

Today's Date: _____ Patient Name _____ DOB _____ Acct# _____
Age _____ Physician requesting consult _____ Family Physician _____

CHART NOTE (Initial consult, follow-up)
CHIEF COMPLAIN (REASON FOR VISIT)

HISTORY OF PRESENT ILLNESS: DETAILS OF INJURY/ILLNESS

1. Location of pain/symptoms (Circle all that apply) Head Neck Right Arm Left Arm Mid Back Low Back Right Leg Left Leg
2. Quality of pain, condition or symptoms (Circle all that apply) Better Same Worse Electrical Burning Throbbing Constant
3. Severity of pain condition or symptoms (10 being most severe) 10 9 8 7 6 5 4 3 2 1
4. Duration of pain, condition or symptoms Days _____ Months _____ Year _____ **Date of first symptom or injury/accident** _____
5. Timing of pain, condition or symptoms: Check applicable details below:

Did your symptoms or pain start after: A work injury? _____ Auto Accident? _____ Personal injury? _____ Other? _____
6. Context of pain or symptoms (Circle all that apply) WHICH HURTS THE MOST OR HAS THE MOST SYMPTOMS:
Head or neck? Mid back or low back? Right arm or left arm? Right leg or left leg?

7. Modifying Factors: What treatments have you undergone to help modify or alleviate your symptoms? (Circle all below that apply)

- NSAIDS:** Advil Aleve Motrin Nuprin Relafen Tolectin Daypro
Cataflam Indocin Feldene Anaprox Naprosyn Lodine
OPIATES: Codeine Darvocet Lorotab Methadone Percocet Tylenol #3 Tylox
Vicodin Lorcet Talacen Norco Oxycotin Lorcet Plus
VicodinES MS Contin Kadian
MUSCLERELAXANT: Baclofen Flexeril Parafon Forte Robaxin Skelaxin Soma
Valium Norflex Xanax Zanaflex Flexeril
OTHER: Non-NSAIDS-Ultram Steroids- Medrol Zomig Midrin Cafergot Inderal Tegretol Neurontin
Elavil Paxil Prozac Zolof Effexor Trazodone Braces
Corsets Collars TENS unit Vioxx Celebrex Bextra Colchicine
Maxalt Patch Lidoderm Duragesic Pain Clinic/ Name of clinic _____
Dilantin Vicoprofen Axert Lexapro
Steroid injection into muscle/or into spine Spinal facet blocks or facet rhizotomy
Spine Surgery? _____ Evaluation by other Neurosurgeon? _____
Are you on any of the following? **Asprin, Persantine, Plavix, Coumadin, other Nsaid's (Advil, Motrin, ibuprofen), other blood thinner?** _____ **Insulin, Glucophage?** _____

PHYSICAL THERAPY Chiropractic Therapy Aqua Therapy **HOME THERAPY:** Exercise Heat Ice Rest Traction Walking Spine Exercises
OTHER: _____

REVIEW OF SYSTEMS (Circle all that apply)

1. Constitutional Symptoms: (fever weight loss), 2. Eyes- (vision double-vision blurred vision loss of vision in one eye) 3. Ear/Nose/Throat: (hearing smelling swallowing speech problems), 4. Cardiovascular: (chest pain, pain in legs with walking pain in left arm), 5. Respiratory: (breathing coughing blood in sputum), 6. Gastrointestinal: (blood in stool diarrhea), 7. Integumentary: (skin/breast problems), 8. Allergic/immunologic: (allergies), 9. Endocrine: (tunnel vision breast drainage), 10. Hematologic/lymphatic: (HIV AIDS leukemia frequent rare infection), 11. Genitourinary: (urine/sexual dysfunction), 12. Musculoskeletal: (muscle spasms), 13. Neurological: (headaches facial pain vision loss bowel/bladder incontinence pain/numbness/weakness in right/left leg, neck, mid back, or low back pain/tenderness/knot in muscle/trouble walking/inability to walk Cramps seizures face/neck swelling), 14. Psychiatric: (depression anxiety insomnia inability to sleep nervousness 15. All systems reviewed and are negative

Past Medical History

Allergy: _____ **Do you have metal in your body?** _____
Meds: _____ **Do you take Coumadin or Blood Thinner?** _____
Surgeries: _____ **Prior Illnesses/accidents/neck or back injuries in the past** _____

Family History (Circle all that apply) Stroke Cancer Heart Attack Bleeding Diabetes Migraines Aneurysms Polycystic Kidney Marfans
Social History 1. Disabled? Yes No 2. Pregnant? Yes No 3. Breastfeeding? Yes No 4. Overweight? Yes No

5. Current Employment: _____ 6. Type of Work you do _____ 7. Smoking? Yes No
8. Alcohol Yes No Drinks/day for _____ years 9. Level of education _____ 10. Vocational rehabilitation program? Yes No

11. Year/month/date last worked _____
- | | |
|--|--|
| 1. YES NO Do you have any prior pending charges/convictions? | 14. YES NO Ever had a morning eye opener to start your day? |
| 2. YES NO Ever attempted suicide? | 15. YES NO Have you ever sued a health care provider? |
| 3. YES NO Suicidal or planning suicide? | 16. YES NO Have you ever received medications from internet? |
| 4. YES NO Any thoughts of suicide past or present? | 17. YES NO Have you ever used/abused illegal substances? |
| 5. YES NO Ever made plans for suicide? | 18. YES NO Have you ever abused legal substances? |
| 6. YES NO Ever overdosed? | 19. YES NO Have you ever had needle track marks on your skin? |
| 7. YES NO Ever addicted? | 20. YES NO Have you ever been diagnosed with schizophrenia, psychosis, hallucinations, major depression, bipolar, antisocial or borderline personality disorder, hepatitis C, AIDS, liver disease? |
| 8. YES NO Drug treatment, rehab, or detox? | |
| 9. YES NO Drug conviction, indictment, or investigation? | |
| 10. YES NO Ever bought, sold, or abused drugs? | 21. YES NO Has anyone in your family or household had any type of substance abuse or drug problem? |
| 11. YES NO Any recreational drug use? | 22. YES NO Would you ever sue one of our doctors if you felt you had a complication or bad outcome? |
| 12. YES NO Ever felt you should cut down or felt guilty about substance abuse? | |
| 13. YES NO Ever felt annoyed by other's criticism of your substance abuse? | |

23. Explain any of the yes answers above: _____
By signing I certify the information is truthful, if something has not been marked nothing has changed since my initial or last office visit.

Patient Signature _____ **PATIENTS: DO NOT WRITE BELOW THIS LINE- (New Patient Only 3 of 6)** 1. Ht _____ 2. Wt _____ 3. Temp _____ 4. BP _____ 5. Pulse _____ 6. Resp _____

NEUROCRANIAL: 5. General appearance, 6. Ophthalmoscopic examination of optic discs (eg sig, C/D ratio, appearance) and posterior segments (eg vessels changes, exudates, hemorrhages), 7. Examination of carotid arteries-pulse 8. Orientation to person, place and time (eg. oriented x 3), 9. Recent and remote memory (eg. three objects at five minutes), 10. Attention span and concentration, 11. Language (eg. repeating phrases, speech), 12. Fund of knowledge (eg. current President), 13. 2nd cranial nerve (visual acuity, fundi), 14. 3rd, 4th and 6th cranial nerves (eg. +/- ptosis), 15. 5th cranial nerve (eg. facial sensation, corneal reflexes), 16. 7th cranial nerve (eg. facial symmetry), 17. 8th cranial nerve (eg. hearing, whispered voice), 18. 9th cranial nerve (eg. sensation for gag reflex), 19. 11th cranial nerve (eg. shoulder shrug strength, turning head), 20. 12th cranial nerve (eg. tongue protrusion, midline), 21. Examination of sensation (eg. touch, pin, vibration, proprioception), 22. Examination of deep tendon reflexes in upper and lower extremities, 23. Test coordination (eg. finger/nose), 24. Examination of gait and station, 25. Assessment of muscle strength in upper and lower extremities, 26. Assessment of muscle tone in upper and lower extremities (eg flaccid) with note of any atrophy or abnormal movement **NEUROSPINAL:** 27. Head inspection and palpation (tenderness), 28. Neck inspection and palpation (tenderness), 29. Neck range of motion (normal vs. decreased), Neck muscle strength and tone (spasm, atrophy), 30. Spine, thoracolumbar inspection and palpation (misalignment, tenderness), 31. Spine, thoracolumbar range of motion (normal vs. decreased, pain), 32. Spine, thoracolumbar muscle strength and tone (spasm, atrophy), 33. Right lower extremity range of motion (straight leg raising test), 34. Left lower extremity range of motion (straight leg raising test), 35. Right upper extremity range of motion (Spurling's test), 36. Left upper extremity range of motion (Spurling's test), 37. Reflexes with notation of any pathologic reflex (eg. Babinski, clonus), 38. Exam of sensation (eg. touch, pin, proprioception), 39. Mood and affect (eg. depressed, anxious, agitated)

DATA REVIEWED: (eg. X-Ray/CT scan/Myelogram/MRI/Multiple images reviewed, outside studies/reports/referrals)
DIAGNOSES: See dictated note. Functional status and ADL's (Improved, stable)

RISKS/BENEFITS OF SURGICAL & NONSURGICAL OPTIONS were discussed with patient/guardian (& see dictated note)
I have performed and reviewed today's patient and physician information form, initial office visit, and other office chart notes.
RN/LPN/MA Signature (if applicable) _____ Physician Signature _____

PATIENT CONTRACT – CONDITIONS/TERMS FOR TREATMENT

ACCT #: _____

NAME: _____ DOB: _____ AGE: _____ SSN: _____ - _____ - _____ DATE: _____

MAILING ADDRESS: _____ APT # _____ CITY: _____ STATE: _____ ZIP CODE: _____

HM PHONE: () _____ WK PHONE: () _____ CELL PHONE: () _____ EMPLOYED BY: _____

SPOUSE/PARENT (if child) NAME: _____ DOB: _____ SSN: _____ - _____ - _____

ADDRESS IF DIFFERENT: _____ EMPLOYED BY: _____ W K PHONE: () _____

NAME OF HIPAA REPRESENTATIVE: _____ HOME PHONE: () _____

IN CASE OF EMERGENCY PLEASE CONTACT _____ PHONE: () _____

HAVE YOU BEEN IN A MOTOR VEHICLE ACCIDENT, WORKER'S COMP INJURY OR PERSONAL INJURY? YES OR NO, DATE OCCURRED: _____
DO YOU HAVE AN ATTORNEY? YES or NO (SUPPLYING FALSE OR FRAUDULENT INFORMATION MAY RESULT IN DISMISSAL FROM THIS PRACTICE.)

INSURANCE CO #1: _____ POLICY NO: _____ PHONE: () _____

INSURANCE CO #2: _____ POLICY NO: _____ PHONE: () _____

W/C CONTACT _____ (CIRCLE) APPROVED _____ (CIRCLE) DENIED _____

OTHER COMMENTS _____

I agree that I will be seen and examined by Physician Services, PSC staff, LPN's, RN's, and physicians today and will answer all questions truthfully.

Physician Services has agreed to participate with numerous managed care programs. It is extremely difficult for us to keep track of all the individual requirements of the numerous plans. Each one has different policies regarding how often services may be rendered and even more importantly, where those services may be performed. **I agree that if I do not supply copies of all insurance cards and applicable referrals on each visit that may be secondary to motor vehicle, personal injury or workers' comp coverage, I will be responsible for all charges in full that are not covered by the liability carrier.** Providing quality medical care to our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at EACH time of service exactly what those guidelines are. You may need to contact your carrier (customer service number is usually on the back of the card) and ask for this information. We are unable to do this for you. If you do not inform us of any kind of special requirement in your contract and we subsequently order services, i.e.; lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. You will be responsible for those charges. With your cooperation and help, you should be able to receive all of the benefits offered to you and we will be able to concentrate on caring for your medical needs.

The initial visit ranges in price from \$195 to \$450 Follow-up visits range from \$90 to \$235. I understand that if I am seen via TELEHEALTH there will be an additional \$25.00 charge for the audio visual transmission fee. UDT and BAT charges range from \$250-\$350. Forms are \$60 per page and narrative reports are \$600 and both must be prepaid. P3 Testing is \$350.00. MRI Scans range in price from \$2425 to \$5375 per scan. **I understand that I have a choice regarding orthotics suppliers, diagnostic imaging centers, lab testing centers, physical therapy centers, pharmacies, psychologist, psychiatrist, MRI centers, urine drug testing, hospitals, physicians, etc. regarding my care.** I agree that only formulary medications will be prescribed to provide cost effective quality care.

I understand my insurance will be billed as a courtesy to me. If my insurance does not pay within 45 days, I will be responsible for the bill in full. You are responsible for any co-payment or amount that is not paid by insurance within 45 days. I understand interest at the rate of 1.5% compounded monthly will be added to my account on any balance over 45 days and I will also be responsible for all interest charges on my account. **I will also be responsible for collection fees not exceeding fifty (50%) per cent of the account balance, interest fees, attorney's fees, and all court costs incurred to collect my balance.** If I am involved in litigation regarding a motor vehicle accident, personal injury, Worker's Compensation injury, I authorize Physician Services, PSC to intervene in the litigation to collect any monies owed for medical services related to my injury. I authorized release of my PIP log to Physician Services, PSC.

I hereby authorize the Physician Services, PSC to furnish any information concerning my illness to my insurance carrier(s) and my attorney. I authorize payment for medical services to go directly to the physician. I understand that I am responsible for paying any amount not covered by my insurance. I understand that if my treatment is for a non-work related injury or I seek treatment out of network, I will be responsible for the bill in full. I understand and agree that Physician Services, PSC does not issue refunds to patients that receive backdated or spend down Medicaid cards. Physician Services, PSC accepts Medicaid insurance cards and submits claims on my behalf for dates of service on and after presentation of the medical card. I authorize release of my past, present, and future medical records (including drug, alcohol, behavioral health) from all and any health care providers to and from Physician Services, PSC or any surgical assistant or their employer. I will authorize Physician Services, PSC to obtain narcotic profile and authorize release of past, present, and future profiles. I authorize the release and use of my medical records for the purpose of advancing medical knowledge. I understand that if my condition worsens or fails to improve, I am to return to the office or go to the emergency room immediately. I authorize my free copy(s) of medical records to go to the medical provider that sent me here as well as with my bill to the insurance company. I understand that receiving controlled substances from more than one doctor is a felony. I understand that no diagnosis or treatment can be done by phone.

I have read and understand the above statement regarding office policy and procedures and consent for Physician Services, PSC. I understand that I personally will be responsible for any amount not covered by my insurance; i.e., P3's, physical therapy, MRI, pain procedure, surgery, etc. I further certify that if I am unable to read or write that the witness below has explained this form to my satisfaction. I also give full consent to be treated by physicians and staff of Physician Services, PSC and understand that no guarantees have been made regarding outcome. Noncompliance, such as missing appointments, rude behavior, not following physician orders may result in patient being released from this practice. I understand that doctors seek to deliver good care and if I have any questions or problems whatsoever a separate office visit and conference may be scheduled with office manager and doctors. I understand if I allow other people to accompany me to my office visit, I give consent for them to hear my personal health information. If I have a complaint, I will leave complaint in writing today with office manager.

I understand that many times there will be long delays before being seeing a physician. I understand I may wait up to 4 to 8 hours and then have the appointment canceled. I understand that office appointments are for nonemergent problems and agree to hold Physician Services and staff harmless for any delays. I understand I may seek treatment elsewhere at any time with other medical practices. I certify that I have not provided false information on the in-take form, to referring physicians, or seeking care under false pretense. I agree to obtain a second opinion before initiating treatment.

I understand that it may be necessary to be referred for outside services as a result of the information obtained from my P3. Should this occur, I will be notified by mail of the location and date of my appointment. If I am unable to keep this appointment, it will be my responsibility to reschedule. Failure to reschedule could result in my release as a patient from Spine and Brain Neurosurgical Center. I understand that non surgical and surgical treatments have risks up to and including death.

ATTENTION SSI AND MEDICAID RECIPIENTS - PLEASE BE ADVISED, IF YOU ARE AN SSI OR A MEDICAID RECIPIENT, THE INFORMATION REGARDING THE PATIENT'S RESPONSIBILITY FOR PAYMENT OF SERVICES CONTAINED IN THE ABOVE AGREEMENT DOES NOT APPLY TO YOU. NO REFUND WILL BE PROCESSED AFTER PATIENT HAS SEEN THE PHYSICIAN/NURSE/MEDICAL ASSISTANT/STAFF.

Patient signature
PHARMACY PHONE NUMBER _____

Witness
PHARMACY FAX # _____

Date

RN/LPN/MA Signature (if applicable)

Physician Signature

Revised 070908