



GEORGIA
SPINE
& NEUROSURGERY
CENTER

Appointment

Date: _____

Time: _____

Welcome to Georgia Spine & Neurosurgery Center!

Thank you for entrusting us with your healthcare needs.

Our office phone number is (404) 299-3338.

We have four convenient locations:

Decatur

(campus of Dekalb Medical Center)
2675 N. Decatur Rd.
Suite 110
Decatur, GA 30033

Midtown

(Campus of Piedmont Hospital)
105 Collier Rd.
Suite 3060
Atlanta, GA 30309

Stockbridge

(Across from Blockbuster on Hwy 138)
3579 Hwy 138 SE
Suite 204
Stockbridge, GA 30281

Newnan

(Summit Healthplex)
1755 Hwy 34 E
Suite 3400
Newnan, GA 30265

Comments are always welcome. If your experience does not meet your expectations, please do not hesitate to let us know.

www.GaSpine.com



Patient Information

Please Print

Name _____ Date of Birth _____ Male ___ Female ___
First middle last

Address _____
Street Apt City, State Zip

Social Security Number _____ - _____ - _____ Home Phone (_____) _____ Marital Status _____
(s-single, m-married, w-widow)

Mobile Phone Home Phone (_____) _____ Email Address _____

Do you have any special cultural, religious, or ethnic beliefs that we need to know about? _____

Do you have a living will? _____ Do you have any special learning barriers? _____

Individual to contact in an emergency: Name _____

Relationship to patient _____ Home (_____) _____ Work Phone (_____) _____

Employment Information

Employer Name _____ Occupation _____ Work Phone (_____) _____

Address _____
Street Suite City, State Zip

Insurance Information

Primary Insurance _____ Contact Number _____ Policy Number _____

Group Number _____ Co-pay Amount _____

Primary Insurance _____ Contact Number _____ Policy Number _____

Group Number _____ Co-pay Amount _____

Policy Holder Information (If different from patient)

Name _____ Date of Birth _____ Male ___ Female ___

Relationship to patient _____ Social Security Number _____ - _____ - _____ Home Phone (_____) _____

Address _____
City State Zip

Assignment of Benefit/Consent for Treatment. I do hereby assign all medical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all my charges not paid by my insurance. I hereby voluntarily consent to me treatment at this office and authorize such treatments, examinations, and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by my attending physicians. I have read this consent, am aware of its contents and fully understand the same. I acknowledge that no assurance or promises have been given the patient concerning the results, which may be obtained by such treatments and procedures hereby, affirmed by the signature undersigned.

Patient Signature _____ Date _____

FINANCIAL POLICY

We are committed to meeting your health care needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this cost-effective manner, we ask that you adhere to the following guidelines:

1. Payment is expected at time of service.
2. We will file your insurance for you if we are a participating provider of your plan. You will be responsible for any and all services in excess of your insurance limits as well as all non-covered services.
3. All co-payments are due at the time of service.
4. If we are not participating providers of your plan, full payment is due at the time of service, unless prior arrangements have been made. We will give you complete forms that will be accepted by your insurance company for reimbursement.

We will mail to you a monthly billing statement for any outstanding balances.

By signing at the bottom of this page, I acknowledge that I understand and accept this financial policy.

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs and participate with Medicare. We have contracts with these insurance carriers, as you do with your carrier, which obligate us both to certain requirements.

If you are enrolled in **Medicare**, we are obligated by law to attempt to collect your co-insurance. Medicare has a fee schedule that we must abide by. Medicare reimburses us 80% of the allowable amount and expects you to pay the 20%. If you have a Medigap or supplemental plan, the secondary will pay your 20%. You are also expected to pay your deductible at the beginning of each year.

If you are enrolled in a managed care plan, you are required to pay a co-payment at the time you receive services. This amount varies by insurance plan and the type of service you are receiving. As we are a specialty service, you must be referred by your primary care physician, who must provide us with a referral number. Many of the plans also require that we obtain a pre-certification number authorizing us to perform services other than normal office visits, such as surgical procedures and hospital services. Unless these **referral and pre-certification** numbers are obtained prior to providing services, no payment will be made. To assist you, Georgia Spine and Neurosurgery Center will make calls to verify your insurance requirements and to obtain these numbers, but it is often very difficult to get a response. Please assist us by requesting a referral number from your primary care physician and ensuring that we have these numbers prior to your visit. Be aware that these are also **Medicare and Medicaid managed care** programs available that also have these requirements.

Notify us immediately if you obtain new insurance or your insurance changes.

If you have a secondary insurance plan, we will file one copy for your benefit. However, in 90 days the balance will be turned over to you for payment.

If you have no insurance, a Financial Counselor will contact you to set up a payment plan. If you are unable to meet the payments, your physician will be contacted to recommend a method of providing services that will meet your financial needs.

PRIVACY POLICY

By signing at the bottom of this page, I acknowledge that I have reviewed a copy of the Georgia Spine & Neurosurgery Center's notice of privacy policies. I understand that a complete copy of the policy is available on Georgia Spine & Neurosurgery Center's website (www.GaSpine.com) or by print at the office upon request.

Patient Signature

Date

This signature acknowledges that I have read and understand both the Financial and Privacy Policies.



PAIN MEDICATION & PERSCRIPTION POLICY

Georgia Spine & Neurosurgery Center can only provide pain medication for patients who require a surgical procedure. Our practice does not provide long-term pain management services. The following outlines our pain medication prescription policy:

- Patients may be prescribed pain medication during our initial evaluation and surgical preparation period, if it is felt that surgery will likely be required. If surgery is not required, the patient will be referred back to his or her primary care physician to manage pain or make additional referrals.
- If surgery is necessary, pain medication will be prescribed prior to surgery if needed. Pain medication may also be prescribed for a predetermined period of time after the procedures performed. During the recovery process, the amount of medication will be gradually reduced to help the patient avoid dependence on the drug.
- Pain medication is to be taken as prescribed. Patients are not to increase medication dosage without consulting a nurse, physician assistant or physician of Georgia Spine & Neurosurgery Center.
- Improper use of medications can lead to the termination of the physician-patient relationship.
- So that we may carefully review all patient records, we require a 24-hour advance notice for prescription refills.
- Requests for prescription refills can only be accepted during regular office hours. Because we must have access to a patient's medical records, prescriptions cannot be filled in the evening, on weekends or holidays. Refill requests after noon on Friday will not be filled until the following Monday.
- If long-term pain management is required, the patient will be referred to a pain clinic or to his or her primary care physician.

I have read and understand the above stated pain medication and prescription policy for Georgia Spine & Neurosurgery Center.

Signature of patient or responsible party

Date

Georgia Spine & Neurosurgery Center

NEW PATIENT QUESTIONNAIRE: BRAIN

IF YOUR PROBLEM IS NOT RELATED TO YOUR BRAIN (for example, if you are here for a spine, back, or neck problem, or for carpal tunnel syndrome), DO NOT FILL OUT THE REST OF THIS FORM.

Who referred you to our office? _____

What problem do you have that brings you to see us today? (ie, what kind of symptoms are you having?)

When did this problem begin, or how long have you had this problem? _____

What would you like the doctor to do for you today? _____

Georgia Spine & Neurosurgery Center

Medical History: Please mark next to any medical problems that you **have now or have had in the past:**

- I have had **no medical problems** now or in the past
 - Diabetes Hypertension (high blood pressure) Emphysema / COPD Asthma TB
 - Stroke Heart Disease Bleeding disorder High cholesterol Aneurysm
 - Stomach ulcers Hepatitis Acid reflux Hypothyroidism or other abnormalities
 - Osteoporosis Seizures Reactions to Anesthesia (please describe) _____
 - Rheumatoid Arthritis Osteoarthritis (degenerative arthritis) Fibromyalgia
 - Cancer (type): _____ Other medical illness (describe): _____
 - Depression Other psychiatric illness _____ Are you on any blood thinners? _____
 - For woman only: Currently Pregnant? Post menopausal Hysterectomy
 - What doctors have you seen in the past 3 years? _____
-

Surgical History: Please list any surgery you have had in the past and the approximate date of your surgery. (List additional surgeries reverse side)

Medications: List medications and dose that you take. (List additional medications on the reverse side if needed)

Medication Allergies: Codeine Penicillin Sulfa Other _____
 I do not have any known allergies to medication.

Family History: Please check any medical problems that run in your family.

- Diabetes Hypertension (high blood pressure) Heart Disease
- Emphysema / COPD Stroke Bleeding disorder Cancer (type): _____
- Reactions to Anesthesia (please describe) _____
- Other medical illness (describe): _____

Social History: Mark all boxes that apply to your work or school status:

- What is your current occupation? _____
- I am currently working: Full time part time limited duty I am unable to work
 - The last date I worked was _____ I have been on disability since _____
 - What is your **marital status**? Single Married Divorced Widowed
- Please mark you highest level of education (mark only one): Did not complete high school (HS)
- Completed HS Some college Bachelor's degree Advanced degree

Please mark all personal habits that apply to you:

- I never smoked cigarettes or used any tobacco products I chew tobacco I smoke cigars
- I have smoked for ____ years I quit smoking _____years/months ago
- I currently smoke < 1/2 a pack per day (PPD) 1/2 - 1 PPD 1 - 2 PPD > 2 PPD
- I drink alcohol: often sometimes occasionally rarely never
- I am in recovery from a drinking problem I use or have used recreational drugs
- I have or had a narcotic addiction

Review of Systems: Have you had any of the following problems? **Please mark all that apply** and comment as needed.

- Chest pain Shortness of breath Dizziness Fainting or loss of consciousness
- Hearing problems Visual problems Seizures Frequent or severe headaches
- Anxiety or nervousness Chronic fatigue Frequent infections Blood clots
- Bleeding problems Nausea and vomiting Frequent heartburn
- Bowel problems (constipation, incontinence) Bladder problems (increased frequency, urgency, incontinence) Trouble urinating Kidney problems
- Recent visits to ER Other _____
- I have had none of these problems

Please use the space below for any additional comments. Thank you for filling out this medical questionnaire.