LIBERTY SPINE CARE

King of Prussia Office: Merion Building | 700 S Henderson Rd, Suite 110 | KoP, PA 19406
Sewell Office: 556 Egg Harbor Rd | RFB Surgical Plus, Suite A | Sewell, NJ 08080

Office Phone: 610-265-5795 | **Fax:** 610-992-9022

**Referring DR: ______

**Primary Care DR: ______

PERSONAL INFORMATION

1 Patient information

Today's Date ______

Last Name ______ First Name ______ MI ______

Address ______

City ______ State ______ Zip ______

Personal Phone # ______ Work Phone # ______

Email ______

Social Security # ______ Medicare # ______

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth (M/D/Y) ______ Age ______

Ethnicity ______ Sex (M/F) ______

Occupation (If retired, list prior occupation) ______

______

Employer's Address ______

City ______ State ______ Zip ______

Emergency Contact ______ Telephone # ______

Name of Personal Doctor ______

City ______ State ______

2 Person responsible for payment

(Leave blank if same as patient)

Last Name ______ First Name ______ MI ______

Address ______

City ______ State ______ Zip ______

Personal Phone # ______ Work Phone # ______

Social Security # ______

Date of Birth (M/D/Y) ______ Age ______ Sex (M/F) ______

Occupation (If retired, list prior occupation) ______

______

Employer's Address ______

City ______ State ______ Zip ______

3 How did you hear of us?

☐ Friend/Relative ☐ Newspaper/Magazine ☐ Yellow pages ☐ Internet ☐ Insurance directory ☐ Referral - Dr. name ______

4 Insurance information

Primary Insurance ______

Policy # ______ Group # ______

Claims Address ______

City ______ State ______ Zip ______

Insurance Telephone # ______

Name of Policy Holder ______

Secondary Insurance ______

Policy # ______ Group # ______

Claims Address ______

City ______ State ______ Zip ______

Insurance Telephone # ______

Name of Policy Holder ______

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If applicable, WORK-RELATED INJURY REPORT FORM

1 Universal injury or accident statement

Last Name ____________________ First Name ____________________ MI ______ Today's Date ____________

Please complete the following statement. Most insurance companies request accident details and this may be forwarded with your insurance claim or provided to an adjuster to complete your claim. Please complete the sections that apply to your injury and sign at the bottom of the form.

Dateofinjury ____________________

Place where injury occurred (work, home, parking lot, car, friend's house, etc.) ____________________

2 Please describe how the injury or accident occurred

____

____

____

3 Work related injury

Was the injury work related? ☐ Yes ☐ No (If yes, complete this section)

Name of Employer ____________________

Telephone # ____________________

Employer's Address ____________________

City ____________ State ______ Zip ______

Workman's Compensation Carrier ____________________

Policy # ____________ Group # ____________

Claims Address ____________________

City ____________ State ______ Zip ______

4 Third party liability settlement

Is there a possible third party liability settlement? (e.g., auto, homeowners, property)

☐ Yes ☐ No (If yes, complete this section)

Name of Insurance ____________________

Telephone # ____________________

Adjuster's Name (if known) ____________________

Telephone # ____________________

5 Authorization

I certify that this information is true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury and the nature of the treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a "non-covered" service and may make me personally liable for the medical charges incurred.

Patient Name (or signature of responsible party) ____________________ Today's Date ____________

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YOUR MEDICAL HISTORY page 1

1 Patient info

Name ______________________

Height ______________ Weight ______________

Right or Left Handed ______________________

2 Your symptoms

Are your symptoms mostly in back, neck or elsewhere? ______________________

How long have you had these symptoms?

☐ ≤ 6 weeks ☐ ≥ 7 - 12 weeks ☐ 4 months or more

Do you have pain radiating past your knee or elbow? ☐ Yes ☐ No

Does your leg or arm ever go numb? ☐ Yes ☐ No

Have you lost bowel or bladder control? ☐ Yes ☐ No

The pain is: ☐ Constant ☐ It comes & goes

Does your pain wake you up at night? ☐ Yes ☐ No

What things makes the pain better? (rest, ice, heat, pills) ______________________

What makes the pain worse? (sitting, standing, lifting) ______________________

Do you have pain that radiates into the arm or leg? ☐ Yes ☐ No

(If yes, describe) ______________________

Lost any control over bowel or bladder functions? ☐ Yes ☐ No

(If yes, describe) ______________________

Any weakness or numbness in an arm or leg? ☐ Yes ☐ No

(If yes, describe) ______________________

How long can you: ________ Sit ________ Stand ________ Walk

Is your pain the result of a: ☐ Work Injury ☐ Auto accident

☐ Other (list) ______________________

3 Current status

Is there a law suit pending on problem? ☐ Yes ☐ No

Which of the following describes you currently?

☐ Working; if yes: ☐ Full duties ☐ Limited

☐ Not working because of back or neck problem

☐ Not working because of another health problem

☐ Homemaker, retired or unemployed

How long have you been at that job? ______________________

Does your job require lifting, standing, sitting? ☐ Yes ☐ No

Employer at time of injury ______________________

4 Previous treatments and tests

Name of the doctor that treated you FIRST for this problem and the city. ______________________

Have you seen a spine surgeon in the past? ☐ Yes ☐ No If **YES**, please provide the name of the surgeon______________________

What treatments did you have? ______________________

Have you ever been hospitalized? Explain: ______________________

What tests have you had? ☐ CT scan ☐ MRI ☐ X-ray ☐ EMG

☐ Other (list) ______________________

Did you have any injections for your problem? ☐ Yes ☐ No

(If yes, describe) ______________________

Did these injections help? ☐ Yes ☐ No

(If yes, describe) ______________________

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YOUR MEDICAL HISTORY page 2

5 Previous treatments & tests

Did you have previous back or neck surgery? ☐ Yes ☐ No
(If yes, describe) ______

List any other PREVIOUS SURGERIES you had, and dates: ______

Have you ever had a blood transfusion? ☐ Yes ☐ No
(If yes, describe) ______

Did you have physical therapy before for your problem? ☐ Yes ☐ No
(If yes, describe) ______

Did this therapy help? ☐ Yes ☐ No
(If yes, describe) ______

Do you do any special exercises for your back or neck? ☐ Yes ☐ No
(If yes, describe) ______

List any medications you are taking: ______

What other medications have you tried? ______

What do you hope we can accomplish today? ______

What other concerns do you have? ______

6 Your health

List any ALLERGIES you have to medications, foods, etc. ______

Do you have any adverse reactions to anesthesia? ☐ Yes ☐ No
(If yes, describe) ______

Do you smoke? ☐ Yes ☐ No (If yes, how many packs a day?) ______

Do you drink alcohol? ☐ Yes ☐ No (If yes, how many days a week?) ______

Have you had problems with drugs? Please explain. ______

Do you have any of the following medical problems:

AIDS/HIV	☐ Yes ☐ No	Nerve problems	☐ Yes ☐ No
Arthritis or joint pain	☐ Yes ☐ No	Psychiatric problems	☐ Yes ☐ No
Bleeding disorders	☐ Yes ☐ No	Stomach problems	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Anxiety/Depression	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Recently, have you had...	
Heart problems	☐ Yes ☐ No	Fever or chills	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Weight loss	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No	Chest pain	☐ Yes ☐ No
Migraines/headaches	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Muscle diseases	☐ Yes ☐ No	Worse pain at night	☐ Yes ☐ No
Swollen ankles	☐ Yes ☐ No	Night sweats	☐ Yes ☐ No

Other problems: ______

7 Your family history

Do any family members have a history of:

Back/neck problems	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Arthritis or joint pain	☐ Yes ☐ No	Migraines/headaches	☐ Yes ☐ No
Bleeding disorders	☐ Yes ☐ No	Muscle diseases	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Nerve problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric problems	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Stomach problems	☐ Yes ☐ No
Heart problems	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No

Other problems? ______

Is your Mother Living or Deceased? (Please circle one)
Is your Father Living or Deceased? (Please circle one)

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CONSENT FORM

1 Financial agreement

I hereby give authorization for payment of insurance benefits to be made directly to the provider and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Insurance authorization must be obtained before a patient is seen. If I do not inform the physicians seen in this clinic of my current insurance and the insurance is denied because of no authorization, I will be responsible for payment. If authorization is not obtained from the insurance company before my scheduled appointment and I still choose to see the doctor, I will be responsible for the bill at the time of service.

Patient Name ____________________

Signature of responsible party ____________________

Today's Date ____________________

2 Consent for minor

I grant the physicians associated with the practice the authority to administer treatments and perform such procedures as may be deemed necessary for the patient.

Signature ____________________ Date __________

Relationship to patient ____________________

3 Notice of privacy practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area. I will be offered a copy of any amended Notice or Privacy Practices.

Signature ____________________ Date __________

If not signed by the patient, please indicate the relationship between the signee and the patient:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

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PRIVACY NOTICE | YOUR PERSONAL HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully. We understand that the privacy of your personal information is important to you. As your physician, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to ask us. We need to collect personal information about you and your family as part of our registration process, during the course of your care, and from other health care entities you utilize such as hospitals, laboratories, other physicians, imaging facilities and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide via our website. During the course of your treatment we will collect health information regarding diagnosis, treatment plans, progress and any test results or films.

HOW YOUR INFORMATION IS USED

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. We do not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment alternatives or other health related-benefits and services that may be of interest to you.

SAFEGUARDING YOUR PERSONAL AND HEALTH INFORMATION

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you. We maintain physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have that right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment. You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

I have received a copy of this Privacy Policy.

Patient Name (printed): ______________________ Signature: ______________________ Date: __________

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OUR PAIN MEDICATION POLICY

In the course of your treatment, you may receive pain medications. However, all physicians are required by federal law to follow stringent policies related to the use of prescription drugs, especially narcotics.

Consequently, all patients need to make arrangements to obtain any necessary prescription refills prior to the weekend. We will not provide pain prescriptions or pain prescription refills during the weekend which begins each Friday at noon and ends the following Monday at 8:30 a.m.

The goal of our spine center is to help patients become less dependent on pain medications. Consequently, our policy is to NOT provide prescription refills by phone. So you may need to see the physician or the physician assistant to make these arrangements. Please call at least four days prior to your last dose. This will assure the most prompt response to your request. Do not wait until the day your medication runs out. Our clinical staff needs sufficient time to review your request for refill.

URINE DRUG SCREENS

This office will obtain urine drug screens at initial office visit and follow up visits as deemed medically necessary at the providers discretion.

USE ONE PHARMACY

Using the same pharmacy helps assure that the pharmacy will stock your medication for refills and that the pharmacy will know that you have a legitimate need for pain medication. Consequently, it is in your best interest to use only ONE pharmacy for refills of your pain medication.

PROTECT YOUR MEDICATION FROM LOSS

You are personally responsible for the safekeeping of your medication. Please do not sell, trade or give it away. If your medication is damaged, stolen or lost you must notify us right away.

Please do not seek pain medication from any other doctor unless approved by our clinical staff. Let us know if at any time another doctor prescribes medication for you.

The above restrictions apply a variety of prescription drugs, including, but not limited to:

1. Narcotics. (Example include, Vicodin, Percocet, Oxycontin & Codeine)
2. Non-Steroidal Anti-Inflammatory drugs, "NSAIDS". (Example include, Motrin, Celebrexx & Naprosyn)
3. Non-narcotic and other Pain Medicine. (Example include, Ultram or Darvocet)
4. Muscle Relaxants. (Example include, Flexeril or Soma)

Permission is granted for this provider to view my prescription history from external sources. Please sign and print name below.

Date____________________ **Signature** ____

Print Name ____

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VA/DoD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain
Appendix C: Agreement

1. I understand that my provider and I will work together to find the most appropriate treatment for my chronic pain. I understand that the goal of treatment are not to completely eliminate pain but to partially relieve my pain in order to improve my ability to function. Chronic opioid therapy is only ONE part of my overall pain management plan.
2. I understand that my provider and I will continually evaluate the effect of opioids on achieving the treatment goals and make changes as needed. I agree to take the medication at the dose and frequency prescribed by my provider. I agree not to increase the dose of opioids on my own and understand that doing so may lead to the treatment with opioids being stopped.
3. I understand that the common adverse effects of opioid therapy include constipation, nausea, sweating and itchiness of the skin. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.
4. I will not seek opioid medications from another physician. Regular follow-up care is required and only my provider will prescribe these medications for me at scheduled appointments.
5. I will attend all appointments, treatments and consolations as required by my providers. I will attend all pain appointments and follow pain management recommendations.
6. I will not give or sell my medication to anyone else, including family members; nor will I accept any opioid medication from anyone else. I agree to be responsible for the secure storage of my medication at an times. If these medications are stolen, I will report this to the police and my provider and I will produce a police report of this event.
7. I understand that if my prescription runs out early for any reason (for example, If I lose the medication or take more than prescribed}, my provider will not prescribe extra medication for me. I will have to wail until the next prescription is due.
8. I understand that the use of other medications can cause adverse effects or interfere with opioid therapy, Therefore, I agree to notify that if necessary I will notify my provider of the use of all substances, including marijuana, alcohol, tranquilizers and all illicit drugs.
9. I agree to periodic unscheduled drug screens.
10. I understand that I may become dependent on opioid medications, which in a small number of patients may lead to addiction; I agree that if necessary, I will permit referral to addiction specialists as a condition of my treatment plan.
11. I understand that my failure to meet these requirements may result in my provider choosing to stop writing opioid prescriptions for me. Withdrawal from the medications will be coordinated by the provider and may require specialist referrals.
12. I hereby agree that my provider has the authority to discuss my pain management with other health care professionals and my family members when it is deemed medically necessary in the provider's judgment.

Please date, sign and print name below.

Date______________________ **Patient Signature** ______________________________________

Print Name ____