810 Shoney Drive Ste. 105
Huntsville, AL 35801
256-461-7760

PLEASE BRING THE FOLLOWING ITEMS WITH YOU:

***Your insurance cards**

***Your driver's license or picture I.D.**

MRI/X-RAY films of the affected area if applicable

***Payment for your co-pay, or deductible if not met this year**

IMPORTANT REMINDERS

***Nothing to Eat or Drink 6 hours prior to your appointment**

***Stop blood thinners 7 days prior to appointment – please consult your prescribing physician**

***You may take your regularly prescribed medication morning of appointment with small sip of water, except NO DIABETIC MEDICATION, – Consult your physician**

***Make sure you have a driver, and they will need to stay with you during your appointment**

***Arrive for your appointment 20 minutes early. If you need to fill out paperwork on-site, arrive ONE HOUR EARLY**

******As a new patient your appointment will take significantly longer than a follow up visit. Our doctors are dedicated to providing all of our new patients with an extensive exam and a thorough consultation in order to assess your needs.**

Thank you!

PATIENT INFORMATION

Date: _______________ How did you hear about us? _____________________________________

First Name: ________________________ MI: ________ Last Name: ____________________________________

Problem Area: (circle) Neck Low Back Other: _________________________________

SSN#: _______________________________ DOB: _______________________ Sex: ____________

Address: ____

City: _______________________________________ State: _____________________ Zip: __________________

Home Phone: __________________Cell Phone: ___________________ Work Phone: _____________________

E-Mail: ____

Emergency Contact: _____________________________________ Phone: _________________________________

Do you have any x-rays or MRIs for this problem area? ____

If you don't have the films, where did you get them done?____

Did a physician refer you to us for today's visit? ____ If so, Physician name: ____ ___________________________

Referring Physician Address/City: _____________________________________ Phone: _____________________

INSURANCE INFORMATION

Type: (circle) Auto Worker's Compensation Major Medical Medicare

Primary Insurance: ____Effective Date:____________

Policy Number: _________________________ Group Number: _____________ Accident Date: _____________

Policy Holder Name: (name on card) ________________________________ Relationship to Patient: ___________

SSN #: ______________________________ DOB: _________________ Sex: ________

Policy Holder Employer: ___________________________

Secondary Insurance: ____ Effective Date:____________

Policy Number: __________________________Group Number: _____________ Effective Date:________

Policy Holder Name: (name on card) ____________________________ Relationship to Patient: ___________

SSN #: ___________________________ DOB: ___________________ Sex: ________

Policy Holder Employer: ___________________________

Acceptance as Patient

I understand and agree that the doctors of Alabama PainCare/SpineCare have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a medical history and the conduction of a physical examination are not considered treatment, but are part of the process of the information gathering concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

____ _______________

Signature of patient (or parent, if patient is a minor) Date

Financial Statement

Thank you for choosing SpineCare. We are committed to your successful care. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Our financial policy is designed to give you a number of payment options to choose from to fit your unique financial needs.

We make every effort to verify your coverage and benefits prior to your doctor visit. This information is provided as a courtesy. It remains your full responsibility to know and understand your policy and benefits.

We require the payment of either the co-payment amount or the co-insurance percentage and any outstanding deductible at the time of service. If your primary and/or secondary insurance company reduces or denies any billed claim(s), you will be responsible for paying the remaining balance. If the insurance company has not paid a claim with 60 days of submission, we require patient payment for the balance via an approved payment method. You will ultimately be responsible for these charges.

SpineCare accepts cash, check, and these credit cards: Visa, MasterCard, Care Credit, Amex, and Discover.

Additional charges include a returned check fee of $25, and a missed visit fee, which will be assessed for $30-$50 when an appointment is missed without the required 24-hour notification. This fee will be waived in the event of an unforeseen emergency.

Thank you for trusting us with your health care. If you have any questions about our financial policy, or would like to discuss payment plan options, please inquire with the receptionist.

By signing below, I am acknowledging that I have read, understand, and agree to the provisions of this financial policy.

Signed: ____

Printed Name: ____

Date: ____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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/or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments

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 healthcare options. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____

Signature: ____

Date: ____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the *Notice of Privacy Practices* Acknowledgement, but was unable to do so as documented below:

Date: __________________ Initials: _____________ Reason: ____________________________________

PERSONAL MEDICAL INFORMATION FORM

NAME ____________________________________ APPOINTMENT DATE ____________________

HEIGHT ________ WEIGHT _________ BIRTHDATE ____________________ AGE ______________

FAMILY DOCTOR (Name, Address) ____

REFERRING DOCTOR (Name, Address) ____

Person filling out form, if not self: Name______________________________ Relation ______________________

PLEASE RANK ONLY 3MAIN PAIN COMPLAINTS

1) ____

2) ____

3) ____

Briefly describe WHEN, WHERE, and HOW you began having your pain complaint:

____

____

____

Accident or Injury date, if applicable ________________

Injury occurred:______ At work or work-related

______ At home

______ In a car accident

______ Unknown cause (happened spontaneously)

______ Other ____

Were you taken off work by a doctor? Yes / No Doctor's Name_____________________________________

Have you ever been treated for Substance Abuse? Yes / No When and where?__________________________

Are you currently or have you ever been enrolled in a Methadone Clinic? Yes / No

Methadone Clinic Date of Last Visit and Dosage_______________________________________

Have you been charged with any crime concerning illegal drugs or prescription medications? Yes / No

Are you or have you ever been enrolled in law enforcement or court ordered program because of alcohol or illegal drugs or prescription medications? Yes / No

TESTS PERFORMED example: MRI X-Rays Labs Myelograms Etc…	PERFORMED WHEN AND WHERE?	ORDERED BY WHAT PHYSICIAN?	TEST RESULTS REVEALED WHAT FINDINGS?	RECOMMENDED TREATMENT?

When is your worst time of day? Not Applicable / Morning / Afternoon / Evening / Night

What activities or positions cause your pain to ***worsen*** or start?____

____

What positions, activities, treatments ***improve*** your symptoms?____

____

How long have you had this pain?____

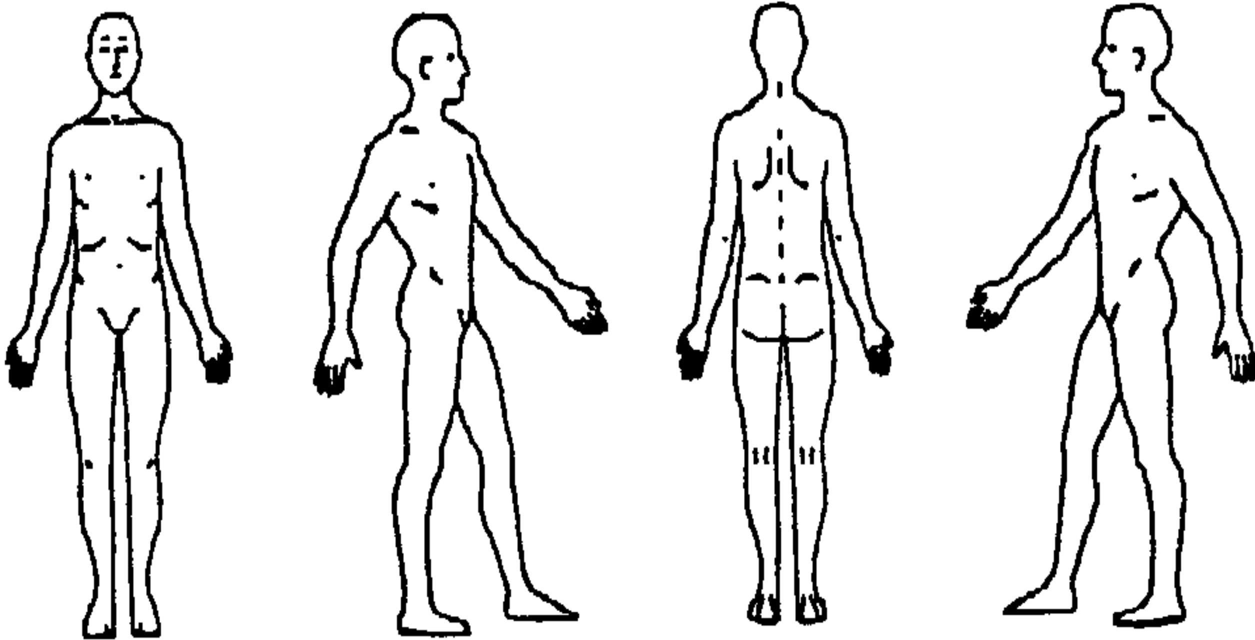
How often does the pain occur and how long does it last?____

____

√Check all that apply	Pain Description	***WHERE*** is this type of pain located?
	constant	
	comes and goes	
	dull ache	
	sharp stab	
	throbbing	
	knots	
	cramps	
	burning	
	electrical	
	tingling / pin pricks	
	stiffness	
	soreness	
	tightness	
	stationary	
	radiates (moves)	
	numbness	

PRESENT SYMPTOMS:

Mark primary pain areas with xxxxx
Mark areas of numbness with ……..
Mark areas of weakness with //////////



ZERO = NO PAIN >>>>>>>>>>>>>> TEN = WORST PAIN *EVER* EXPERIENCED

Circle the number that best describes your pain at its **worst during the last month**.

0 1 2 3 4 5 6 7 8 9 10

Circle the number that best describes your pain at its **least during the last month**.

0 1 2 3 4 5 6 7 8 9 10

Circle the number that best describes your pain **on average during the last month**.

0 1 2 3 4 5 6 7 8 9 10

Circle the number that best describes your pain as it is **right now**.

0 1 2 3 4 5 6 7 8 9 10

Present Functioning

How long are you able to walk? ________ minutes / hours
What prevents you from walking longer? ____
How long can you comfortably sit? ____
I am able to perform household duties/chores: Almot Always / Most of the time / Occasionally / Rarely
I sleep about ______hours at night. My sleep is….Good….Fair….Poor
If you have trouble sleeping, what interferes with your sleep?____
List your usual activities/hobbies/chores that you enjoy and indicate if you have been able to do them since your condition has occurred:

____

____

____

Past or Present Treatment:√ Check ALL that you are CURRENTLY using or used in the PAST

	Modality	Last Time Used or Performed	Results
	Rest at Home		
	Home Exercise program		
	TENS Unit		
	Chiropractic Care		
	Accupuncture		
	Physical Therapy		
	Occupational Therapy		
	Work Hardening		
	Epidural Nerve Blocks/Duramorphs		
	Spinal column Stimulator		
	Implanted Medication Pump		
	Other		

Current Medicines (name, strength, how many per day)

____

____

____

____

List your pharmacies and telephone numbers

____

____

Past Medications that Have Helped **Past Medications that were NOT Helpful**

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

What Medications Cause What Type of ALLERGIC Reaction?

____

____

Your Past Medical History- Please √ check or List all OTHER medical conditions:

- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Peptic Ulcer Disease or severe Heart Burn
- ☐ Arthritis
- ☐ Other ____
- ☐ Other ____
- ☐ Other ____

Your Past Surgical History - Please list all operations and procedures you have had

DATE	OPERATION	SURGEON

Social History

Marital Status: ____Single ____Divorced ___Separated

____*Married* ____*Remarried* ___*Widowed*

Children:	number	ages	live at home	deceased
boys				
girls				

Do you smoke? YES / NO How much? _______________ How long have you smoked? __________________

Do you drink alcohol? YES / NO What type?________________ How much? ________________________

Do you currently use "Street" drugs like marijuana, cocaine, etc? YES / NO What kind?___________________

Family History

Mother: Living / Deceased Medical Problems: ____

Father: Living / Deceased Medical Problems: ____

How many:
Brothers______ Medical Problems ____

Sisters ______ Medical Problems ____

Work/Employment History (more than one may be marked as needed)

- [ ] Employed by ____
- [ ] Currently working
- [ ] Currently off work for now because of this medical condition
- [ ] When was the last time you worked? ______________________________
- [ ] Retired
- [ ] Early Retirement because of disability
- [ ] Temporary Disability from Worker's Compensation — MMI given? Y N Date________
- [ ] Permanent Disability from Worker's Compensation — PPI ______% By:_____ ________
- [ ] Personal or Group Temporary Disability — FCE done? Y N Date________
- [ ] Personal or Group Permanent Disability — Restrictions:________________
- [ ] Applying for group Disability or Early Retirement — _________________
- [ ] On Social Security Disability Income — _________________
- [ ] Applying for Social Security Disability — Restrictions given by:_____________
- [ ] Other____

Do You Now Have or Ever Have Had Problems With Any of the Following Areas?

___ENT ___Eyes ___Heart or Vessels ___Abdomen ___Genitourinary

___Skin ___Hormones ___Muscles ___Psychological/Psychiatric Treatment

___ *Weight Swings* ___*Hepatitis* ___*HIV (Aids Virus)*

___*Other:*____

List of Current Medications

Name: ____________________

Date: ____________________

Primary Care Physician: ____________________

	Medicine	Dose/mg	Frequency	Doctor	Pharmacy
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					

Patients Please do not write below this line

Office Use Only:

Pain Scores:

Today: ______ /10

Average This Month: ______ /10

Activities: Self Care ______

Housebound ______

Exercise ______

Work ______

BP **HR** **RESP**

WT **HT**

UDS Obtained: Yes No

Aberrant Behaviors: ______

Adverse Reactions: ______

Analgesic (Effectiveness): ______

New Pain Complaints: ______