SPORTS AND SPINE INSTITUTE
McDONOUGH and MARIETTA

CONFIDENTIAL PATIENT INFORMATION SHEET

DATE: ____________________ ARE SYMPTOMS RELATED TO A MOTOR VEHICLE ACCIDENT? YES or NO

ATTORNEY NAME ____________________________________ ATTORNEY PHONE # ____________________

REFERRING DOCTOR __________________________________ DOCTOR PHONE # ____________________

PRIMARY CARE DOCTOR ______________________________ DOCTOR PHONE # ____________________

LAST NAME ____________________ FIRST NAME: ____________________ MI: ________

RESPONISIBLE PARTY (IF A MINOR): ____

ADDRESS: ____ APT. # _____________

CITY: ______________________________ STATE: ____________________ ZIP: __________________

HOME #: ______________________ CELL #: ______________________ WORK PHONE #: ____________________

DATE OF BIRTH: ______________ SEX: ( ) M ( )F SOCIAL SECURITY #: ______________________

EMAIL ADDRESS: ____

( ) SINGLE ( ) MARRIED ( ) DOMESTIC PARTNER ( ) SEPARATED ( ) DIVORCED ( ) WIDOWED

Race (check all that apply)

__American Indian or Alaska Native

__ Pacific Island

__ Asian

__ White

__ Black or African American

__ Native Hawaiian or Other

__ Other

Ethnic Group (check one)

__ Declined

__ Hispanic or Latino

__ Not Hispanic or Latino

Preferred Language

__ English

__ Spanish

EMPLOYER INFORMATION

EMPLOYER NAME: ______________________________

OCCUPATION: ______________________________

EMPLOYER ADDRESS: ______________________________

CITY: ______________________ STATE: ________ ZIP: ________

PRIMARY INSURANCE

__ BlueCross BlueShield	__ Medicaid	__ Peach State Health Plan
__ Humana	__ Ambetter	__ AmeriGroup
__ United Healthcare	__ Medicare	__ Ambetter
__ Cigna	__ Wellcare	__ Worker's Comp

SECONDARY INSURANCE

__ BlueCross BlueShield	__ Medicaid	__ Peach State Health Plan
__ Humana	__ Ambetter	__ AmeriGroup
__ United Healthcare	__ Medicare	__ Ambetter
__ Cigna	__ Wellcare	__ Worker's Comp

EMERGENCY CONTACT

NAME: ______________________________

RELATIONSHIP: ______________________________

ADDRESS: ______________________________

CITY, STATE & ZIP: ______________________________

HOME & CELL PHONE #: ______________________________

PREFERRED PHARMACY

NAME: ______________________________

ADDRESS: ______________________________

NUMBER: ______________________________

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN WHERE INDICATED:

RELEASE AND ASSIGNMENT

I, the undersigned hereby authorize the release of all information necessary to secure the payment of benefits submitted for services rendered by the Physicians and Staff of Sports & Spine Institute McDonough/Marietta of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Sports & Spine Institute McDonough/Marietta to submit claims for benefits for any service rendered without obtaining my signature on each and every claim form and that I will be bound by this signature as though the undersigned had personally signed the particular claim form.

I, the undersigned, have coverage with the insurance companies as listed on the other side of this Patient Information Form and assign directly to Sports & Spine Institute McDonough/Marietta all claims benefits, if any, otherwise payable to me for services rendered. I acknowledge and understand that I am financially and fully responsible for all charges incurred from the services rendered by my physician, whether or not paid by the insurance company. If any portion of my account balance is not reimbursed by my insurance company, for any reason, I agree to cooperate and arrange prompt payment to clear my bill. I understand that payment is due upon receipt of my monthly statement.

This Release and Assignment is effective for the period of 2016 - 2026.

____ ______/_______/____________

Signature of Patient or Legal Guardian Date

Fees and Insurance

Payment is expected at the time of service for all office visits and office procedures. All estimated insurance deductible, co-payments, and co-insurances are collected before services are rendered. If payment is not received from the insurance company within 60 days of the filing date, payment responsibility will be transferred to the patient. It is the responsibility of the patient to ensure that we have all of the correct insurance information and any referrals or authorizations required by your insurance company.

____ ______/_______/____________

Signature of Patient or Legal Guardian Date

Receipt of Notice of Privacy Practices Written Acknowledgement

I have received Notice of Privacy Practices and I have been provided the opportunity to review it.

____ ______/_______/____________

Signature of Patient or Legal Guardian Date

Patient's Consent to Photograph

I, the undersigned, do hereby authorize Sports & Spine Institute McDonough/Marietta to utilize my photograph while under the care of the above institution. I understand this is solely for identification purposes and will not be used for any other reason.

____ ______/_______/____________

Signature of Patient or Legal Guardian Date

Office Policies

I, understand and agree that if my physician orders me to follow up within a certain time frame it should be considered medically necessary that the follow up appointment is mandatory unless my physician has given PRN (as needed basis) orders. I understand and agree it is my sole responsibility to manage my appointments that my physician orders for me. I agree that I will follow all recommended follow up visits, test etc. I, understand and agree that in the event I choose to seek legal representation or become involved in litigation against Sports & Spine Institute McDonough/Marietta my case must be supported by a board-certified physician in the same specialty as my physician or Pain Management.

_______________________________ ____/____/________

Signature of Patient of Legal Guardian Date

Patient Cancellation and No Show Policy

Sports & Spine Institute McDonough/Marietta requires a 24-hour notice of any appointment cancellation or reschedule. Offenders will be charged. **ALL CHARGES WILL BE PAID BEFORE BEING SEEN AGAIN!**

- **1st & 2nd** Offense - The patient is charged a $50.00 no show fee for not giving 24-hour notice of cancellation or rescheduling.

- **3rd** Offense- the patient is charged a $50.00 no show fee and is dismissed from this practice. The patient will have to find another doctor.

- Procedures that are no showed will be charged a $100.00 fee.

Payment & Fees

All co-pays, deductibles, and co-insurances are collected in full at time of service. We welcome cash, MasterCard, Visa, & Discover.

Disability and Medical Forms

Forms are completed at the discretion of your attending physician. It should be discussed at your visit and if he agrees to complete the forms, the following fee schedule will apply.

Form Fees: $ 80.00

Medical Records

We will gladly send your medical records to another physician free of charge. If the patient wants a copy or any insurance company or lawyer's office requests them, there will be a charge.

Children

Either a parent or a legal guardian should accompany all minors. Children are not to be left unsupervised in the waiting room. Please bring another adult with you to supervise your children while you visit with the doctor.

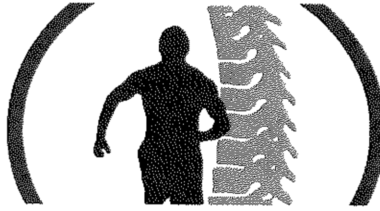
Late Policy

As a **NEW** patient, if you are more than 10 minutes late for your appointment, you will have to reschedule. For any follow-up visit, if you are more than 5 minutes late, you will have to reschedule your appointment. Traffic is not an excuse.

I have read and agree to the office policies of Sports & Spine Institute McDonough/Marietta.

_______________________________ ____/____/________

Signature Date



SPORTS AND SPINE INSTITUTE
McDONOUGH and MARIETTA

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPPA), established a Privacy Rule to help insure that personal health care information is protected by privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or previously signed consent.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive always to take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum information necessary only to those we feel are in need of your healthcare information and information about treatment, payment, or healthcare operation, in order to provide your healthcare needs.

There are times when you may wish other family members and friends to inquire about your appointments or have access to your medical information. We will not release any information to anyone that is not listed below. If you wish us to leave messages on your answering machines/voicemail other than to say "please call us back," please indicate this also.
Answering Machine/Voicemail:

_______ Do not leave message other than to return our call

_______ You may leave messages with information

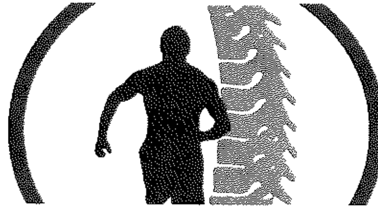
List any family member or others you wish to have access to your records, for example, who may call us regarding your condition or who may call for you. **We will not release information to spouses or children unless you list them below.** We will require signed releases from you for anyone wanting access to your records other than the insurance companies you have listed with us, your healthcare provider as necessary for your care, or persons listed below.

Name	How related to you
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

I acknowledge that I have received copy of Sports & Spine Institute McDonough/Marietta Notice of Privacy Practices. This notice describes how Atlanta Sports & Spine may use and disclose my protected healthcare information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected healthcare information. I also understand that I may revoke this authorization at any time or receive a copy of this authorization.

PRINTED NAME: ______________________________

SIGNATURE: ______________________________ DATE: ______________



SPORTS AND SPINE INSTITUTE
McDONOUGH and MARIETTA

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date of Birth: ______________________ **Social Security Number:** ___________________________

I, ____, hereby authorize **Sports and Spine Institute of McDonough/Marietta** to

Release or Obtain my medical records to/from: ____

Address: ____

____

any Medical information from my health record for the prose of continuity of care. Information to be disclosed includes:

Office Notes, Test Results, Medication History, Surgery Reports, and Lab Results, for the purpose of treatment.

AUTHORIZATION INCLUDES AUTHORITY TO RELASE MENTAL HEALTH/REHABILITATION/ALCOHOL OR DRUG RECORDS/ HIV TEST RESULTS AND/OR DIAGNOSIS AND TREATMENT. (IF UNDER 18 YEARS OF AGE, PARENT OR GUARDIAN MUST SIGN). INITIAL EACH BOX THAT APPLIES IF SUCH INFORMATION IS NOT BE RELEASED.

____ My diagnosis and/or treatment for alcoholism and/or drug abuse or dependency **may not be released** to the recipient noted above.

____ My diagnosis and/or treatment concerning mental health/rehabilitation **may not be released** to the recipient noted above.

____ HIV Antibody test results and/or AIDS diagnosis and treatment **may not be released** to the above noted recipient.

Purpose of disclosure: ____

I understand that this consent is revocable by me in writing at any time except to the extent that action has been taken in reliance on it. I also understand that this consent will expire in three hundred sixty-five (365) days after the date of the signature or automatically when the records requested on this form have been mailed/faxed to the requestor.

PROHIBITION ON REDISCLOSURE: this information has been disclosed to you from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited.

Date: ______________________ Signed: ____________________________________

Medical Record #: ________________

If patient is unable to give consent because of a physical condition or age, complete the following: Patient is a minor, _____ years of age or is unable to give consent because (describe position): ______________________.

Date: ______________________ Signed: ____________________________________ (Parent/Guardian)

SPORTS AND SPINE INSTITUTE
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Medication Agreement

As part of your treatment, our medical staff may prescribe medications for you. As you know, medications can have serious side effects, if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows the prescribed guidelines. No prescriptions will be written unless you accept the following agreement.

1. I agree to follow the dosing schedule prescribed by doctor.
2. I will never share, sell or exchange my medications with anyone for any reason.
3. I understand that I am solely responsible for the safekeeping of my medications. I will treat my medications as I would any valuable possession. I know that Sports & Spine Institute McDonough/Marietta does not replace any **LOST** or **STOLEN** prescriptions or controlled medications.
4. I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive medications.
5. I agree that if I receive a controlled substance prescription from Sports & Spine Institute McDonough/Marietta, I am not allowed to accept controlled substance prescriptions or any pain medications from any other physician without my doctor's consent.
6. I agree to use only one pharmacy for my pain-related medications. In the event that circumstances require the use of another pharmacy, I will notify Sports & Spine Institute McDonough/Marietta of this immediately and provide them with all pertinent contact information.
7. I understand that prescriptions involving narcotics requires a scheduled appointment in the office. Narcotic refills will not be called into a pharmacy. Narcotic dosages will not be increased by phone.
8. I know that I can be asked to bring any or all of my prescribed medications to my office appointment or at a random time for a prescription compliance check (pill count).
9. I understand that abusive behavior or harassment toward any of the staff at Sports & Spine Institute McDonough/Marietta will not be tolerated. The doctor will determine what actions can be considered harassment on a case-by-case basis and, if warranted, I can be dismissed from the practice.
10. I understand that dealing with a forged, falsified or altered prescription will result in my immediate dismissal from Sports & Spine Institute McDonough/Marietta and may be reported to the local police.
11. I understand that Sports & Spine Institute McDonough/Marietta reserves the right to PERFORM **A URINE DRUG SCREEN AT ANY TIME WHILE I AM BEING TREATED WITH PRESCRIBED CONTROLLED SUBSTANCES.** If the results of the urine drug screen do not reflect medicine prescribed by my doctor or test positive for illegal drugs, I understand that I can be dismissed immediately from the practice. I also agree to pay any cost not covered by my insurance.
12. I understand that if I have a problem or need to change my medication(s), I will need to make an appointment and bring in **ALL MEDICATIONS PRESCRIBED BY** Sports & Spine Institute McDonough/Marietta. If I fail to bring them, Sports & Spine Institute McDonough/Marietta will not issue a new prescription.

By signing this agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood and accepted these terms. Non-compliance with this agreement will be terms for dismissal from the practice.

PATIENT NAME (PRINT) ____

PATIENT SIGNATURE: ______________________________ DATE ______________

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URINE DRUG SCREEN POLICY

Prescription pain medications are potentially addictive. The number of deaths in the US from prescription drug overdoses has doubled in the past 10 years. More than 30,000 deaths are occurring per year. Prescription medications are the number one abused drugs in our country.

At Sports & Spine Institute McDonough/Marietta, we are committed to helping our patients have the best quality of life possible and that includes prescribing pain medications. Part of this responsibility includes random drug screens at a minimum of two times per year.

Please be prepared to offer a urine sample at every visit. If you are unable to provide a urine sample when asked, we will not be able to prescribe any pain medication(s).

Please understand that our patient's health and safety is our number one priority and we are committed to providing excellent patient healthcare at Sports & Spine Institute McDonough/Marietta.

Sincerely,

Management

By signing below, I understand that urine drug screens are a part of the medication agreement. I have signed and agreed to do my part as a patient to ensure compliance with all my pain medications.

Patient Name (Print) ____

Patient Signature ______________________________________ Date ______________

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Initial Clinical Data Form

NAME: ______________________ **DATE:** ______________________

PAST MEDICAL HISTORY: If you have any of the following medical conditions, please put a check mark by them.

__ AIDS/HIV	__ Anemia	__ Arthritis	__ Asthma
__ Bleeding Disorder	__ Blood Clotting	__ Blood Thinners	__ Cancer
__ COPD	__ Depression	__ Diabetes	__ Dialysis
__ DVT/Phlebitis	__ Fibromyalgia	__ GERD	__ GI Bleeding
__ Gout	__ Heart Disease	__ Hypertension	__ Hepatitis. Type: ______
__ Kidney Disease	__ Liver Disease	__ Migraine Headaches	__ Osteoarthritis
__ Osteoporosis	__ Rheumatoid Arthritis	__ Seizures	__ Stroke
	__ Stroke	__ Ulcers	

FAMILY HISTORY: Please tell us about any family members have or have had major health problems

Mother: __ Alive __ Deceased

Health Problems ______________________

Father: __ Alive __ Deceased

Health Problems ______________________

Siblings __ Brother __ Sister __ Alive __ Deceased

Health Problems ______________________

__ Unknown / Adopted

SOCIAL HISTORY

Hand Dominance: __ Right __ Left __ Bilateral

Exercise Level: __ None __ Occasional __ Moderate __ Heavy

Smoking Status: __ Never Smoked __ Former Smoker __ Current every day Smoker __ Current Some day smoker

How much do you smoke? __ 1 PPW __ 2 PPW __ ¼ PPD __ ½ PPD __ 1 PPD __ 1 ½ PPD __ 2 PPD __ 3+ PPD

Has smoked since age _____ Chewing Tobacco: __ None __ 1 per day __ 2-3 per day __ 4 + per day

Illicit Drugs? Yes / No, If yes, list ______________________

Alcohol Intake: __ None __ Occasional __ Moderate __ Heavy

Are you currently pregnant? Yes No

REVIEW OF SYTEMS: Please place a check by all that apply

__ Fever
__ Cough
__ Fainting Spells
__ Night Sweats
__ Shortness of Breath
__ Weakness
__ Weight Gain
__ Weight Loss
__ Cough w/ Blood
__ Difficulty Urinating
__ Dizziness
__ Fatigue
__Headaches
__ Rash
__ Vision Changes
__ Chest Pain
__ Numbness
__ Diarrhea
__ Vomiting
__ Nose / Sinus Problems
__ Hearing Loss
__ Irregular Heartbeat
__ Swollen Glands
__ Itching/Hives
__ Abdominal Pain

Patient Signature ________________________ Date: ____________________ Provider Signature: ___________________

ANY OTHER medical conditions that were not listed above?

____
____
____
____
____

List **ANY surgeries** you've previously had and the year they were performed.

____
____
____
____
____
____
____

List **ANY medication** you are currently taking, how often you take it, and the dose of the medication.

____
____
____
____
____
____
____

List **ANY ALLERGIES** that you have including any allergies to medications.

____
____
____
____
____
____

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Name:______________________________________

Date:______________________

OPIOID RISK TOOL

		Mark each Box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse:	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse:	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16-45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL		[ ]		

SPORTS AND SPINE INSTITUTE
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SCREENING INSTRUMENT FOR SUBSTANCE ABUSE POTENTIAL (SIASP) QUESTIONNAIRE

1. If you drink, how many drinks do you have on a typical day?
2. How many drinks do have in a typical week?
3. Have you used marijuana or hashish in the last year?
4. Have you ever smoked cigarettes?
5. What is your age?

____
Print Name

____
Signature/Date

Office Use Only

MR #:____________________

Opioid Treatment Consent Form:

Please review the information listed here and put your INITIALS next to each item when you have reviewed it and feel you understand and accept what each statement says.

My provider is prescribing opioid pain medications for the following conditions(s):

____

_________When I take these medications, I may experience certain reactions or side effects that could be dangerous, including sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing.

_________When I take these medications, it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused, or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.

_________When I take these medications regularly, I can become physically dependent on them, meaning that my body will become accustomed to taking the medications every day, and I would experience withdrawal sickness if I stop them or cut back on them too quickly. Withdrawal symptoms feel like having the flu, and may include abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety, and sleep problems.

_________I may become addicted to these medications and require addiction treatment if I cannot control how I am using them, or if I continue to use them even though I am having bad or dangerous things happen because of the medications.

_________Anyone can develop an addiction to opioid pain medications, but people who have had problems with mental illness or with controlling drug or alcohol use in the past are at higher risk. I have told my provider if I or anyone in my family has had any of these types of problems.

_________Taking too much of my pain medication, or mixing my pain medications with drugs, psychiatric medicine, or other medications that cause sleepiness, such as benzodiazepines, barbiturates, and other sleep aids, could cause me to be dangerously sedated or to overdose and stop breathing.

_________I understand that taking certain medications such as buprenorphine (Suboxone®, Subutex®, naltrexone (ReVia®), nalbuphine (Nubain®), pentazocine (Talwin®), or butorphanol (Stadol®) will reverse the effects of my pain medicines and cause me to go into withdrawal.

*Adapted from the American Academy of Pain Medicine
http://www.painmed.org/Workarea/DownloadAsset.aspx?id=321 1

Office Use Only

MR #:____________________

_________It is my responsibility to tell any provider that is treating me or prescribing me medications that I am taking opioid pain medications so that they can treat me safely and do not give me any medicines that may interact dangerously with my pain medicines.

_________I have discussed the possible risks and benefits of taking opioid medications for my condition with my provider and have discussed the possibility of other treatments that do not use opioid medications, including but not limited to: therapy, injections, topical agents, neurostimulation, pain psychiatry, referral to surgeon

________These medications are being prescribed to me because other treatments have not controlled my pain well enough. These medications are to be used to decrease my pain, but they will not take away my pain completely and allow me to participate in daily activities of living.

________These medications are to be used to help improve my ability to work, take care of myself and my family, and meet other goals that I have discussed with my provider, but if these medications do not help me meet those goals, they will be stopped.

_________**For Men:** Taking opioid pain medications chronically may cause low testosterone levels and affect sexual function.

_________**For Women:** It is my responsibility to tell my provider immediately if I think I am pregnant or if I am thinking about getting pregnant. If I become pregnant while taking these medications and continue to take the medicines during the pregnancy, the baby will be physically dependent on opioids at the time of birth and may require withdrawal treatment.

I have reviewed this form and have had the chance to ask any questions to my provider and his staff. I understand each of the statements written here and by signing give my consent for treatment of my pain condition with opioid medications.

____________________	____________________	__________
Patient Signature	Patient Name (Please Print)	Date

____________________	____________________	__________
Provider Signature	Provider Name (Please Print)	Date

*Adapted from the American Academy of Pain Medicine
http://www.painmed.org/Workarea/DownloadAsset.aspx?id=321 1

SPORTS AND SPINE INSTITUTE
McDONOUGH and MARIETTA

NEW POLICIES

Dear Patients:

As of January 1, 2019 all patients will be required to bring in all medications for a pill count on every visit. Patients may also be subjected to a random Urine Drug Screen, per the narcotic agreement which was signed by each patient. Please be advised that patients will have **ONE** time to change their pharmacy, and that will then be your permanent pharmacy, any other changes to pharmacy can only be done in the office in person and discussing with staff or the doctor. Pharmacies will not be changed over the phone. Prescriptions will **NO LONGER** be called into a pharmacy that is not listed in the patient's chart. If your pharmacy does not have your medication in at the time your prescription was sent in, you will have to wait until that pharmacy receives your medication or come back in and obtain a printed prescription.

Please **do not** call the office for pain medication refills if you have run out of your medication early or decide to reschedule your appointment. All prescriptions will be refilled at your appointment. If you reschedule your appointment, you will have to wait until you are seen at your rescheduled visit in order to get a refill on any prescriptions, unless you have a doctor's note for being sick or hospitalized and it is faxed to the office and confirmed by our staff first. This does not apply to patients who can only get 14 days of their medication at a time, per their insurance company.

Patients will not receive any imaging/diagnostic testing results over the phone. Patients will not be notified of normal imaging/diagnostic testing results, but may be posted to the patient portal if normal. If you have questions about your results you must schedule an appointment to speak to the doctor.

Patients will no longer be allowed to call 2 weeks after a procedure to update the doctor on their symptoms. All patients will have to schedule a 2-week post procedure follow up according to their insurance company.

If you have any questions, please notify the staff. Thank you for your cooperation.

____________________ Print Name

____________________ Signature/Date