SPINE OPTIONS - INSURANCE INFORMATION

JEINL	. OF HONS — HVSC	MAINCE INFORMA	ATION	
NAME:				MARITAL STATUS M S D W
STREET ADDRESS:				(CIRCLE ONE)
CITY: STATE: ZIP:				
HOME PHONE #: () CELL #:	()	WORK PH	HONE #: ()	
DATE OF BIRTH: AGE:	SEX: M F	EMAIL:		
SOCIAL SECURITY #:				
NAME OF EMPLOYER:		OCCUPA ⁻	TION:	
STREET ADDRESS:	CITY:	STA	ATE:	ZIP:
EMERGENCY CONTACT:	RELATION	SHIP:	PHONE #:	
PRIMARY CARE PHYSICIAN:			PHONE #:	
REFERRED BY:			PHONE #:	
WORKMENS COMPENSATION		NO FAULT		
WERE YOU HURT ON THE JOB?		AUTOMOBILE ACC	IDENT?	
DATE OF ACCIDENT:		DATE OF ACCIDEN	IT:	
EMPLOYER AT THE TIME OF INJURY:		INSURANCE COMP	PANY:	
INSURANCE COMPANY:		INSURANCE ADDR	ESS:	
INSURANCE ADDRESS:		CITY/STATE/ZIP:		
CITY/STATE/ZIP:		CARRIER TELEPHO	ONE #:	
CARRIER TELEPHONE #: FAX#:		ADJUSTER NAME:		
CC#: WEB#:		FILE#:		
ADJUSTER NAME & #:		INSURED:		
NURSE CASE MANAGER & #:				
ATTORNEY NAME:				
ATTORNEY ADDRESS/TELEPHONE#:				
OBTAIN THIS INFORMATION FROM YOUR INSU	RANCE ID CARD	OR FORM		
PRIMARY INSURANCE:		SECONDARY INSU	IRANCE:	
PATIENT ID #: GROUP#:		PATIENT ID #:	GROUF	#:
POLICY HOLDERS NAME:		POLICY HOLDERS	NAME:	
POLICY HOLDERS SSN:		POLICY HOLDERS	SSN:	
POLICY HOLDERS D.O.B:		POLICY HOLDERS	D.O.B:	
POLICY HOLDERS EMPLOYER:		POLICY HOLDERS	EMPLOYER:	
POLICY HOLDER'S OCCUPATION:		POLICY HOLDER'S	OCCUPATION:	
POLICY TYPE:		POLICY TYPE:		
RELATIONSHIP TO INSURED:		RELATIONSHIP TO	INSURED:	
		1		
I verify the accuracy of the above information and I a	uthorize the releas	e of information as p	provided on the reverse s	ide of this form
PATIENT/GUARDIAN SIGNATURE & DATE				
I am in agreement with "Responsibility to Pay" and the PATIENT/GUARDIAN SIGNATURE & DATE	ne "Authorization to	Pay" statement on t	the reverse side of this fo	orm
a ball				

RESPONSIBILITY FOR PAYMENT:

I understand that I am ultimately responsible for any and all charges for physician, including deductible and co-insurance, unless the physician participates in my medical insurance plan, which I certify is currently active.

AUTHORIZATION TO RELEASE MEDICAL RECORDS:

I authorize my physician to release any and all of my medical records, as per "NOTICE OF INFORMATION PRACTICES" executed by me, including but not limited to medical history, records of office visits and treatment rendered, clinical laboratory reports, diagnostic test results and imaging reports.

Such records must be released to my attorney on my quest, another physician, or any other health care professional for the purposes of discussing my condition, consulting on my case, or reviewing my medical records for further treatment.

These records may also be released to any governmental agencies, insurance companies and employees of insurance companies for the purpose of pursuing payment, insurance reimbursement, submitting claims for services rendered or to be rendered to me, or performing quality assurance reviews as required by law.

If coverage is under a Group Contract held by an employer, an association, trust fund, union or similar entity this authorization also permits disclosure to them if requested for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in the effect until revoked in writing. This authorization shall be binding upon me, my dependents, heirs, executors and administrators.

MEDICARE/MEDICAD:

I request that payment of authorized benefits be made to this office for any services rendered to me. I authorize any holder of medical information about me to release to the Center for Medicare and Medical Services and its agents any information needed to determine these benefits payable for related services.

AUTHORIZATION TO PAY:

I request that the physician bill and request payment directly from the insurance company(s) which I have indicated on the reverse side of this form.

SPINE OPTIONS

I hereby acknowledge that I have received and read the information documenting my rights as a patient and the responsibilities of Spine Options under the Health Insurance Portability and Accountability Act of 1996.

Patient's signature		
Print Name		
Date		
Please list family and/or friends with who information, diagnosis, and/or financial account		cal condition, demographic
Name:		
Relationship:	Phone Number:	
Name:		
Relationship:	Phone Number:	
Name:		
Relationship:	Phone Number:	

SPINE OPTIONS

Patient Printed Name

BRADLEY S. CASH, M.D.,F.A.A.P.M.R., MEDICAL DIRECTOR LYLE POSECION, M.D.,F.A.A.P.M.R.

Dear Patient:

Therapy is designed to treat patients on a one to one basis, and a specific and discreet time is reserved for each appointment. In order to accommodate all patients, and to provide the best care, please be on time for your appointment, and kindly be aware of the following cancellation and no-show policy:

- 1) 24 hour notice is required to cancel any physical therapy appointment. If your appointment is on a Monday please leave a message with the answering service over the weekend.
- 2) The fee for a missed initial physical therapy & follow up session without a 24 hour cancellation notice (no-show or a same day cancellation) will result in a \$75 fee.

The following is our cancellation policy for medical appointments:

24 hour notice is required to cancel any EMG and EPIDURAL INJECTION appointments. The fee for a missed EMG or an Epidural Injection appointment is \$200. These fees are for no-show and same day cancellations as well.

*****YOUR INSURANCE COMPANY WILL NOT PAY FOR THESE FEES******
Thank you for your understanding and, in advance, for your adherence to the above policy
Sincerely, SPINE OPTIONS MANAGEMENT
I have read and understand the above policy for cancellations.

Signature

244 Westchester Avenue Suite 312 White Plains, NY 10604 Tel: 914-948-7400 Fax: 914-948-5171 www.spineoptions.com

Using Adobe Acrobat Reader 8.0 or later

Patient History

Please answer every question

STAFF: Handwritten responses must be entered **MANUALLY**.

	PI FΔSF PRINT	PATIENT'S LAST NAM	F.		
Marking Instructions	A LEASE I KIIVI	TAILUT S LAST WAIVE			
Marking Instructions	DI EASE DRINT	PATIENT'S FIRST NAN	AE DATI	ENT'S DATE OF	DIDTU
Please use a # 2 pencil Fill in the complete oval as shown	PLEASE PRINT	PATIENT 3 FIRST NAM	TE PATI	ENT 3 DATE OF	DINITI
riii iii the complete oval as shown			Mont	h Day	Year
What is the reason for today's visit?					
What is your height? Feet 3 4 5	6 7 7				
Feet 3 4 5 5 Inches 1 2 3 3	6 7 7 4 5 5	6 🔾	7 0 8 0	9 🔾	10 0 11 0
What is your weight?					
	500	600		22	
Pounds 10 20 30 1 2 3 3 1 2 3 3 1 2 3 3 1 3 1 3 1 3 1 3	40 50 50 4 5		0 80 7	90 	
Are you:		handed O	left handed		ambidextrous O
Comment associate of association (a) as a scale of					
Current severity of symptom(s) on a scale o	of $\mathbf{U} - \mathbf{1U}$ ($\mathbf{U} = \mathbf{leas}$	t painjui 10 = m	ost painjui)	\odot	
	2 3 4 5	6 7 8	9 10 M	ost Painful	
Have you ever had problems with anesthes	ia? (i.e. high feve	er, malignant hyp	erthermia)		yes ono o
MEDICATIONS Please Include prescriptions (pills, inhale vitamins and supplements	ers, creams, shots	• •	r medication (asp		s, etc.),
		Name of N			l Francisco
		mame or n		Dosage	<u>Frequency</u>
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Name of Medication Dosage	rrequency		<u>icuitation</u>		
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Name of Medication Dosage					
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	please fol	d on dotted line			
Pharmacy name, address and phone number ALLERGIES Please indicate if you have	er:e allergies to any	of the following I	oy writing "yes" o	r "no" on th	e provided lines.
Pharmacy name, address and phone number	er:e allergies to any	of the following I		r "no" on th	
Pharmacy name, address and phone number ALLERGIES Please indicate if you have I HAVE NO KNOWN ALLERGIES contrast dye	penicilli sulf	of the following I	oy writing "yes" o	r "no" on th	e provided lines.
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Using Adobe Acrobat Reader 8.0 or later

Patient History

Please answer every question



SOCIAL HISTORY			
What is your occupation?			
What is your marital status?	single O	domestically partnered	divorced
Dlagge describe your	married O	separated	widowed Ct status unknown C
Please describe your cigarette smoking status.	currently (every day) currently (some days)		vn if ever smoked
	or in the past)	never unknov	
Counseled to quit smoking?	yes O	no O	20 /20
<u> </u>	es no	in the past	
If yes, how many drinks per week		1-3 4-7 8-1	4 >14
How often do you exercise? never	•	mes / wk 3-5 times / w	
Have you ever been addicted to or dep			
Do you take any pain medication?		ye	
Are you on a pain contract?		ye	
		, -	
YOUR MEDICAL HISTORY	Please indicate if <u>YOU</u> have a h please fold on dotted	istory of the following. (Mark all tine	that apply.)
○ Diabetes	Chronic UTI	MRSA	
Insulin Dependent	 Irritable Bowel Syndron 		
Blood Transfusions	Kidney Failure	Pacemaker	
Sleep Apnea	Kidney Transplant	Heart Valve Im	plant
C-PAP	Osteoporosis	Emphysema	.
Chemotherapy / Radiation	Lupus / SLE	Tuberculosis (T	В)
Hepatitis	Paralysis	Fibromyalgia	
Head Injury	Epilepsy	Dialysis	
High Blood Pressure	Alzheimer's Disease	Kidney Stones	
Chest Pain	Anemia	Jaundice	
Heart Disease	Bleeding Problems	Rheumatoid Ar	thritis
Cardiac Stent	Blood Clots	Gout	
Implanted Defibrillator	 Peripheral Vascular Dise 		
Asthma	Major Injuries	Seizure	
Bronchitis	Cancer	Balance Proble	ms
Breast Biopsy	O HIV / AIDS	O Phlebitis	
Pneumonia	Immune System Disorde		
COPD	Eye / Vision Problems	Osteoarthritis	
Mastectomy Roflyy Ecophagitis	Glaucoma Far Nose Threat Diser	Disc Disease	c) or Fragmant(s)
Reflux Esophagitis Kidney Problems	Ear, Nose, Throat DisordCongestive Heart Failure		s) or Fragment(s)
,	_	ine	
OTHER (please specify):	pieuse juia un autrea	Motor Vehicle	
		NONE	. ,
	Does any <u>FAMILY MEMBER</u> of y	ours have a history of any of the f	ollowing?
Alcohol Abuse	Colon Cancer	Multiple Sclerosis	
Anemia	Depression	Osteoporosis	
Arthritis	Diabetes	Seizures	
Asthma	Fibromyalgia	Stroke	
Back or Neck Problems	High Blood Pressure	 Surgical Complication 	ns
Bladder Problems	High Cholesterol	Thyroid Problems	
Bleeding Disorders	Kidney Disease	Other Disease, Cance	er, or Medical Illness
Brain Cancer	Lung / Respiratory Disea		
Breast Cancer	Migraines	○ NONE	
(U.S. Patent No. 7,487,102) (U.S. Patent No. 7,941,328)	Page 2 of 4	Copyright © PatientLink	Card 360 (Rev. 11/29/2011)

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Patient History

Please answer every question



EYES visual disturbances glasses / contacts NONE EAR, NOSE, AND THROAT hearing loss seasonal allergies oral ulcers NONE CARDIOVASCULAR chest pain palpitations swelling hands / feet NONE BREAST mass / lump breast pain nipple discharge NONE Please fold on dotted line RESPIRATORY difficulty breathing wheezing coughing blood NONE GASTROINTESTINAL constipation reflux hemorrhoids		ark only the symptoms you CURR f you have no symptoms in a categ		
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please fold on dotted line	nair changes 🔾	not flashes	neat intolerance	NONE —
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Using Adobe Acrobat Reader 8.0 or later

Patient History

Please answer every question



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Using Adobe Acrobat Reader 8.0 or later

Pain

Please answer every question

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Marking Instructions																	
Please use a # 2 pencil	PLE	ASE	PRII	NT PA	TIEN	NT'S I	FIRS'	T NA	ME		PATI	ENT	'S DA	ATE O	F BI	RTH	
Fill in the complete oval as shown																	

This questionnaire is designed to help us better understand how pain affects your everyday life.

Mark ONE statement in each section that most closely describes your pain.

Wark ONL Statement in Each Section	that most closely describes your pain.
Pain Intensity I have no pain at the moment. The pain is very mild at the moment. The pain is moderate at the moment. The pain is fairly severe at the moment. The pain is very severe at the moment. The pain is the worst imaginable at the moment.	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 half an hour. Pain prevents me from standing for more than 10 minutes. Pain prevents me from standing at all.
Personal Care I can look after myself normally without causing extra pain. I can look after myself normally but it is very painful. 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.	Sleeping My sleep is never disturbed by pain. My sleep is occasionally disturbed by pain. Because of pain I have less than 6 hours sleep. Because of pain I have less than 4 hours sleep. Because of pain I have less than 2 hours sleep. Pain prevents me from sleeping at all.
Lifting I can lift heavy weights without extra pain. I can lift heavy weights but it gives extra pain. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned. I can lift only very light weights. I cannot lift or carry anything at all.	Not applicable. My sex life is normal and causes no extra pain. My sex life is normal but causes some extra pain. My sex life is nearly normal but is very painful. My sex life is severely restricted by pain. My sex life is nearly absent because of pain. Pain prevents any sex life at all.
Walking Pain does not prevent me walking any distance. Pain prevents me walking more than one mile. Pain prevents me walking more than a quarter of a mile. Pain prevents me walking more than 100 yards. I can only walk using a stick or crutches. I am in bed most of the time and have to crawl to the toilet.	Social Life My social life is normal and causes 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, e.g. sport, etc. Pain has restricted my social life and I do not go out as often. Pain has restricted social life to my home. I have no social life because of pain.
Sitting I can sit in any chair for as long as I like. I can sit in my favorite chair as long as I like. Pain prevents me from sitting for more than 1 hour. Pain prevents me from sitting for more than half an hour. Pain prevents me from sitting for more than 10 minutes. Pain prevents me from sitting at all.	Traveling I can travel anywhere without pain. I can travel anywhere but it gives extra pain. Pain is bad but I manage journeys over two hours. Pain restricts me to journeys of less than one hour. Pain restricts me to short necessary journeys under 30 minutes. Pain prevents me from travelling except to receive treatment.