GEORGIA SPINE & NEUROSURGERY CENTER

Minimally Invasive Maximum Results

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)
2001 Peachtree Rd.
Suite 550
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

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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_____

Race: Black☐ White☐ Asian☐ Ethnicity: Hispanic☐ Non-Hispanic☐ Other☐ _____

Preferred Language: English☐ Spanish☐ Other☐ _____

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 my 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.

5. There will be a $50 no-show fee for not properly cancelling your appointment.

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 there 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.

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PAIN MEDICATION & PERSCRIPTION POLICY

Georgia Spine & Neurosurgery Center can only provide pain medication for patients who have already had or will 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 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 may 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: SPINE & NERVE

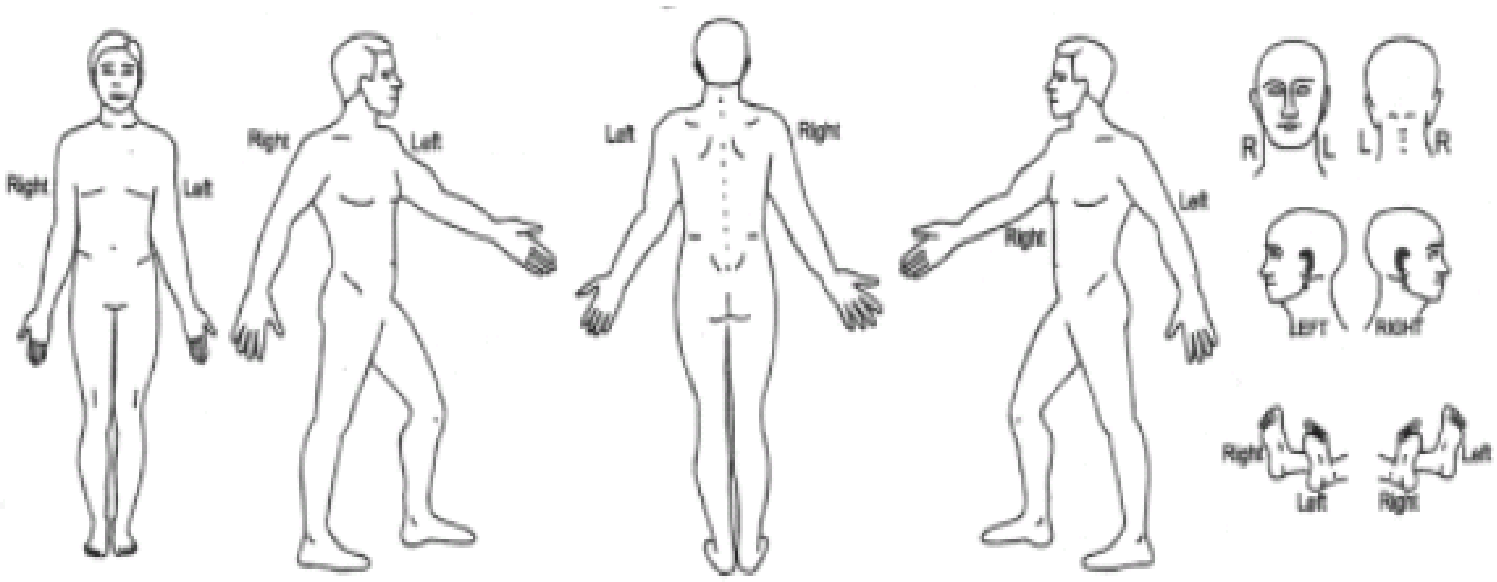
Name: _____ Date: _____

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.

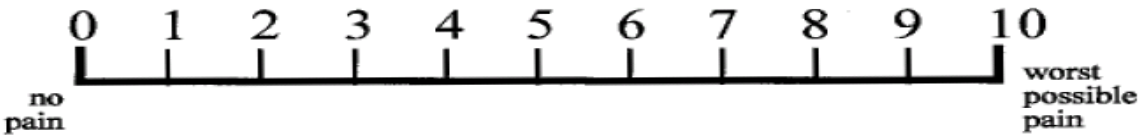
Who referred you to our office?_____
Who is your Primary Care Provider?_____
What problem do you have that brings you to see us today?_____
When did this problem begin, or how long have you had this problem? _____
Is this problem the result of a car accident or injury at work? Yes____No___If Yes please give date and description of accident:_____
What would you like the doctor to do for you today?_____

PAIN, Tingling, or Numbness

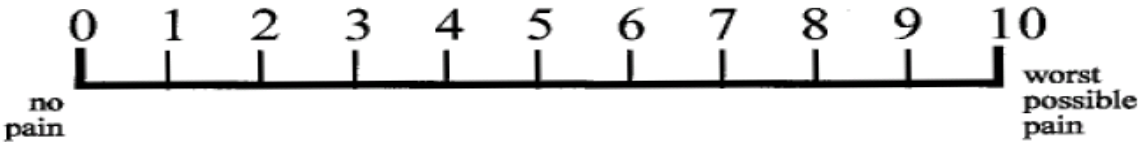
1) Please draw where your symptoms are mostly on the diagram below



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**

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

I don't take any medications routinely ☐

Medication	Dosage	How many times a day?

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
☐ Acid reflux ☐ Asthma ☐ Aneurysm ☐ Bleeding disorder ☐ Cancer (type): _____
☐ Depression ☐ Diabetes ☐ Emphysema / COPD ☐ Fibromyalgia
☐ Heart Disease, if yes, who is your cardiologist?_____
☐ Hepatitis ☐ High cholesterol ☐ Hypertension (high blood pressure) ☐ Hypothyroidism or other abnormalities
☐ Osteoarthritis (degenerative arthritis) ☐ Osteoporosis
☐ Reactions to Anesthesia (please describe) _____ ☐ Rheumatoid Arthritis
☐ Seizures ☐ Stomach ulcers ☐ Stroke ☐ TB ☐ Other medical illness (describe):_____
☐ Other psychiatric illness _____ ☐ Are you on any blood thinners? If so please list:_____
☐ For woman only: ☐ Currently Pregnant? ☐ Post menopausal ☐ Hysterectomy

Please list any other doctors have you seen in the past 3 years?

Name	Reason	Name	Reason

Medication Allergies: Please list medication and the reaction you have when you take it:

☐ I do not have any known allergies to medication.
☐ Penicillin: _____
☐ Codeine: _____
☐ Sulfa: _____
☐ Other: Please list other medications and reactions:
_____

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

Date	Procedure	I have never had surgery ☐

Family History: Please check any medical problems that run in your family.
☐ Bleeding disorder ☐ Stroke ☐ Cancer (type): _____
☐ Diabetes ☐ Emphysema / COPD ☐ Heart Disease ☐ Hypertension (high blood pressure)
☐ 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
Highest level of education (mark only one): ☐ Did not complete high school (HS)
☐ Completed HS ☐ Some college ☐ Bachelor's degree ☐ Advanced degree

☐ **I never smoked cigarettes or used any tobacco products**
☐ I currently smoke cigarettes ☐ < 1/2 a pack per day (PPD) ☐ 1/2 - 1 PPD ☐ 1 - 2 PPD ☐ > 2 PPD
☐ I have smoked for ____ years ☐ I quit smoking (when?) _____ ☐ I chew tobacco ☐ I smoke cigars

I drink alcohol: ☐ often ☐ sometimes ☐ occasionally ☐ rarely ☐ never ☐ I am in recovery from a drinking problem

I currently use or have previously used recreational drugs: ☐ Yes ☐ No ☐ 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.

☐ **I have had none of these problems**

☐ Anxiety or nervousness
☐ Bleeding problems
☐ Blood clots
☐ Bladder problems (increased frequency, urgency, incontinence)
☐ Bowel problems (constipation, incontinence)
☐ Chest pain
☐ Chronic fatigue
☐ Dizziness
☐ Fainting or loss of consciousness
☐ Frequent heartburn
☐ Frequent infections
☐ Frequent or severe headaches
☐ Hearing problems
☐ Kidney problems
☐ Nausea and vomiting
☐ Recent visits to ER
☐ Seizures
☐ Shortness of breath
☐ Trouble urinating
☐ Visual problems
☐ Other _____

_____

Please use the space below to list any additional problems or concerns: