

PATIENT REGISTRATION					
PATIENT NAME (FIRST, MIDDLE, LAST)					
HOME ADDRESS		CITY	STATE	ZIP	HOME PHONE
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	AGE	MARITAL STATUS	EMAIL
EMPLOYER			OCCUPATION	WORK PHONE	
REFERRING PHYSICIAN (NAME, ADDRESS, PHONE)					

EMERGENCY CONTACT INFORMATION		
NAME	PHONE	RELATIONSHIP TO PATIENT
ADDRESS	CITY	STATE ZIP

PRIMARY INSURANCE INFORMATION			
INSURANCE COMPANY			
INSURANCE COMPANY ADDRESS (CITY, STATE, ZIP)			PHONE
SUBSCRIBER'S NAME	DOB	SUBSCRIBER'S SS#	RELATIONSHIP TO PATIENT
GROUP NUMBER	ID OR POLICY NUMBER	EFFECTIVE DATE	

SECONDARY INSURANCE INFORMATION			
INSURANCE COMPANY			
INSURANCE COMPANY ADDRESS (CITY, STATE, ZIP)			PHONE
SUBSCRIBER'S NAME	SUBSCRIBER'S SS#	RELATIONSHIP TO PATIENT	
GROUP NUMBER	ID OR POLICY NUMBER	EFFECTIVE DATE	

WORK RELATED INJURIES ONLY COMPLETE THE FOLLOWING		
COMPENSATION INSURANCE CARRIER	CLAIM NUMBER	
INSURANCE COMPANY ADDRESS (CITY, STATE, ADDRESS)	PHONE NUMBER	
EMPLOYER'S NAME	PHONE NUMBER	
DATE OF INJURY	WAS INJURY REPORT FILED	NAME OF INSURANCE ADJUSTER

## POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Patients who carry health insurance should remember that professional services fees are charged to the patient and not to the insurance company. Your insurance company has no obligation to pay for services provided by Virginia Spine Institute; its obligation is to you, the policyholder. Even though an insurance claim is filed, you will receive a statement each month if your account has a balance due. You are responsible for payment of your account within the time limits of our credit policy. A service charge of 1.5% per month will be added to unpaid account balances after insurance pays or rejects. Although this office cannot accept responsibility for checking late insurance payments or negotiating a settlement on a disputed claim, we will try to assist you with any problems concerning your insurance. In the event of default of your account you understand that you will be responsible for 33.33% attorney collection fees or collection agency charges.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Financially Responsible Party

## PATIENT AUTHORIZATION

I, \_\_\_\_\_ request that payment of authorized Medicare/BC/BS National Capital Area/Blue Shield of Virginia/ \_\_\_\_\_ benefits be made either to me or on my behalf to Virginia Spine Institute, P.L.C. for any services furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or my insurance company named above any information needed to determine these benefits or the benefits payable for related services.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing. I request that payment of authorized Medigap benefits be made either to me or on my behalf to Virginia Spine Institute, P.L.C. for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to \_\_\_\_\_ any information needed to determine these benefits payable for related services.

I authorize Virginia Spine Institute, P.L.C. to file a complaint if necessary on my behalf with the State Corporation Commission Bureau of Insurance.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Subscriber or Beneficiary

## REFERRALS AND PRE-CERTIFICATION REQUIREMENTS

I hereby take full responsibility for all referrals and pre-certification requirements as described or requested by my insurance company. I understand it is my duty and responsibility to contact the insurance company to make certain that the referrals have been issued. I further understand that failure to provide referral or pre-certification information to Virginia Spine Institute, P.L.C. could result in reduced or rejected coverage and that I will take full responsibility for payment of all balances due.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Guarantor / Responsible Party

# PATIENT INFORMATION SHEET

Please complete all four pages of this form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Type of work done: \_\_\_\_\_

Who referred you to this office? \_\_\_\_\_

Significant sporting or recreational activities: \_\_\_\_\_

What is the main reason for your visit? (e.g. pain, weakness, numbness, scoliosis) \_\_\_\_\_

\_\_\_\_\_

Where is the pain/numbness? (e.g. neck, right arm, low back, left thigh, shoulder, hip, etc.) \_\_\_\_\_

\_\_\_\_\_

When did your back or neck symptoms begin? \_\_\_\_\_

When did your arm or leg symptoms begin? \_\_\_\_\_

Is this related to an injury? (yes / no / possibly) \_\_\_\_\_ Date of injury: \_\_\_\_\_

Classify the injury:

- Injury on the job
- Vehicular accident; State accident occurred:  MD  VA  \_\_\_\_\_
- Sporting injury
- Slip & fall
- Lifting/bending
- Other: \_\_\_\_\_

Please describe the injury (e.g. stopped at a traffic light when rear-ended, or bent over to pick up a box. or no known injury)

\_\_\_\_\_

If you were injured on the job, was an injury report filed?  Yes  No

Who was your employer at the time of the injury? \_\_\_\_\_

Work Status:

- Employed without restrictions or limitations
- Employed with restrictions or limitations
- Homemaker without restrictions or limitations
- Homemaker with restrictions or limitations
- Temporarily not working because of pain
- Released from work because pain prevents job completion
- Not employed
- On disability
- Student
- Retired
- On Workman's Compensation
- Other: \_\_\_\_\_

Legal Action:

- None
- Potential
- Progressing
- Settled

Do you have a living will?  Yes  No

Do you have either bowel or bladder incontinence?  Yes  No

If yes, please explain: \_\_\_\_\_

Are your symptoms worse in the:

- Morning
- Afternoon
- Evening
- Night
- Varies
- Does not apply

Does the pain waken you during the night?  Yes  No

What is the one activity or position which best relieves your symptoms? \_\_\_\_\_

What is the one activity or position that makes your symptoms the worst? \_\_\_\_\_

What can you not do because of your pain? \_\_\_\_\_

Which of the following diagnostic tests have you had done:

- None
- X-rays
- MRI
- CT Scan
- Myelogram
- EMG
- Bone Scan

Other: \_\_\_\_\_

Do you have a family history of spinal problems?  Yes  No

**SOCIAL HISTORY:**

Who do you live with?  Family  Friends  Alone  Other: \_\_\_\_\_

Do you smoke?  Yes  No If yes, how many packs per day? \_\_\_\_\_

Do you drink alcohol?  None  Rarely  Socially  Daily

**MEDICAL HISTORY:**

Physician's name: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

Do you have any medical problems?

- |  |  |
|--|--|
| <input type="checkbox"/> None                | <input type="checkbox"/> Ulcers                |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Blood clots           |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Thyroid               |
| <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Other: _____          |

List all your past surgeries (for any surgeries performed in the past three years, list the month and year) \_\_\_\_\_

What medications do you regularly take, or are you currently taking? \_\_\_\_\_

List the medications to which you are allergic: \_\_\_\_\_

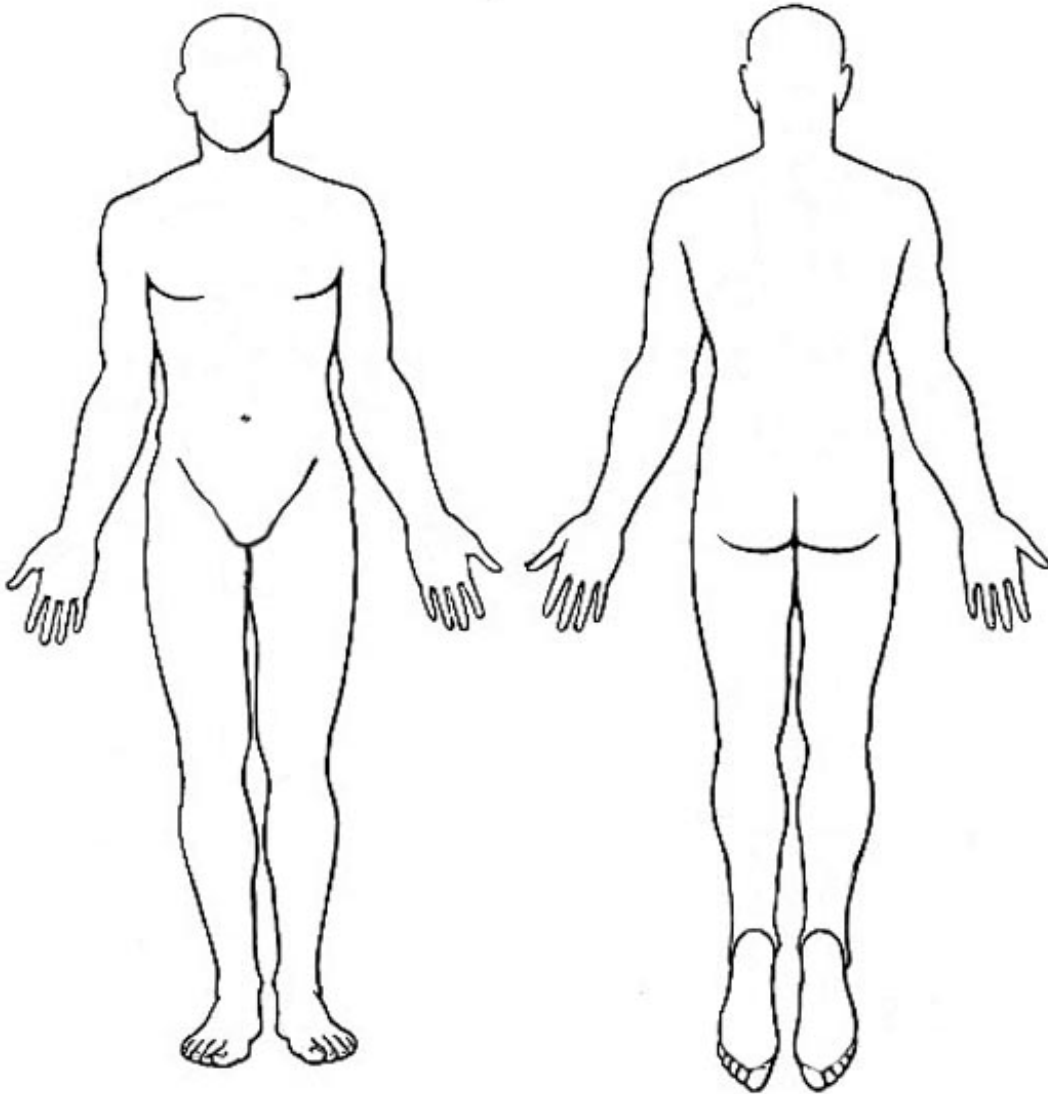
**GENERAL REVIEW OF SYSTEMS:** Please check yes or no, for current and unexplained symptoms.

- |                                |                              |                             |
|--------------------------------|------------------------------|-----------------------------|
| Recent unexplained weight loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blurred or double vision       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hearing loss or ringing        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest pain                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shortness of breath            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nausea or vomiting             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood in stool                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Burning or painful urination   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rash or itching                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Light headed or dizzy          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Memory loss or confusion       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding or bruising tendency  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fever                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

HAVE YOU HAD PRIOR BACK OR NECK SURGERY ?  Yes  No

Mark the area of your body where you feel abnormal sensations and / or pain. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness: -----  
 Pins and needles: \*\*\*\*\*  
 Burning: xxxxxxxxxxxxxxxxxxxxxxx  
 Stabbing: ///////////////////////////////////  
 Pain: + + + + + + + + + + + + + + + +



Please circle the number which represents your average pain over the past week:



# INFORMATION REGARDING PREVIOUS SPINE SURGERY

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Anatomical location of previous spine surgery:

- Cervical
- Thoracic
- Lumbar

Procedure:

- Laminectomy
- Discectomy
- Fusion with metal
- Fusion without metal
- Anterior (front) procedure
- Posterior (back) procedure
- Date of surgery: \_\_\_\_\_

Date of onset of symptoms before surgery: \_\_\_\_\_

Symptoms before surgery (e.g., pain, numbness, weakness): \_\_\_\_\_

Location of symptoms before surgery (e.g., arm, leg, back, neck): \_\_\_\_\_

Describe specific location of symptoms on extremities (e.g., back of thigh, back of calf, bottom of foot):

Was surgery a success?

- Yes
- No
- Partial

Post-op improvement:

- 10%
- 20%
- 30%
- 40%
- 50%
- 60%
- 70%
- 80%
- 90%
- 100%
- None
- Surgery worsened my symptoms

How long were your symptoms absent after surgery? \_\_\_\_\_

# NOTICE OF PRIVACY PRACTICES

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**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.**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. This includes the physical examination, scheduling other exams or appointments with other providers, calling in prescription refills, physician-to-physician discussion for coordination of care and physician to staff discussion for coordination of care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill to your insurance company for payment.
- Health care operations include the business aspects of running our practice on a daily basis. These functions include, the entire staff having access to your file to obtain authorization of medications or medical procedures, filing of paperwork, recording phone messages or vitals from your visit, confirming your appointments with our office, scheduling your appointments with our office and obtaining the medical complaint for your visit, writing referrals for other physicians, and dictating notes to an outside source of your visit.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

We reserve the right to update these practices at any give time. You will then be required to review and resign acknowledging the changes and consenting to the changes.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- Close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction, we must abide by it unless you agree in writing to remove it.

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- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
  - The right to inspect and copy your protected health information.
  - The right to amend your protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October 16, 2002, and we are required to abide by the terms of the Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

The Virginia Spine Institute has on-going research projects in collaboration with the Spinal Research Foundation and other spine centers. With your written authorization, your protected health information may be used and shared with the research team for research purposes. The Virginia Spine Institute will protect your information according to State and Federal laws. Officials of Federal or State government agencies may inspect and photocopy your research record. When the results of the research are published or discussed in conferences, no information will be included that would reveal your identity.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquires, note "Attention Privacy Officer" at:

**Virginia Spine Institute, P.L.C.**  
**1831 Wiehle Avenue Second Floor**  
**Reston, VA 20190**  
**703.709.1114**  
**(Fax) 703.709.1117**

For more information about HIPAA or to file a complaint:

**The U.S. Department of Health & Human Services**  
**Office of Civil Rights**  
**200 Independence Avenue, S. W.**  
**Washington, D.C. 20201**  
**(202) 619-0257, or Toll Free: 1-877-696-6775**

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operation such as the business aspects of running the practice on a daily basis.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

### **Authorization to release protected health information (PHI) for research purposes**

By signing this authorization, I agree to allow the research team to use and share my PHI for research purposes. The Virginia Spine Institute will protect my information according to State and Federal Laws. Officials of Federal or State government agencies may inspect and photocopy my research record. When the results of the research are published or discussed in conferences, no information will be included that would reveal my identity. My authorization is voluntary, may be withdrawn, does not expire and will not affect my treatment.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_