SPINE OPTIONS – INSURANCE INFORMATION

NAME:	MARITAL STATUS **M S D W** (CIRCLE ONE)
STREET ADDRESS:	
CITY: STATE: ZIP:	
HOME PHONE #: ( ) CELL #: ( ) WORK PHONE #: ( )	
DATE OF BIRTH: AGE: SEX: **M F** EMAIL:	
SOCIAL SECURITY #:	
NAME OF EMPLOYER: OCCUPATION:	
STREET ADDRESS: CITY: STATE: ZIP:	
EMERGENCY CONTACT: RELATIONSHIP: PHONE #:	
PRIMARY CARE PHYSICIAN: PHONE #:	
REFERRED BY: PHONE #:	

WORKMENS COMPENSATION	**NO FAULT**
WERE YOU HURT ON THE JOB?	AUTOMOBILE ACCIDENT?
DATE OF ACCIDENT:	DATE OF ACCIDENT:
EMPLOYER AT THE TIME OF INJURY:	INSURANCE COMPANY:
INSURANCE COMPANY:	INSURANCE ADDRESS:
INSURANCE ADDRESS:	CITY/STATE/ZIP:
CITY/STATE/ZIP:	CARRIER TELEPHONE #:
CARRIER TELEPHONE #: FAX#:	ADJUSTER NAME:
CC#: WEB#:	FILE#:
ADJUSTER NAME & #:	INSURED:
NURSE CASE MANAGER & #:	
ATTORNEY NAME:	
ATTORNEY ADDRESS/TELEPHONE#:	

OBTAIN THIS INFORMATION FROM YOUR INSURANCE ID CARD OR FORM

PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
PATIENT ID #: GROUP#:	PATIENT ID #: GROUP#:
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:

I verify the accuracy of the above information and I authorize the release of information as provided on the reverse side of this form

PATIENT/GUARDIAN SIGNATURE & DATE

I am in agreement with "Responsibility to Pay" and the "Authorization to Pay" statement on the reverse side of this form

PATIENT/GUARDIAN SIGNATURE & DATE

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 whom we may discuss your medical condition, demographic information, diagnosis, and/or financial account if necessary:

Name: _____

Relationship: _____ **Phone Number:** _____

Name: _____

Relationship: _____ **Phone Number:** _____

Name: _____

Relationship: _____ **Phone Number:** _____

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

A CENTER FOR NON-SURGICAL CARE OF
BACK AND NECK PAIN

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.

_____ _____

Patient Printed Name Signature

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

WORKERS COMP PATIENTS ONLY

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL S32 IS APPROVED

WCB CASE NO. (If known)	CARRIER CASE NO. (If known)	DATE OF INQUIRY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC.SEC NO.

Patients Job Title or Job Description			
Usual work activities on date of injury/illness			
Claimant	NAME	ADDERESS NO.	APT
Employer			
Insurance Carrier			

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law S32 in which you waive your right to medical benefits from the workers' compensation carrier/ self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature _____ Date _____

Provider's Name and Address _____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file claim for workers' compensation, or fail to notify your employer or your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licenses hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant. Nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. Do not file with the Workers' Compensation Board. You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim. Or 2) the claim is denied. Or 3) the treatment is not casually related to the work injury. Or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Patient History

Please answer every question

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

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

What is the reason for today's visit? _____

What is your height?

Feet	3 ○	4 ○	5 ○	6 ○	7 ○						
Inches	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○	10 ○	11 ○

What is your weight?

	100 ○	200 ○	300 ○	400 ○	500 ○	600 ○			
Pounds	10 ○	20 ○	30 ○	40 ○	50 ○	60 ○	70 ○	80 ○	90 ○
	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○

Are you: right handed ○ left handed ○ ambidextrous ○

please fold on dotted line

Current severity of symptom(s) on a scale of 0 – 10 *(0 = least painful 10 = most painful)*

☺ No Pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ☹ Most Painful

Have you ever had problems with anesthesia? *(i.e. high fever, malignant hyperthermia)* yes ○ no ○

MEDICATIONS

Please list all medications you are currently taking.

Include prescriptions (pills, inhalers, creams, shots), over the counter medication (aspirin, antacids, etc.), vitamins and supplements (fish oil, etc). Include medications that you use only as needed.

Name of Medication	Dosage	Frequency	Name of Medication	Dosage	Frequency

please fold on dotted line

Pharmacy name, address and phone number: _____

_____

ALLERGIES

Please indicate if you have allergies to any of the following by writing "yes" or "no" on the provided lines.

I HAVE NO KNOWN ALLERGIES_____

penicillin_____ erythromycin_____ cipro_____
contrast dye_____ sulfa_____ ibuprofen_____ latex_____
iodine_____ aspirin_____ bacitracin_____

other *(please specify)*: _____

Race: American Indian or Alaska Native_____ Black or African American_____ White_____
Asian_____ Native Hawaiian or Other Pacific Islander_____

Ethnicity: Hispanic or Latino_____ not Hispanic or Latino_____

Preferred language: English_____ Japanese_____ Italian_____ Other_____
French_____ Korean_____ Spanish_____

Email address: _____

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Using Adobe Acrobat Reader 8.0 or later

Patient History

Please answer every question

STAFF: Handwritten responses must be entered MANUALLY.

SOCIAL HISTORY

What is your occupation? _____

What is your marital status? single ◯ domestically partnered ◯ divorced ◯ married ◯ separated ◯ widowed ◯

Please describe your cigarette smoking status. currently (every day) ◯ in the past ◯ current status unknown ◯ currently (some days) ◯ never ◯ unknown if ever smoked ◯

How many packs per day? *(now or in the past)* ½ ◯ 1 ◯ 1½ ◯ 2 ◯ >2 ◯

Counseled to quit smoking? yes ◯ no ◯

Do you drink alcohol? yes ◯ no ◯ in the past ◯

If yes, how many drinks per week? occasionally ◯ 1-3 ◯ 4-7 ◯ 8-14 ◯ >14 ◯

How often do you exercise? never ◯ rarely ◯ 1-3 times / wk ◯ 3-5 times / wk ◯ daily ◯

Have you ever been addicted to or dependent on drugs or pain medication? yes ◯ no ◯

Do you take any pain medication? yes ◯ no ◯

Are you on a pain contract? yes ◯ no ◯

YOUR MEDICAL HISTORY

Please indicate if YOU have a history of the following. *(Mark all that apply.)*

please fold on dotted line

- ◯ Diabetes
  - ◯ Insulin Dependent
- ◯ Blood Transfusions
- ◯ Sleep Apnea
  - ◯ C-PAP
- ◯ Chemotherapy / Radiation
- ◯ Hepatitis
- ◯ Head Injury
- ◯ High Blood Pressure
- ◯ Chest Pain
- ◯ Heart Disease
- ◯ Cardiac Stent
- ◯ Implanted Defibrillator
- ◯ Asthma
- ◯ Bronchitis
- ◯ Breast Biopsy
- ◯ Pneumonia
- ◯ COPD
- ◯ Mastectomy
- ◯ Reflux Esophagitis
- ◯ Kidney Problems
- ◯ Chronic UTI
- ◯ Irritable Bowel Syndrome (IBS)
- ◯ Kidney Failure
- ◯ Kidney Transplant
- ◯ Osteoporosis
- ◯ Lupus / SLE
- ◯ Paralysis
- ◯ Epilepsy
- ◯ Alzheimer's Disease
- ◯ Anemia
- ◯ Bleeding Problems
- ◯ Blood Clots
- ◯ Peripheral Vascular Disease
- ◯ Major Injuries
- ◯ Cancer
- ◯ HIV / AIDS
- ◯ Immune System Disorder
- ◯ Eye / Vision Problems
  - ◯ Glaucoma
- ◯ Ear, Nose, Throat Disorder
- ◯ Congestive Heart Failure
- ◯ MRSA
- ◯ Heart Attack
- ◯ Pacemaker
- ◯ Heart Valve Implant
- ◯ Emphysema
- ◯ Tuberculosis (TB)
- ◯ Fibromyalgia
- ◯ Dialysis
- ◯ Kidney Stones
- ◯ Jaundice
- ◯ Rheumatoid Arthritis
- ◯ Gout
- ◯ Stroke
- ◯ Seizure
- ◯ Balance Problems
- ◯ Phlebitis
- ◯ Skin Disorders
- ◯ Osteoarthritis
- ◯ Disc Disease
- ◯ Metal Implant(s) or Fragment(s)
- ◯ Work Related Injury(ies)

please fold on dotted line

◯ **OTHER** *(please specify)*: _____

◯ Motor Vehicle Accident(s)

◯ **NONE**

FAMILY MEDICAL HISTORY

Does any FAMILY MEMBER of yours have a history of any of the following?
(Include only parents, grandparents, siblings, and children.)

- ◯ Alcohol Abuse
- ◯ Anemia
- ◯ Arthritis
- ◯ Asthma
- ◯ Back or Neck Problems
- ◯ Bladder Problems
- ◯ Bleeding Disorders
- ◯ Brain Cancer
- ◯ Breast Cancer
- ◯ Colon Cancer
- ◯ Depression
- ◯ Diabetes
- ◯ Fibromyalgia
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ Kidney Disease
- ◯ Lung / Respiratory Disease
- ◯ Migraines
- ◯ Multiple Sclerosis
- ◯ Osteoporosis
- ◯ Seizures
- ◯ Stroke
- ◯ Surgical Complications
- ◯ Thyroid Problems
- ◯ Other Disease, Cancer, or Medical Illness

◯ **NONE**

REVIEW OF SYMPTOMS

Please mark only the symptoms you CURRENTLY are experiencing.
Mark all that apply. If you have no symptoms in a category, please mark "NONE."

GENERAL
- fever
- weight loss
- weight gain
- persistent infections
- fatigue
- NONE

EYES
- visual disturbances
- glasses / contacts
- NONE

EAR, NOSE, AND THROAT
- hearing loss
- seasonal allergies
- sinus pain
- oral ulcers
- NONE

CARDIOVASCULAR
- difficulty breathing on exertions
- chest pain
- shortness of breath
- palpitations
- swelling hands / feet
- NONE

BREAST
- mass / lump
- breast pain
- nipple discharge
- NONE

please fold on dotted line

RESPIRATORY
- difficulty breathing
- wheezing
- chronic cough
- coughing blood
- NONE

GASTROINTESTINAL
- nausea
- vomiting
- constipation
- chronic diarrhea
- change in bowel habits
- reflux
- hemorrhoids
- abdominal pain
- NONE

FEMALE GENITOURINARY (WOMEN ONLY)
- pelvic pain
- urinary frequency
- excessive urination at night
- urinary urgency
- blood in urine
- urine leakage
- vaginal dryness
- vaginal discharge
- vaginal itch or burning
- painful intercourse
- NONE

MALE GENITOURINARY (MEN ONLY)
- excessive urination at night
- urine leakage
- urinary frequency
- urinary urgency
- impotence
- NONE

MUSCULOSKELETAL
- joint pain
- muscle pain
- muscle weakness
- NONE

SKIN
- dry skin
- rash
- skin ulcer
- NONE

ENDOCRINE
- hair changes
- hot flashes
- cold intolerance
- heat intolerance
- NONE

please fold on dotted line

NEUROLOGIC
- change in taste
- smell
- coordination
- difficulty with speech
- disorientation
- dizziness
- fainting
- headaches
- imbalance
- loss of balance
- falls
- loss of consciousness
- memory loss
- muscle weakness
- numbness
- tingling
- seizures
- stroke
- temporary paralysis
- NONE

PSYCHIATRIC
- change in sleep pattern
- depression
- anxiety
- NONE

HEME / LYMPHATIC
- easy bruising
- excessive bleeding
- gland problems
- NONE

Print in Color or Grayscale Only
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Pain

Please answer every question

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

Please use a # 2 pencil
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.

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.

Sex Life

- 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.

(U.S. Patent No. 7,487,102) (U.S. Patent No. 7,941,328)