Welcome to Georgia Spine & Neurosurgery Center!

Our office phone number is (404) 299-3338.
We have two convenient locations:

Decatur	Midtown
(campus of DeKalb Medical Center)	(campus of Piedmont Hospital)
2675 N Decatur Rd	105 Collier Road
Suite 710	Suite 3060
Decatur GA 30033	Atlanta GA 30309

KAVEH KHAJAVI, M.D., F.A.C.S.

Dr. Khajavi received his undergraduate degree from Emory University, and then obtained his medical degree from Georgetown University School of Medicine on an Air Force scholarship. He completed his neurosurgical residency at the Cleveland Clinic Foundation.

Dr. Khajavi returned to active duty and served in the Department of Neurosurgery at Walter Reed Army Medical Center. Dr. Khajavi was the first Air Force officer to ever be given an appointment in the department of Neurosurgery at Walter Reed. While there, he served as the Chief of Epilepsy and Functional Surgery sections. He held an appointment as Assistant Professor of Surgery at the Uniformed Services University of Health Sciences, and also held a secondary appointment in the department of Neurology.

Dr. Khajavi has an broad research background, and has participated in protocols in the fields of epilepsy, brain tumors and seizures, brain hemorrhages, strokes, and Parkinson's disease. He is the author of several publications on the above topics, as well as spinal disc degeneration and neurosurgical infections, and has given many national presentations on the above subjects.

Dr. Khajavi specializes in the surgical treatment of disorders of the spine, brain, and peripheral nerves, and has a special interest in complex spinal pathology and minimally invasive surgical techniques. Dr. Khajavi's practice, Georgia Spine & Neurosurgery Center, opened on October 20, 2003.

First visit

For your first visit, please bring with you:

- ✓ All x-ray, MRI, CT or other films & reports you may have relating to your visit. **Please make sure you bring the actual films**, as Dr. Khajavi will need to review your films personally.
  - ✓ Any recent lab work.
  - ✓ All of the medications you are taking at this time.
  - ✓ Your insurance card and co-pay.
  - ✓ Your referral from your primary care physician.

Referrals

If your insurance requires a referral before you can be seen by a specialist, please make sure that our office has the referral prior to your visit. In general, you are responsible for making the appointment, calling your primary care physician with the date and time, and confirming that the referral has been processed.

Insurance

We currently accept the following insurance plans:

Aenta AARP, US Healthcare, Beech Street, Blue Cross/Blue Shield PPO, Cigna, Coventry Healthcare, Companion Workplace Health, Evolutions Healthcare, First Health/ CCN PPO, Humana, Medicare, Medicare Railroad, Medicaid, MRN, One Health Plan, PHCS, Promina Employee Benefit, Pro America, State Health, Southcare, Tricare, United Healthcare and USA.

If your healthcare care plan is not listed above, please contact our office at 404-299-3338.

Directions

For door to door directions to our office, please visit our website at www.GaSpine.com

You can hear directions to the DeKalb office by calling (404)501-2787.

You can hear directions to the Piedmont office by calling (404) 605-1111.

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 (___) __________ 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 Phone (___) __________ Work Phone (___) __________

Employment Information

Employer Name_________________________ Occupation_____________ Work Phone (___) _________

Address____
Street Suite City, State Zip

Insurance Information

Name_______________________________________ 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____
Street Apt 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.

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

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

Patient Financial Responsibilities

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 caries 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 hat 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 theses 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 balanced 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.

I have read and understand my financial responsibilities as stated and agree to accept them as described.

Signature:______________________________________ **Date:**________________

Georgia Spine & Neurosurgery Center

KAVEH KHAJAVI, M.D., F.A.C.S.

NEW PATIENT QUESTIONNAIRE: SPINE & NERVE

IF YOUR PROBLEM IS NOT RELATED TO YOUR SPINE OR NERVES (for example, if you are here for a brain problem or head injury), 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?____________________________________

____

____

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

Is this problem the result of a car accident or injury at work?__________________________________

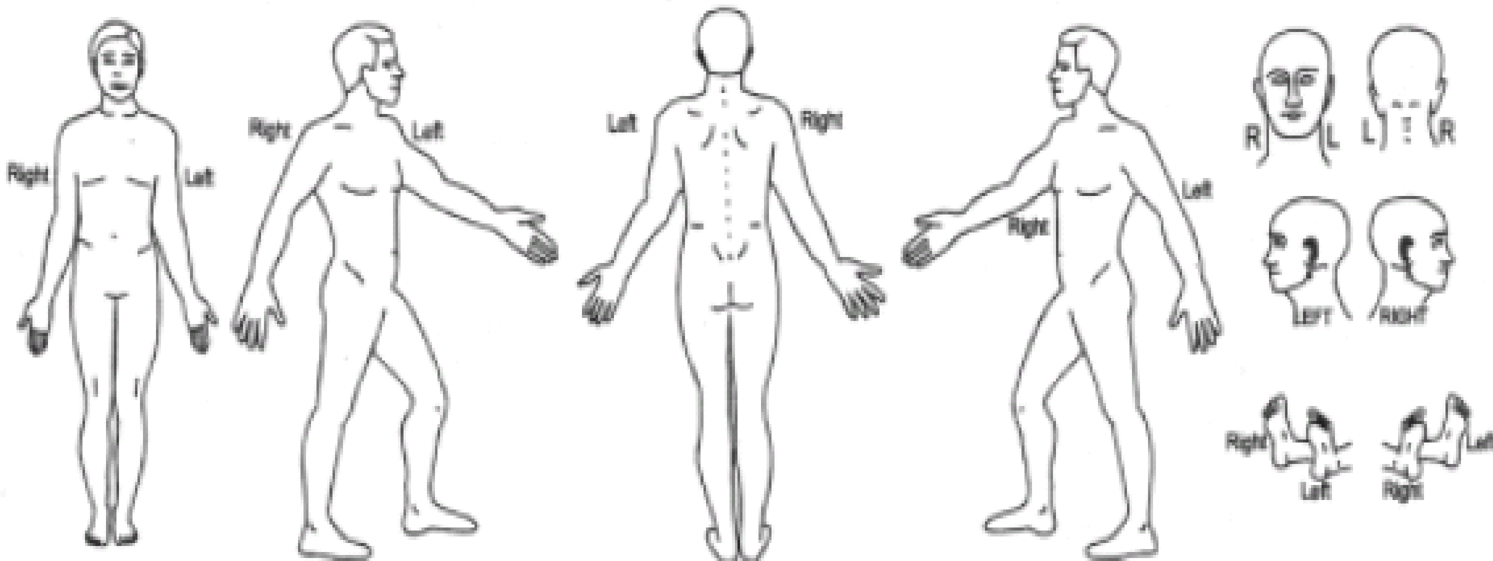
____

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

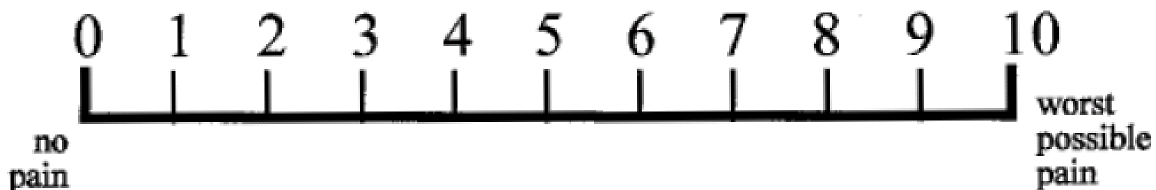
____

PAIN, Tingling, or Numbness

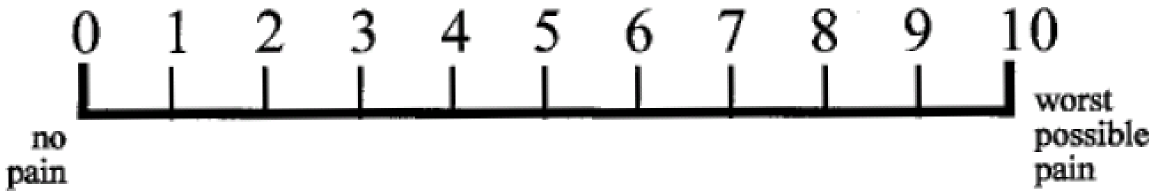
1) Please draw where your symptoms are mostly on the diagram below



2) On the line below, please circle where your **BACK or NECK PAIN** falls most of the time



3) On the line below, please circle where your **LEG OR ARM PAIN** falls most of the time:



4) Can you describe your pain? (ex: throbbing, aching, sharp, dull, electric…) ________________________

5) What makes the symptoms worse? ________________________

6) What makes the symptoms better? ________________________

7) How do your symptoms affect your life? (ex: sleep, appetite, sex, relationship with others, work, physical activity, emotional…) ________________________

Associated Problems

This section deals with problems that may occur in some people with spinal disorders. **Please mark all that apply to you.**

- ❑ Headache ❑ Uncontrollable pain ❑ Inability to control bowel or bladder ❑ Fevers or chills
- ❑ Weight loss unexplained by diet or change in activity ❑ Erectile dysfunction
- ❑ Clumsiness in my hands ❑ A heavy sensation in my legs ❑ Frequent stumbling or falling
- ❑ I am unable to stand up straight ❑ Difficulty walking or a change in the way I walk (describe)
- ❑ Weakness (please describe):________________________
- ❑ Other (please describe): ________________________
- ❑ **I HAVE NONE OF THE ABOVE PROBLEMS**

Diagnostic Tests and Non-Surgical Treatment

What **non-surgical treatment** have you had? Please **mark all that apply, and indicate whether or not that treatment was helpful:**

- ❑ Physical Therapy: .... ❑ Helped a lot ❑ somewhat ❑ little ❑ none ❑ made me worse
- ❑ Back or Neck Exercise Program: ...... ❑ Helped a lot ❑ somewhat ❑ little ❑ none ❑ made me worse
- ❑ Chiropractic: .... ❑ Helped a lot ❑ somewhat ❑ little ❑ none ❑ made me worse
- ❑ Epidural Steroid Injections: .... ❑ Helped a lot ❑ somewhat ❑ little ❑ none ❑ made me worse
- ❑ Local or "Trigger Point" Injection: .. ❑ Helped a lot ❑ somewhat ❑ little ❑ none ❑ made me worse
- ❑ Massage: .... ❑ Helped a lot ❑ somewhat ❑ little ❑ none ❑ made me worse
- ❑ Brace, corset, other support: .... ❑ Helped a lot ❑ somewhat ❑ little ❑ none ❑ made me worse
- ❑ Alternative therapy or supplements (describe) ________________________
- ❑ **I have had none of the above treatments**

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.