenter.com

Welcome Packet

Thank you for choosing United Spine Center for the treatment of your medical care. During your first visit, after a thorough exam, you will have the opportunity to discuss your symptoms and offered a variety of treatment options. These options may include patient education, physical therapy, interventional procedures, or non-opioid medications. This will enable you to make an informed decision, with your doctor, to find the treatment plan that is best for you.

To prepare for the first visit

It is imperative that you bring your current insurance card and driver's license or form of identification. Failure to bring your insurance card and an ID may result in the cancellation of your appointment.

If you have specific insurance questions it would be helpful to check with your insurance company and review your benefits prior to your appointment. If your insurance policy requires a referral from your primary care physician, this must be received prior to your appointment. Failure to do so may result in you being held responsible for the charges

Complete the New Patient packet

Please read and answer each question to the best of your ability. Be sure to bring everything with you to you appointment.

In the meantime, please know that we are highly committed to our patient's long term comfort and well-being. We will make every effort to ensure each visit is pleasant and beneficial to your needs. Should you find you are unable to keep your appointment please give at least 24 hours prior notice so we can provide this time to another patient in need. Thank you in advance for your help.

Sincerely,

Jon Mader, M.D.

What to bring with you (checklist):

- ❑ This entire completed New Patient packet
- ❑ Medical Insurance Card and ID
- ❑ Referral documentation from your referring physician (if required)
- ❑ All previous MRI's, X-Rays, CT scans
- ❑ Reports of MRIs, X-Rays, CTs, etc.
- ❑ List of your current medications.
- ❑ Form of payment for co-pay/deductible

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Attn Patient:

The purpose of this letter is to tell you about our general practice policies and position on using controlled substances, such as opioids (narcotics), to treat pain.

The United Spine Center's physicians are specialists in the management of spinal pain and pathology. Our policy, which coincides with current research, operates under a non-opiate treatment protocol. As such, medications such as Dilaudid, Percocet, Oxycotin, Morphine, Vicodin, etc. are not given as part of our treatment program.

We give this letter to all of our patients. After you read this letter, tell your doctor if you have any questions.

We will explore ALL medical treatment options within the scope of our medical practice to help you regain function and lead an active and healthy life, using a variety of treatment methods to accomplish treatment goals, including physical therapy, basic injection procedures, heat and/ or cold therapy, a home exercise program, non-controlled medications. To help us decide on the best treatment method for you we expect you to obtain your medical records from your primary care doctor and any other doctor who has treated you.

We want you to know that we are committed to treating you and doing what is medically acceptable and appropriate for you to help you control your pain. We look forward to serving you and helping you control your pain.

Sincerely,

_____

Jon Mader, M.D.

Patient Signature: _____ **Date :** _____

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Patient Name:_____ Date_____

Primary Care Physician's Name_____ Phone _____

Referring Provider's Name (if applicable)_____ Phone_____

Who referred you to United Spine Center? _____

Your Age _____ Height (aprox): _____ Weight (aprox):_____

Onset of Symptoms

Approximately when did this pain begin? _____

What caused your current pain episode? _____

Was there an injury or accident that initiated the symptoms? _____

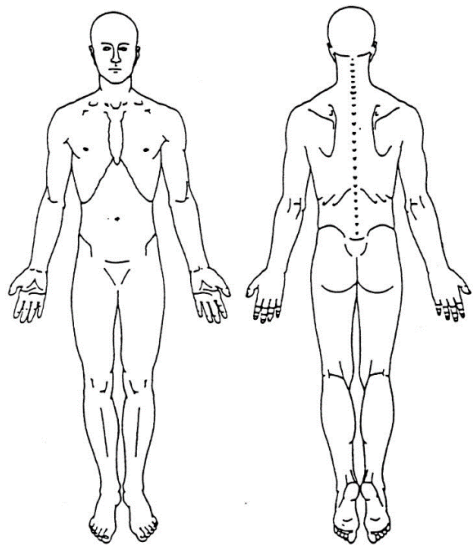
How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Pain Intensity and Location

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_____ The Best It Gets_____ The Worst It Gets_____

Use the Diagram to indicate the area of your current pain. Please do not indicate areas of pain that are not related to your present injury or condition. Mark the location with an "X"	

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Pain Description

When is your pain at its worst?

☐ Mornings ☐Daytime ☐ Evenings
☐ Middle of the night ☐ Always the same

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present ☐ Intermittent (comes and goes)

How does the pain feel?

☐ Dull/Aching ☐ Stabbing/Sharp ☐ Shooting
☐ Cramping/Tight ☐ Throbbing ☐ Hot/Burning
☐ Other_____

What makes it worse?

☐ Bending ☐ Lifting ☐ Exercise ☐ Movement
☐ Sitting ☐ Standing ☐ Walking ☐ Laying Down
☐ Changing Positions (eg. sitting to standing) ☐ Climbing UP stairs
☐ Other_____

What makes it better?

☐ Bending ☐ Stretching ☐ Exercise ☐ Repositioning
☐ Sitting ☐ Standing ☐ Walking ☐ Laying Down
☐ Changing Positions (eg. sitting to standing)
☐ Other_____

Do you have any of the following symptoms?

☐ Numbness/Tingling Where?_____

☐ Muscle Weakness Where?_____

☐ Bowel/Bladder incontinence

☐ Tripping/Falling

☐ Difficulty sleeping?

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Please check any previous treatments for current pain:

□ None □ Physical Therapy □ NSAIDS □ Pain Medications □ Heat/Ice

□ Acupuncture □ Chiropractor □ Massage □ Herbal Remedies □ Oral Steroid

□ Injections □ Tens Unit □ Other_____

If yes, please list injections_____

Mark all of the following tests that you have related to your current pain complaints:

☐ MRI of the: _____ Date:_____
☐ X-Ray of the: _____ Date:_____
☐ CT Scan of the:_____ Date:_____
☐ Other Diagnostic Testing:_____ Date:_____
☐ I have not had ANY diagnostic tests for my current pain complaint

Past Medical History (Please check all that apply)

General Medical
☐ Cancer – Type _____
☐ Diabetes – Type_____

Cardiovascular/Hematologic
☐ Anemia
☐ Heart Attack
☐ Coronary Artery Disease
☐ High Blood Pressure
☐ Peripheral Vascular Disease
☐ Stoke/TIA
☐ Heart Valve Disorders

Gastrointestinal
☐ GERD (Acid Reflux)
☐ Gastrointestinal Bleeding
☐ Stomach Ulcers
☐ Constipation

Urological
☐ Chronic Kidney Disease
☐ Kidney Stones
☐ Urinary Incontinence
☐ Dialysis

Neuropsychological
☐ Multiple Sclerosis
☐ Peripheral Neuropathy
☐ Seizures
☐ Depression
☐ Anxiety
☐ Schizophrenia
☐ Bipolar Disorder

Head/Ears/Eyes/Nose/Throat
☐ Headaches
☐ Migraines
☐ Head Injury
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Glaucoma

Respiratory
☐ Asthma
☐ Bronchitis/Pneumonia
☐ Emphysema/COPD

Musculoskeletal/Rheumatologic
☐ Bursitis
☐ Carpal Tunnel Syndrome
☐ Fibromyalgia
☐ Osteoarthritis
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Chronic Joint Pains

Other Diagnosed Conditions
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

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Past Surgical History

Please list any surgical procedures you have had done in the past including date:

1) _____ Date? _____
2) _____ Date? _____
3) _____ Date? _____
4) _____ Date? _____
5) _____ Date? _____

☐ I have **NEVER** had any surgical procedures performed.

Current Medications

Are you currently taking any blood thinners or anti-coagulants? ☐ YES ☐ No

If YES, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other _____

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

	Medication Name	**Dose**	**Frequency**
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Allergies

Do you have any drug/medication allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

	Medication Name	Allergic Reaction
1)		
2)		
3)		
4)		
5)		

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

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Family History

Mark all appropriate diagnoses as they pertain to your first degree relatives:

☐Arthritis ☐Cancer ☐Diabetes

☐Headaches/Migraines ☐High Blood Pressure ☐Kidney Problems

☐Liver Problems ☐Osteoporosis ☐Rheumatoid arthritis

☐Seizures ☐ Stroke

☐Other Medical Problems: _____

☐ I have no significant family medical history

Social History

Occupation: _____ When was the last time you worked? _____

Who is in your current household? _____

Are there any stairs in your current home? _____ If so how many? _____

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

Are you currently under worker's compensation? ☐ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

Alcohol Use:

☐ Social Use ☐ History of alcoholism ☐ Current alcoholism ☐Never

☐ Daily use of alcohol

Tobacco Use:

☐ Current user ☐ Former user ☐ Never used

☐ Packs per day? _____ ☐ How many years? _____ ☐ Quit Date: _____

Illegal Drug Use:

☐ Denies any illegal drug use ☐ Currently uses illegal drugs

☐ Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

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Review of Systems

Mark the following symptoms that you currently suffer from:

Constitutional:	☐ Chills	☐ Difficulty sleeping	☐ Easy bruising
	☐ Night Sweats	☐ Fatigue	☐ Fevers
	☐ Insomnia	☐ Low sex drive	☐ Tremors
	☐ Unexplained Weight Gain		☐ Weakness
	☐ Unexplained Weight Loss		

Eyes:	☐ Recent Visual changes

Ears/Nose/Throat/Neck:	☐ Dental Problems	☐ Earaches	☐ Hearing Problems
	☐ Nosebleeds	☐ Sinus problems	

Cardiovascular:	☐ Chest Pain	☐ Bleeding Disorder	☐ Blood Clots
	☐ Fainting	☐ Palpitations	☐ Swelling in feet
	☐ Shortness of breath during sleep		

Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of breath

Gastrointestinal:	☐ Constipation	☐ Acid Reflux	☐ Abdominal Cramps
	☐ Diarrhea	☐ Nausea/Vomiting	☐ Hernia

Musculoskeletal:	☐ Back Pain	☐ Joint Pains	☐ Joint Stiffness
	☐ Joint Swelling	☐ muscle spasms	☐ Neck Pain

Genitourinary/Nephrology:	☐ Flank Pain	☐ Blood in Urine	☐ Painful Urination
	☐ Decreased Urine Flow/Frequency/Volume		

Neurological:	☐ Dizziness	☐ Headaches	☐ Tremors
	☐ Numbness/Tingling		☐ Seizures

Psychiatric:	☐ Depressed Mood	☐ Feeling Anxious	☐ Stress Problems
	☐ Suicidal Thoughts	☐ Suicidal Planning	
	☐ Thoughts of Harming Others		

United Spine Center

NEW PATIENT FORM

Account Number

Last Name	First Name	Middle Initial	Social Security Number
Sex: Male / Female	Prefix / Suffix	Date of Birth (mm,dd,yy)	Student: No/ Full Time/ Part Time
Street Address	City/State	Zip Code	Emergency Contact
Home Telephone	Work Phone	Cell. Phone	Email Address:
Race:	Marital Status: Single/Married/Divorced/ Widowed	School Name/Phone Number (if applicable)	Job Title
Assigned Preferred Provider (PCP)		Preferred Pharmacy Name/Phone Number	
Employer	Employer Address/Phone Number		

RESPONSIBLE PARTY/BILLING INFORMATION

Last Name	First Name	Middle Initial	Prefix	Suffix
Date of Birth	Sex: Male/ Female	Social Security #	Relationship to Patient:	
Street Address (if different from above)		City/State	Zip Code	
Home Telephone	Work Telephone	Employer Name	Job Title	
Employer	Employer Address			

PRIMARY INSURANCE INFORMATION

Policy #	Group #	Effective Date	Primary Insurance: Yes / No
Office Co-Pay $	Specialist Co-Pay $	Name of Insurance Company/Plan	
Insurance Co. Address		City/State	Insurance Co. Telephone
Insured's Name	Date of Birth	Home Telephone	Social Security Number
Insured's Employer	Address/State/Zip Code		Employer Telephone

SECONDARY INSURANCE INFORMATION

Policy #	Group #	Effective Date	
Office Co-Pay $	Specialist Co-Pay $	Name of Insurance Company/Plan	
Insurance Co. Address		City/State	Insurance Co. Telephone
Insured's Name	Date of Birth	Home Telephone	Social Security Number
Insured's Employer	Address/State/Zip Code		Employer Telephone

PATIENT AUTHORIZATIONS

I authorize my insurance benefits to be paid directly to **United Spine Center** and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to **United Spine Center**, Loudoun Medical Group P.C., or any of its affiliates or agents, lenders, or any third party servicer acting for **United Spine Center**, Loudoun Medical Group, P.C., or any of its affiliates.

I agree to promptly pay for services rendered for me or the patient named above. If I fail to meet my financial commitment to **United Spine Center** and/or Loudoun Medical Group, and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. I further agree to pay for any missed appointments of which I did not notify the medical office within a reasonable amount of time.

I hereby understand that with treatment at any **United Spine Center** and/or Loudoun Medical Group offices I have given consent to testing and release of test results related to infection with human immunodeficiency virus or hepatitis B or C viruses, if in their opinion, an employee has suffered an exposure incident as a result of my treatment, as defined by the Centers for Disease Control and the Occupational Safety and Health Administration. I also understand I have consented to the release of such test results to the person who was exposed.

Signature _____ Date _____

Printed Name _____

CANCELLATION POLICY

United Spine Center requires at least 24 hours advanced notice for canceled appointments and/or procedures.

Any appointment or procedure that is not canceled with an advanced notice of 24 hours will be subject to the following cancellation fee schedule:

Office Visit Cancellations: $35.00
Procedure Cancellations: $50.00

This cancellation fee is the responsibility of the patient and will not be billed to your insurance company.

Your signature below constitutes that you fully understand, acknowledge, and agree with the above policies set forth by **United Spine Center.**

Signature _____ Date _____

Printed Name _____

RECEPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I have read and received a copy of the Loudoun Medical Group/United Spine Center's **NOTICE OF PATIENT PRIVACY PRACTICES** policy**.**

Signature _____ Date _____

Printed Name _____

UNITED SPINE CENTER
GENERAL ACKNOWLEDGMENT AND WAIVER

BILLING POLICY

DEDUCTIBLES ARE DUE IN FULL AT THE TIME OF SERVICE.

Deductibles, co-payments and co-insurance amounts must be paid in full prior to seeing a physician and/or receiving medical care. Patients are responsible for verifying the amount of their deductible with their insurance company prior to their initial visit.

We accept cash, check, and major credit cards. Please note that a $25 service fee will be issued for any unpaid returned checks. Patient accepts responsibility for payment of this fee in addition to the original issued amount of the unpaid returned check.

The patient accepts full responsibility to provide current insurance plan information at the time of initial office visit. If this information is not provided or inaccurate, the patient accepts full responsibility for all charges billed during the visit.

We require re-verification of insurance card at each visit. It is the responsibility of the patient to provide United Spine Center with any changes or updates to the patient's insurance plan. A service fee of $25 will be assessed if a patient's bill is incorrectly submitted to an insurance company due to a lack of updated information. The patient accepts responsibility for this service fee and will be held responsible for all charges not covered by their insurance plan.

Accounts not paid within 90 days with a balance will be automatically turned over to a collection agency. The patient remains financially responsible and will be charged for the collection agency's fee in addition to the past due amount.

Patients are subject to a fee of $10 if additional paperwork such as disability or insurance forms are required to be completed by our office staff.

REFERRAL POLICY

You may receive a statement from your insurance carrier for failure to obtain proper referral from primary care physician if this is required by your insurance company. It is the patient's responsibility to obtain and present proper referral information from their primary care physician during their initial visit if required by their insurance plan. If a patient inadvertently receives medical care or visits with the physician without a required referral, the patient will be financially responsible for the visit. If additional referrals are required, it remains the patient's responsibility to obtain and present the referrals at each applicable visit.

HMO POLICY

It is the patient's responsibility to be verified by our accepted providers and to have proper referral paperwork provided prior to receiving medical care.

All professional services rendered are charged to the patient who accepts responsibility for all charges regardless of the insurance carrier. United Spine Center will bill the patient's primary and/or secondary insurance company on the patient's behalf. Any remaining balance will be billed directly to the patient. Any balance due, regardless of reason, is the patient's responsibility to pay.

Signature _____ Date _____

Printed Name _____

MEDICARE PATIENTS ONLY – CONTINUE TO READ AND SIGN BELOW

Medicare and or your private insurance carrier will only pay for services that determines to be 'reasonable and customary' under Section 1862 (a) (1) of the Medicare law.

It will be the patient's responsibility to verify that your insurance will cover any procedure that you are requesting to be done or that we provide.

Private and Commercial insurances will deny coverage for the following reasons:

A. Patient policy has terminated at time of service and/or patient did not present front desk with a current insurance card
B. Acupuncture, Botox Medication OR any other injection procedure
C. Non-covered Medicare procedures

If Medicare and/or my commercial insurance should deny any or all charges and/or I do not present any of the items above, I agree to be personally and fully responsible for any and all balances due.

Signature _____ Date _____

Printed Name _____

LOUDOUN MEDICAL GROUP PC
d.b.a. United Spine Center
NOTICE OF PATIENT PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions or comments about this Notice please contact:

Loudoun Medical Group, PC
224-D Cornwall St. NW, Suite 403
Leesburg, VA 20176

Our Privacy Officer is: Clara McAuley Nussbaum, Director of Compliance, 703-737-6010

Who Does this Notice Apply to?

Loudoun Medical Group, PC, has published this Notice. It applies to everyone who works for Loudoun Medical Group, PC, including our employees, contractors, and volunteers.

Why Do We Publish this Notice?

As medical professionals, we understand that information about you and your health is sensitive and personal. We are also required by law to maintain the privacy of information we gather and use about our patients, and provide them with notices of our legal duties and privacy practices with respect to their information.

While we are committed to the privacy of our patients' information, in order to serve them we need to gather, keep and use records of this information. We sometimes also need to share information with other parties. This Notice is intended to let you know how we use and disclose your information.

This Notice is also to let you know about certain legal rights you have with respect to the information we hold about you. You have certain rights to review and copy our records of information about you. You may also request that we amend these records, and may ask us to account for certain disclosures we may have made of information about you.

When Is This Notice Effective?

We are required to comply with the terms of this Notice while it is in effect. We reserve the right to change the terms of this Notice, and make the new terms effective for all information to which this Notice applies. This Notice will be in effect from **April 10, 2003** until the date we publish an amended Notice. If we do publish an amended Notice, we will notify you at your next visit. We will also publish the amended Notice in our offices, and will publish it on our web site if we maintain one.

What Information Does this Notice Cover?

This Notice covers all information in our written or electronic records which concerns you, your health care, and payment for your health care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing care, or manage some of our administrative operations.

When Can We Use or Disclose Information About You?

- ***Treatment***. We may use or disclose information about you for treatment purposes to doctors, nurses, technicians, medical students or other individuals who work in our practice who are involved in providing you with health care. We may also disclose information about you to organizations and individuals involved in your care who are outside of our practice, such as consulting physicians, laboratories, social workers, and so on.

  For example, if we refer you to another physician or a hospital for specialty services, we will provide that physician or hospital with all clinical information, which might be necessary or helpful to help them provide you with the right care. Or, if we need to send a sample of your blood to a laboratory for analysis, we will provide the laboratory with the information they need to process your blood correctly.

  These are only examples, and we may use or disclose information about you to provide you proper treatment in many other ways.

- ***Payment***. We may use or disclose information about you for payment purposes to our clerks and officers involved in billing and claims payment. We may also disclose such information to your health plan or other party financially responsible for your care, or to claims and billing services if necessary.

  For example, if you are covered by a health plan we cannot get paid for the services we provide you unless we submit information in a claim. This might include detailed clinical information, depending on the kind of plan and claim. This is only an example, and there may be many other ways in which we may use or disclose information about you in connection with payment for your care.

- ***Health care operations***. We may use or disclose information about you for operations in connection with our practice. These activities might include practice quality improvement, training of medical students, insurance underwriting, medical or legal review, and business planning or administration of our practice.

  For example, we may wish to review the quality of care you receive, in order to help us deliver the best care we can. Or, we may audit our management practices so we can become more efficient. These are

only examples, and we may use or disclose information about you for health care operations in many other ways.

- To a public health agency, for purposes such as controlling disease.
- In case of suspected child abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or it appears necessary to prevent serious harm to you or others.
- To health oversight authorities, for regulatory, licensing and other legal purposes.
- In litigation, subject to certain requirements controlling the terms of the disclosure.
- To law enforcement agencies, subject to applicable legal requirements and limitations.
- Worker's Compensation: In such cases that your treatment is a result of an injury on the job, we may release your information to the appropriate carrier/employer.
- To Funeral Directors/Medical Examiners/Coroners in the event of your death.
- When required by Federal, State or Local law.
- For medical research purposes, subject to your authorization or approval by an institutional review board.
- If you are in the United States military, national security or intelligence, Foreign Service, to your authorized superiors or other authorized federal officials.

We may contact you for information to support your health care, including appointment reminders, information about alternative treatments, and health-related services, which may be of interest to you. We will routinely contact patients via telephone at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments. *Please advise us if you do not wish to receive such communications*, and we will not use or disclose your information for such purposes. If you wish not to receive this kind of communication, you must advise us in writing at our Contact address given above.

We may not use or disclose information about you for any other purpose without your written authorization.

What Legal Rights Do You Have In Connection With Your Information?

The Law entitles you to:

- Ask us to further restrict our use and disclosure of information about you. We are not required to grant such a request, but if we do we must make sure the restrictions are implemented.
- Receive confidential communications from us, at an alternative address you provide to us.
- Review our records of your information.
- Obtain a copy of all or any part of our records of your information. We may charge you a copying charge of a $10 base fee, $.50 per page for pages 1-50, then $.25 for any pages over 50.
- Ask us to amend your records, if you believe that they are incorrect or incomplete. We are not required to make such an amendment. If you request an amendment and we determine we will not make it, you are entitled to have a statement of your disagreement included in your records. If you do include a statement of disagreement in your records, we may include a statement of explanation or response in your records as well.
- Obtain an accounting of all persons to which we have disclosed information about you, for any purpose except your treatment, payment for your treatment, or our health care operations.
- If you believe we have violated your privacy rights, you may forward us a written complaint to our Contact address given above. You may also file a complaint with the Secretary of the United States Department of Health and Human Services. If you do file a complaint we are legally prohibited from retaliating against you.